Agenda Item: Trust Board Paper E

TRUST BOARD – 22 DECEMBER 2014

Emergency Care Performance Report and Response to the Sturgess Report

DIRECTOR:	Richard Mitchell , Chief Operating Officer
AUTHOR:	Richard Mitchell and John Adler
DATE:	14th December, 2014
PURPOSE:	a) To update the Board on recent emergency care performance b) To present the Sturgess Report and the Health Economy's response to that report c) To present the new system-wide Operational Plan and the UHL plan within that d) To report on new enhanced programme management arrangements across the system and within UHL.
PREVIOUSLY CONSIDERED BY:	Emergency Quality Steering Group, Urgent Care Board and System Resilience Group
Objective(s) to which issue relates *	[ ] 1. Safe, high quality, patient-centred healthcare [x] 2. An effective, joined up emergency care system [ ] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [ ] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [ ] 5. Enhanced reputation in research, innovation and clinical education [ ] 6. Delivering services through a caring, professional, passionate and valued workforce [ ] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	Healthwatch representatives on UCB and involved in BCT workstream.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	None undertaken but will be in respect of new pathways within BCT.
Organisational Risk Register/ Board Assurance Framework *	[ ] **Organisational Risk Register** [x] **Board Assurance Framework** [ ] **Not Featured**

ACTION REQUIRED *					
For decision	x	For assurance		For information	

♦ **We treat people how we would like to be treated** ♦ **We do what we say we are going to do**
♦ **We focus on what matters most** ♦ **We are one team and we are best when we work together**♦ **We are passionate and creative in our work*** tick applicable box

REPORT TO:	**Trust Board**
REPORT FROM:	**Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT:	**Emergency Care Performance Report**
REPORT DATE:	**22 December 2014**

Introduction

- Performance in November 2014 was **89.1%** compared to **88.5%** in November 2013 and **90.3%** in October 2014. November 2014 was the first month in six where performance dropped below 90%.
- December 2014, month to date (11/12/14) is **85.1%**.
- Emergency admissions (adult) continue to steadily rise in November; **216** compared to **215** per day in October and **209** per day the month before.
- Emergency admissions in November 2013 were 193 per day (**now 11.9% higher**).
- Delayed transfers of care have risen recently and are at **5.7%.**

Performance overview
Performance has got worse over the last two months. As stated in the board report last month this is a result of a perfect storm of more medical emergency patients admitted, a lack of capacity outside of UHL for these patients to transfer to and internal process failing at times of extreme pressure. Over the last month, UHL has gone onto an internal major incident (IMI) on four occassions. The response to an IMI is; greater speciality input into ED, an increased focus on discharges across all specialities and improved inreach from community partners. The last IMI was on Tuesday 9 December 2014. GPs from West Leicestershire CCG and East Leicestershire and Rutland CCG came into UHL and took part in the incident response, assisting in increasing the discharge rate. Feedback from GP colleagues was encouraging in terms of the high level of internal engagement in addressing the issues faced.

On 11th December, a formal meeting was held between health economy partners and the NHS Trust Development Authority and NHS England. This reflects a high level of ongoing concern about local performance. The meeting reviewed the new action plan prepared in response to the Sturgess Report (see below). The approach being taken was generally endorsed, with particular emphasis being given to:

- Reducing emergency admissions through effective review of GP referrals by both primary and secondary care
- Alternative approaches to hospital conveyance by EMAS
- More effective surge and recovery response across the whole system
- More focus within UHL on morning and weekend discharges (to maintain flow)
- More effective programme management across the system

Actions are being put in place to pursue or enhance these key points before Christmas.

Sturgess report
Dr Ian Sturgess, an expert in emergency care pathways, was commissioned by East Leicestershire and Rutland, Leicester City and West Leicestershire Clinical Commissioning Groups and University Hospitals of Leicester NHS Trust to provide recommendations on how the emergency pathway can improve. The review was conducted between mid-May 2014 and mid-November 2014 and Dr Sturgess spent time with clinicians and staff in primary care, acute and community hospitals, mental health services, NHS 111 and out of hours care, urgent care centres and social care teams.

System wide recommendations
Dr Sturgess found that the local system is ‘relatively fragmented with barriers to effective integrated working’. He stressed the importance of recognising performance against the national 4-hour wait

standard for the Emergency Department as a reflection of the performance of the whole health and care system and he made 183 recommendations for transformation and improvement. His full report is attached as Appendix 1.

The recommendations focus on issues relating to the following themes:

- **Admission avoidance** – ensuring people receive care in the setting best suited to their needs rather than the Emergency Department.
- **Preventative care** – putting more emphasis on helping people to stay well with particular support to those with known long-term conditions or complex needs.
- **Improving processes within Leicester's Hospitals** – improving the Emergency Department and patient flow within the hospitals to improve patient experience and ensure there is capacity in all areas.
- **Discharge processes across whole system** - ensuring there are simple discharge pathways with swift and efficient transfers of care

A number of Dr Sturgess' recommendations relate to longer term transformation and some improvements are already underway or in development as part of the Better Care Together programme. The recommendations were collated into one document and have been considered in detail by all organisations. In some instances the recommendations have not been wholly accepted but alternative interpretations or recommendations have been considered. Each recommendation has then been ranked on the basis of its impact and how quickly it can be implemented, using a scale of of 1 to 4.

The most urgent, highest impact actions in the Sturgess Report form a new 'LLR operational winter urgent care action plan' (Appendix 2) aligned to outcome measures and metrics to monitor integrated process as recommended within the report. This plan focuses on actions over this winter. The Urgent Care Board will closely track the progress of this plan to ensure that actions and outcomes are aligned and resilient across the urgent care pathway as well as within the clinical pathways. Substantially strengthened programme management arrangements are being put in place to ensure that this is the case. This has been an area of acknowledged weakness in the past. As part of these changes, Toby sanders, Managing Director of West Leicestershire CCG has taken over the chair of the Urgent Care Board.

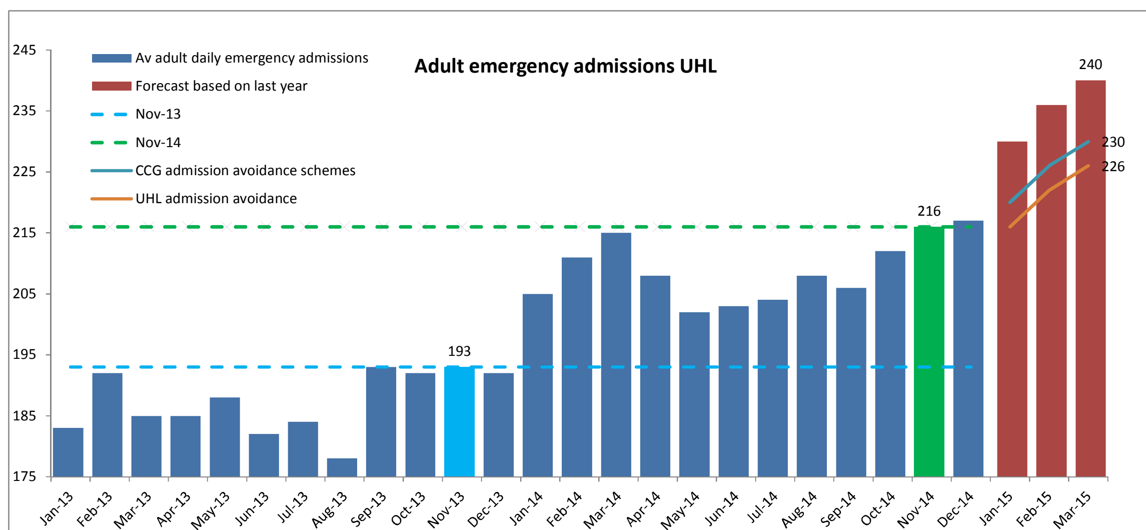
UHL recommendations

Dr Sturgess spent a lot of time at the beginning of his review in UHL and we have therefore had more time to respond to his recommendations. As part of developing the new action plan we have revisted our approach to organising for this sustantial body of work. As a result, we are now working with a small team from Ernst Young to support the project management of our actions and formal programme management arrangements have been put in place. We are focussing on three main workstreams; ED, AMU and base wards and discharge with other secondary workstreams focussing on CDU and Glenfield, surgery, oncology and imaging. These workstreams report into the weekly emergency quality steering group meeting chaired by the Chief Executive. The UHL actions that we are managing form part of the LLR plan at Appendix 2. This arrangement will substantially improve the integration of our actions with those of the wider system.

Conclusion

To achieve sustainable improvement requires all parts of the health economy to improve. The fragile nature of the pathway means that slow adoption of improvements in one part of the health economy will hinder the overall improvement. We need to be ambitious for the level of improvement we require of each other and this is the intention of the new Operational Plan and its supporting arrangements.

The graph below details the average adult emergency admissions at UHL. In November 2013 193 patients were admitted per day and this has risen to 216 in November 2014. If admissions rise at the same rate as last year, this will be 240 admissions per day in March 2015.



It should be noted that the deficit of mitigating actions against the above trend is not as great as it appears as there are are some data artefacts in the headline trend. This means that the “real” rise in emergency admissions is not as great as it appears to be, but it is nevertheless significant and above the level that can be accommodated. We must therefore set challenging expectations for all parts of the health economy (including UHL) and work to ensure these expectations are rapidly met.

Recommendations

The Trust Board is recommended to:

- **Note** the contents of the report
- **Note** the contents of the Sturgess report and to confirm that the system wide action plan appropriately addresses the report’s recommendations
- **Request** monthly updates against the delivery of the new operational plan, including the UHL element
- **Support** the actions being taken to improve performance

Appendix 1

Dr Ian Sturgess
IMP Healthcare Consultancy
14th November 2014

Dr Dave Briggs
Managing Director
East Leicestershire and Rutland CCG

Toby Sanders
Managing Director
West Leicester CCG

Sue Lock
Managing Director
Leicester City CCG

John Adler
Chief Executive
University Hospitals of Leicester

Dear all

Re: Feedback Report on the Urgent Care Pathway in LLR.

'Every system is perfectly designed to deliver the results it achieves'

Executive Summary of Key Recommendations

The Leicester, Leicestershire and Rutland (LLR) health and social care system has, for a number of years, faced challenges in the resilient delivery of urgent and emergency care for its population. To improve, the LLR health and social care system will need to focus on collaborative and integrated working to achieve patient, system and population outcome benefits. This is not just about delivering the 4 hour standard, this is about improving patient outcomes based around the 'domains of quality', that is, it is not about 'hitting a target but missing the point'.

There has been some early improvement seen within University Hospitals Leicester (UHL), however, this has not been matched by the rest of the system. The risk is that 'local optimisation' by improving processes solely within UHL will create a 'supply side driver' increasing activity flowing to the acute sector. The 4 hour Emergency Care Standard happens to be measured within the Emergency Department, yet it is best to consider this 'performance measure' as a measure of resilience of the whole health and social system in how that system responds to urgent care needs within the community. If there is ineffective 'demand management' and poor flow through the system with multiple 'hand offs' and 'barriers' to transitions of care, then a queue is guaranteed within the ED, that is the system has been 'perfectly designed' to deliver that queue.

The system within LLR is relatively fragmented with barriers to effective integrated working. The development of a clear vision of a high quality responsive urgent and emergency care system which is clinically owned and well communicated across the

system is crucial to support the drive for improvement. The summary recommendations below are not to be seen as a series of quick fixes but as a series of improvements to the system focussing on impact and outcomes rather than a set of 'activities'. The implementation of these processes are to be seen as a part of a 'whole system change' rather than 'pilots' and require effective change management.

With this 6 month independent assessment and an appraisal of the whole system, along with the openness of discussions and responses, there is a clear demonstration of a desire to change with commitment from system leaders.

The system needs to consider the following guiding principles in the transformation of urgent and emergency care:

- Anticipatory care for people with long term conditions and/or frailty needs to be planned and implemented in a timely manner to avoid a minor acute illness becoming a crisis.
- When this group of patients access urgent care services, this provides an opportunity to examine the extent of integration of a system to respond to their needs.
- Acute admission to hospital should only occur if there is an evidence based acute intervention that can only be delivered in hospital. Otherwise, the timely delivery of interventions and care should be provided in the community to avoid unplanned default attendance at Hospital.
- If emergency admission to hospital does occur, then the 'home first' principle applies. Namely, that if someone is admitted to hospital and after necessary interventions and treatment, the system's primary aim will be to return that person to the home address from which they came. If there is a need for on-going assessments around decisions for further care, these take place within the persons 'usual environment' where they are likely to function at their best. This is to avoid 'crisis' decision making about the long term care from a 'hospital bed'.
- A recognition that remaining in Hospital when there is no longer any 'acute' need to remain in Hospital, in particular, for people with frailty risks the development of de-conditioning, which can worsen outcomes.
- There is a need to ensure the application of known effective improvement methodology and organisational change methodology in particular with reference to large scale change (http://www.nhsiq.nhs.uk/8530.aspx).

There are a considerable number of recommendations within this report and summarised here are the key priorities for the system to commence work on immediately to start to gain some traction within the system. So far, admission/attendance avoidance schemes have not delivered sufficiently and are not being rigorously performance managed.

1. Relatively Simple Immediate Individual Organisation/Bilateral Actions

a. Delivering the full potential of ambulatory emergency care as described in the Directory of Ambulatory Emergency Care for Adults. As described in the NHS England Operational and Resilience Plan 2014/15, AEC should be considered the default position.
b. Community Hospital transfers back to UHL. Patients to be seen and examined by Out of Hours service with discussion with on-call Consultant

Geriatrician/Physician or relevant specialty Consultant for treatment advice aiming for a 60-80% reduction in 're-presentation' to acute sector. This requires all patients transferred to Community Hospitals to have an expected date of discharge and criteria for discharge on transfer, the transfer of the Patient records with the patient (or a copy thereof) and seamless continuation of rehabilitation from the plan set prior to transfer.

c. Appropriate category calls conveyed by East Midlands Ambulance Service (EMAS) to the Loughborough Urgent Care Centre (UCC). This can be through a design of a set of simple rules which both parties follow.
d. Simplify referral to Community services with a 'referrer decides' with same day access, this could be rapidly facilitated via the 'frailty' team approach, see below. Rapidly improve Single Point of Access (SPA) response times to accommodate demand.
e. Simplify the equipment ordering contract with the provider to allow any member of the Inter-disciplinary team (IDT) to order appropriate equipment.
f. Leicestershire Partnership Trust (LPT) to minimise unscheduled episodes from planned care impinging on the unscheduled care/ICS team by improving 'anticipatory care' of planned care. Aim to significantly increase (50-100%) flow through the 'virtual ward' with a 30/70 or 40/60 split between admission avoidance and early supported discharge
g. Merge 'front door' streaming between UCC and the Emergency Department (ED) at the Leicester Royal Infirmary (LRI) at the 'Minors Desk'. Streaming to appropriate clinical teams with both delivering 'see and treat' model of care. Aiming for 80-90% completed care within 2 hours. Commission the Out-of-Hours service (OOH) to provide mutual aid to UCC both at LRI and at Loughborough, the latter can be implemented by unifying the contract.
h. Implement GP to Consultant (0800 to 2100 hrs) telephone discussions for all but immediate life threatening referrals for acute assessments with the availability of alternative non-admitted pathways (same/next day rapid access clinics, community provision, advice etc.)
i. At UHL, admitting Consultant presence matched to the patient arrival profile, for example the Consultant Physicians covering the assessment units until 2300hrs.
j. Continuity of care for patients who remain on the assessment units/short stay for the first 24 hours. This requires the evening Consultant Physician to review those patients that remain on the Assessment Units or Short Stay at 0800 hrs the next morning.
k. Every admitted patient having an expected date of discharge and clinical criteria for discharge set and owned by the clinical teams within 12-24 hrs as a maximum.
l. Daily Consultant led assertive Board rounding and one stop ward rounding on all acute wards. The aim being to progress case management and to identify and deal with any constraints to flow. This includes an 0800 hrs start to 'capture' new patients and facilitate early discharge in preparation for the 0900 Board Round.

m. Peer to Peer review of patients with ‘trigger’ length of stay. The trigger points require internal definition and this is necessary within both UHL and Community Hospitals.

2. Immediate Interventions Requiring Multi-agency Actions

a. ‘Front Door’ frailty team. Aiming to capture **all** patients with frailty and thus at risk of a long length of stay. This team then tracks these patients through their journey aiming to achieve optimal early transfer of care. Availability determined by demand profile of arrivals of target population. The aim is ‘transfer of care’ home as soon as stable for transfer to avoid in-hospital deconditioning. The transfer of care process will require same day transfer to community based services. The metric for success is a significant reduction in the number of beds occupied by patients aged 65 and over who have been in hospital 10 days or more. Effective interface management across the system minimises the risk of re-admission.

b. Simplification and standardisation of the processes around transfer of care with a move to ‘needs assessment’ and funding decisions around Care Act 2014 eligibility criteria taking place in the patient’s own home. That is home based ‘discharge to assess’ rather than the ‘completion’ of these assessments in Hospital. This process to include assessments for NHS Continuing Care.

c. Care Home urgent and emergency care responses. The default will be to ensure that all residents have advanced care plans, which describe the actions to be initiated for acute exacerbations of long term conditions with the aim that the care goes to the resident. Telemedicine options, for example from Airedale, have resulted in an over 50% reduction in ED attendances with high satisfaction rates.

3. Complex Changes Requiring Planning and Implementation

a. Formation of federation of Primary Care Practices with stream management. Consider configuration may be different for the City versus the County with alignment with Community services in the former and with both Community and Acute in the latter.

b. Development of robust ‘registers’ of people with long term conditions and/or frailty with realisable anticipatory care plans which clearly identify the response needed for predictable urgent care scenarios.

c. Commission a more integrated liaison mental health service avoiding unnecessary stays in the acute hospital sector.

d. Invest in developing an improvement expertise across the system. There is an opportunity to link with NHS Improving Quality, the Universities and regional and national industries with expertise in quality improvement to build a ‘Leicester Improvement Academy’. This would aim to build improvement methodology skills amongst health and social care staff as well as equipping graduates in health and social care with these skills for the future.

Introduction

IMP Healthcare Consultancy was commissioned by the three CCGs and UHL to provide feedback and support on improvement of the urgent and emergency care system from mid May 2014 to mid November 2014. The aim of this report is to stimulate a system that has the potential to be a 'high performing health and social care system'. The risk is that the observations and comments contained herein could be used to create a 'finger pointing and blaming culture' across the system. The opportunity lies 'between the heads' of the leadership of the system to use this report to stimulate a progressive, outcomes focussed quality improvement programme for the urgent and emergency care system within Leicester, Leicestershire and Rutland (LLR). System leaders will need to promote collaboration, vision, communication, enablement of improvement and supporting ideas from the 'grass roots'. The improvements will be about the 'many not the few' with a focus on a 'new future' that is so compelling that engagement will continuously grow.

The LLR system has faced challenges across the urgent and emergency care pathway for some considerable time. The LLR urgent and emergency care pathway lacks cohesion with multiple re-assessments, limited effective exchange of clinical information and patients becoming stuck during parts of their journey through the system resulting in avoidable harm and potential avoidable mortality. 'Good systems' recognise the potential for avoidable harm and mortality whilst 'poor systems' attempt to deny that potential. The advantage of the former is that it 'drives continuous improvement'. Although some indicators have shown a relatively low risk adjusted rate of emergency admissions per head of population, there has been a significant rise in emergency admissions over the last 12 months. A system wide urgent and emergency care pathway requires the whole system to be engaged in aligning the key inputs to the urgent care needs of the population of LLR.

It does appear that organisational relationships across they system have been improving over the last year or two, however, there remains a level of mistrust across the system which is impeding effective integration of processes, this is evidenced by the frequency of repeat assessments across the patient's journey resulting in the patient having to repeat the same information. The providers across the urgent and emergency care pathway operate in relative isolation with some operational processes that 'protect' the impact on the provider rather than focussing on optimising the patient journey. This is akin to 'pulling up the drawbridge and patrolling the borders' to protect costs. LLR non-elective risk adjusted admission rates have been lower than average according to Dr Foster but from data sourced from NHS England on Benchmark Performance reported in Better Care Together it appears that admission rates are average. On reviewing the NHS England source information packs for both Local Authorities and Clinical Commissioning Groups, it does appear that the rate of long term care placements for over 65 year olds has deteriorated between the generation of the two data sets (2013 vs 2014) in all three LA areas.

There have been a number of new initiatives put in place across the system to either manage demand or to support discharge. However, the impact metrics for these new processes do not appear to be effectively monitored nor performance managed,

for instance the ‘Doctor in a Car’ or ‘Clinical Response Team’ has been in place since early this year with an expectation of 16 assessments per day to aim to reduce admissions, on average this process has seen 2 patients per day since inception and the performance of this team has not been discussed at an Urgent Care Board. In addition, it is apparent that a number of the initiatives have actually compromised flow across the system; these will be highlighted under the relevant sections. Transfer of care from hospital for all but the simplest of discharges has become over complicated and confused with the generation of many complex rules. These are ‘classic’ examples of attempts at ‘local optimisation’ which have had an adverse impact on flow and quality productivity.

Up to 60 to 70% of emergency admissions are in people with long term conditions and/or frailty. These patients are ‘known’ to the system and as such there is the potential to have discharge planning, as a generic process, in place before they are admitted with ‘pull’ out of hospital on the same day as a patient is declared fit for discharge. As such, how the system supports discharge as an area for improvement will be reported on in this feedback as it is the system outside of the hospital which can facilitate discharge for these patients.

The key drivers for improvement, mapped against the NHS England Domains (http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/), in the urgent and emergency care pathway are:

1. Patient Safety – preventing avoidable harm and death – Domain 4
2. Patient experience – ‘Everyone counts’ – Domain 5
3. Timeliness – ‘Respecting patient’s time’ Domains 3, 4 and 5
4, Effectiveness – early delivery of known effective clinical interventions without unnecessary delay - Domains 1 and 3
5. Efficiency – reduction of multiple assessments, excessive handovers, unnecessary investigations etc. Domains 3, 4 and 5
6. Equality – valuing individuality and choice - Domains 1-5

The ‘Learning Lessons to Improve Care’ identified opportunities for improvements in patient care to reduce harm and mortality. The urgent and emergency care pathway for older people with frailty is an area of significant opportunity for improvement. The current pathway for this group of patients is heavily bed based and results in a number of moves for patients around the system. The extent of deconditioning/decompensation of older people with frailty occurring across this pathway is potentially significant and resulting in longer length of stay and poorer outcomes at higher cost. The extent of ‘fast track’ and CHC placements appear to be higher than the national average, the former being reported, until recently, to be 4 times the national average. Could these high rates of high levels of care indicate an opportunity to minimise deconditioning?

The purpose of this integrated report is to describe what is happening at the moment and to describe the opportunities for improvement. The statements made follow direct observation of the system and utilising multiple sources of observations by clinicians in the system. Nothing mentioned herein should be used to ‘blame’ elements of the system since no one part is perfect. The whole system has to accept that it has considerable issues in every single sector of health and social

care. In addition, there is fragmentation of services across Leicester, Leicestershire and Rutland (LLR) with complex rules governing access that even experts have difficulty navigating. The systemic issues require an integrated system response focussed on delivering the highest possible quality of care and outcomes for patients who have urgent care needs as close to home as possible.

The public make choices about how they access health care for urgent care needs based on their experience of services, ease of access and convenience. Attempting to 'divert' them to other 'services' to 'avoid inappropriate' attendances elsewhere is fraught with challenges when those alternatives do not deliver the inputs when the person needs/wants that input.

LLR as a system will only improve when there is trust and co-operation and collaboration across the system towards a mutually agreed and well communicated vision for the future which is owned by clinicians across the system. There is much that can be done in the preventative, health promotion and very early response to urgent need that can deliver significant 'demand' control of patients deteriorating to a level of urgent/emergency need which then results in Emergency department attendances and acute admissions. However, these inputs need to be consistent and consumer friendly.

The population of LLR is diverse with Leicester City having a more culturally diverse population, higher levels of deprivation and inequalities in life expectancy compared to the less deprived areas of Leicestershire and Rutland. Long term conditions burden in each of the CCGs are either similar to or significantly less than NHS England average apart from high levels of Diabetes and Mental Health prevalence in the City, depression in the West and Diabetes, heart failure and atrial fibrillation in the East and Rutland (http://ccgtools.england.nhs.uk/cfv/flash/atlas.html). There is still much to be achieved in health promotion, preventative healthcare and pre-hospital care that could significantly impact on the outcomes of the population and its subsequent utilisation of high cost secondary care when preventable acute ill health has developed or because of responsiveness or accessibility or perceptions of appropriateness patients choose to access the Emergency Department for their 'urgent care needs' where other choices might have been more appropriate. The NHS England Report 'Five Year Forward View' released in October 2014 (http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf) has stressed the importance of 'getting serious about prevention', creating a new relationship between the service and people and communities and new models of care.

In LLR there is an excessive focus on the '4 hour standard' and an inappropriate interpretation that it is an 'Emergency Department (ED)' problem rather than actually understanding that it is an 'integrated metric' measuring the capability of the whole health and social care system across LLR that happens to be measured in the ED. The risk of the excessive simplistic focus on the 4 hour standard as an ED or just as an UHL metric will result in the generation of a 'supply side driver' whereby improvements in the flow through the ED and the Hospital will pull more patients in to the Hospital as a consequence of not holding the rest of the system to the same level of accountability.

Complex systems should be governed by simple rules. If there are multiple complex rules attempting to govern a complex system, the result is chaos. An understanding of variability, both the types and how variability can be both planned for and managed is crucial in improving quality of care. There are, in essence, two types of variability (http://www.nhsiq.nhs.uk/media/2402957/final_part_ii-blink_rcl.pdf):

1. Special cause variation. One off events or infrequent events that perturb the system briefly in either a negative or a positive way.
2. Common cause variability, this can be both inherent e.g. the variability of the frequency that patients become unwell, or those that are added to the system by the variability with which processes are managed by the system.

Special cause variability requires specific mention here. Changing the processes that manage common cause variability in a system to deal with a one off or infrequent negative special cause variability is guaranteed to increase the common cause variability and thus the likelihood of a poorer outcome. The way to deal with negative special cause variability is to put in place a mitigation to prevent that event occurring or to manage it as a one-off whilst ensuring that the change does not impact on the processes for the 99.9% of other patients going through the system. For positive special cause variability, i.e. when something goes spectacularly well, the process for that event needs to be examined to see if there is any learning that might be generalizable to improve the whole system. This can and must only be tested through the application of improvement methodology to see if the new proposed process actually does improve the whole system before it is widely implemented. Sadly, the health services around the World are littered with 'fixes' for special cause variability that have totally perturbed common cause variability.

The LLR system, as well as UHL specifically, has had significant input from the Emergency Care Intensive Support Team and 'Right Place Right Time Consulting'. These have both identified the key processes that need to be improved to deliver an effective emergency care pathway. However, these recommendations have not been embedded in a consistent manner with a real time information feedback loop to show how the new processes are working and to make visible the variance between clinical teams in their effectiveness of delivery of these processes. There is a need to understand the reasons why 'good advice' has not been realised in to real improvement. There has been a degree of learnt helplessness/hopelessness along with a 'cultural' block to change, it does appear, over the course of the 6 months of this review, that there is a burgeoning desire to change and improve.

For patients attending at any part of the 'urgent care system', the key principle is 'assess once, investigate once if necessary, decide once, and deliver'. Multiple assessments, none targeted investigations, multiple handovers/ward moves, poorly managed referral processes and lack of focus on the delivery of the case management plan result in very poor patient experience, increased harm and the potential for increased mortality.

For admitted patients, observations are made from the perspective of the four questions they should be able to answer soon after being admitted, namely:

1. **What is wrong with me or what are you trying to find out?** This is achieved by timely competent assessment by a decision making clinician who discusses and explains their findings with the patient:

2. **What is going to happen now, today and tomorrow?** This is achieved by the construction of an end to end case management plan by a senior clinical decision maker in partnership with the patient who ensures that these 'inputs' occur in a timely manner..
3. **What do I need to achieve to go home?** This is achieved by setting individualised patient focussed clinical criteria for discharge whilst maintaining timely monitoring of the progress of the patient and ensuring early intervention if there is any negative deviation from the expected recovery pathway. The aim is to create expectation akin to that seen with the 'enhanced recovery programme' in elective care.
4. **When am I going home?** This is achieved by setting the expected date of discharge which does not include the unnecessary waits known within the system. For admitted patients, assertive board rounding and one stop ward rounds ensure that all tasks are completed on time and that as little of the patient's time is wasted waiting for the necessary inputs to occur. Unnecessary waits are highlighted and managed within the team and if not these waits are escalated.

Some organisations have converted these 4 questions in to a patient held information card which also has the name of the Doctor and Nurse in charge of their care and a contact number.

There are a number of excellent clinical, non-clinical and social care leaders across the whole system who are very committed, have and are investing a considerable amount of time and energy in attempting to improve the situation. These individuals have demonstrated the drive for improvement in the pathway, seeking suggestions for improvement with supportive challenge and hold to account those whose practice falls short of what is expected. These leaders need to be thoroughly supported by the LLR system as they pursue the challenge of modernising and improving the urgent and emergency care pathway.

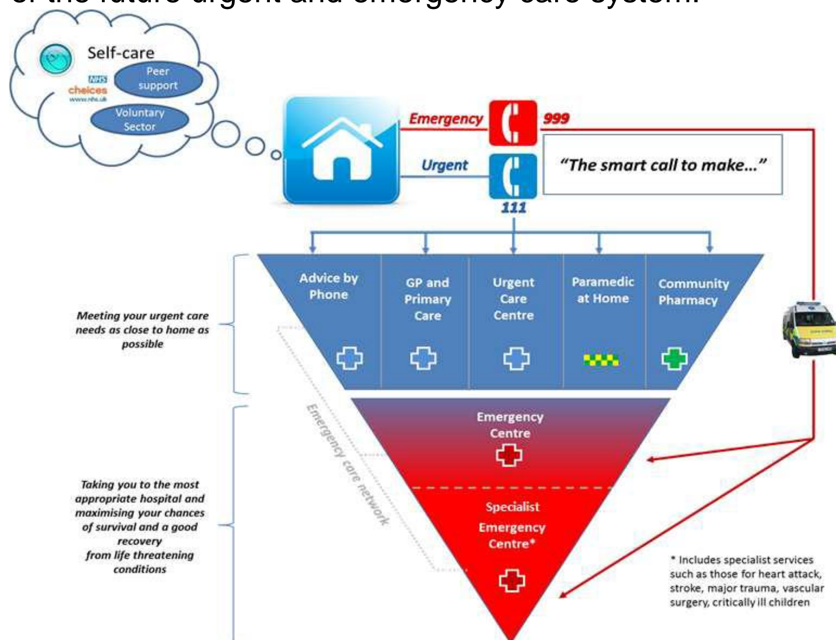
There are three things that are amenable to change:

1. Structure – structural change alone rarely delivers any actual benefit.
2. Process – optimising processes focussing on what adds value to the patient is the main element of any improvement programme.
3. Patterns – relationships, behaviours, motivation, peer to peer support and challenge. This is a crucial element to deliver sustainable improvement. Top down enforced process changes will never sustain, whilst bringing about a desire to see improvement in a collegiate atmosphere drives sustainable improvement.

There is particular attention on urgent and emergency care at a national level following the publication of NHS England's 'Transforming urgent and emergency care in England. Urgent and Emergency Care Review: End of Phase 1 Report' (http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf) and the 'Update on the Urgent and Emergency Care Review' (http://www.nhs.uk/NHSEngland/keogh-review/Documents/uecreviewupdate.FV.pdf) in which the vision for urgent and emergency care is described:

1. Firstly, for those people with **urgent but non-life threatening needs** we must **Provide highly responsive, effective and personalised services outside of hospital.** These services should deliver **care in or as close to people's homes as possible**, minimising disruption and inconvenience for patients and their families. Secondly, for those people with **more serious or life threatening emergency needs** we should ensure they are treated **in centres with the very best expertise and facilities**, in order to **maximise their chances of survival and a good recovery**.

2. Underneath this vision we described, in visual form, the shape and structure of the future urgent and emergency care system:



3. In order to move from the current to the future system we proposed five key elements of change. These should apply to all patients, regardless of their age, location, co-morbidities or physical and mental health needs:
   - Providing **better support** for people to **self-care.** See the Health Foundation report on 'Person centred care: from ideas to action' (http://www.health.org.uk/public/cms/75/76/313/5018/Person-centred%20care_from%20ideas%20to%20action.pdf?realName=06z1oQ.pdf)
   - Helping people with urgent care needs to get the **right advice** in **the right place, first time.**
   - Providing **highly responsive urgent care services outside of hospital** so people no longer choose to queue in A&E.
   - Ensuring that those **people with more serious or life threatening emergency need**s receive **treatment in centres with the right facilities and expertise** in order to maximise chances of survival and a good recovery.
   - **Connecting urgent and emergency care services** so the overall system becomes **more than just the sum of its parts.**

The feedback will comprise two main sections, the first is around strategic 'set up' and recommendations, the second is around observations of the system and recommendations. Both are equally important, failure to focus on the key elements of strategic 'setup' risk an improvement programme developing without focus and direction with resultant disintegration in to frustration and disillusionment amongst the early adopter/early majority group of staff who are keen to progress with change.

1. Strategic Intent

Providing clear leadership and description of strategic intent aiming to deliver a high performing health care system is a key attribute in bringing about large scale change across systems. There have been a number of reviews of high performing health care systems which have sought to identify these key attributes (http://www.kingsfund.org.uk/sites/files/kf/roles-of-leaders-high-performing-health-care-systems-ross-baker-kings-fund-may-2011.pdf,). The common themes were:

- Consistent leadership that embraces common goals and aligns activities throughout the organisation.
- Quality and system improvement as a core strategy.
- Organisational capacities and skills to support performance improvement.
- Robust primary care teams at the centre of the delivery system.
- Engaging patients in their care and in the design of care.
- Promoting professional cultures that support teamwork, continuous improvement and patient engagement.
- More effective integration of care that promotes seamless care transitions.
- Information as a platform for guiding improvement.
- Effective learning strategies and methods to test improvements and scale up.
- Providing an enabling environment buffering short-term factors that undermine success.

The system has started to a clear vision in the form of impact across the system with regard to the urgent and emergency care pathway which is clinically led and well communicated. The Better Care Together process and the Better Care Funds are an opportunity for creating a unifying vision. Although the BCF programmes do have a suite of metrics and to some extent these are reflected in Better Care Together, it is difficult to have absolute clarity of 'what good will look like' at the end of implementation. The outcomes metrics on Pages 9-13 of the June 2014 version of the BCT 5 Year Plan lack clarity. For instance, the percentage reductions in admissions, attendances and occupied bed days are open to differential interpretation. For instance a 25% reduction in emergency admissions for chronic diseases can be influenced by changes in coding practice, and does this represent an absolute or a relative reduction based on demographic changes? The evidence base for the reduction in emergency admissions to hospital is not strong apart for certain specific conditions such as heart failure and chronic obstructive pulmonary disease. The strongest evidence is for the potential marked reduction in occupied hospital bed days through effective integration of processes aligned to minimise the delays in patient journeys through hospital. At the work stream review by the Clinical Reference Group of the BCT programme on the 25th Septe4mber 2014, the members were asked to enunciate the key objectives/improvement aims/system level impacts that the work would deliver. There was clarity regarding the financial challenge to the whole system over the next 5 years but this did not appear to be matched by a clear statement of intent with regards to the quality improvements to be gained by the process.

The CCG/Local Authority Better Care Fund submissions also provide strategic direction and more clearly defined metrics, most of which are defined at the national level. However, a number of the aspirations expressed in these documents have been delivered by other systems before the Better Care Fund programme was

commenced. The challenge to the system is to deliver at pace within the next 6 months the older people with frailty agenda as it is this pathway which is most broken in this system. The principles of an effective system for people with frailty are described by the King's Fund paper 'Making our health and care systems fit for an ageing population' (http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf) with its 'Ten components of care for older people' (see below) and the 'Silver Book: Quality care for older people with urgent and emergency care needs' (http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf). A commitment to reducing by 50% the 'stranded patient' metric described below within 6 months. That is, less than 100 beds occupied by patients aged 75 years and older within UHL who have been in hospital 10 days or more with no increase in re-admissions nor in long term care placement. A better improvement aim is a 50% reduction in the same metric across all acute and community 'therapeutic' beds, however, as of to date, the 'joining' up of the journeys between acute and community hospital beds is not available.

The 'Home First' principle, i.e. the home address you came from will be the address to which you will return, for discharge from Hospital is still not embedded within the system as a key principle and as a result the very significant constraint of 'hospital based deconditioning' is continuously being embedded within the patient journey. This is resulting in poor outcomes.

Recommendations

- **Utilise the principles of 'large scale change' models to create an inspirational and motivating 'story' of what the future will look like. Consider using the NHS Change Model:**

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- **Or using Kotter's 8 steps of change :**

- **Increase urgency by providing clarity about the challenges faced. Focus on describing these using a quality framework such as the Institute of Medicine's 6 domains of quality described in the 'Crossing the Quality Chasm'**

(www.iom.edu/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf), and the IHI Triple Aim objectives (http://www.ihi.org/Engage/Initiatives/TripleAim/pages/default.aspx). Financial drivers alone will not create a social movement for improvement across 'multiple agencies'. A compelling story of improved outcomes for large groups of patients will generate the 'will, ideas and execution' for change. The NHS is awash with 'improvement changes' for the select few e.g. patients with strokes, myocardial infarction or major trauma, real system change is to deliver marked improvements for the 'many' usually the disadvantaged or those suffering discrimination, the latter most commonly older people.

- **Build the guiding coalition. There will be formal leaders but high performing systems also crucially recognise their 'secondary leaders and group leaders' who will demonstrate the need for change from the compelling story. It is these 'secondary leaders' who will want to form coalitions across the system to deliver the changes. It is these 'secondary leaders' who through their actions and behaviours create the 'social movement' for change. Their enthusiasm can be inhibited in a hierarchical system. This is where a 'blaming culture' can do so much to inhibit the coalitions, in systems where there have been long term 'performance' issues, the pressure applied to these systems can result in a blaming culture developing.**
- **Get the vision right. The guiding coalition becomes the central force in creating a change vision and change strategies and describing how the improved models will work. By a relentless focus on the 'what good will look like' with continuous feedback of improvements supported by 'humility' in recognising that others across the system can deliver better, learning from so called 'junior partners' demonstrates a 'learning leadership' that lacks the arrogance of 'hierarchical leadership'.**
- **Communication Strategy – See below.**
- **Empower action. Ensure that the strategic team create the opportunities for changes to take place by removing obstacles to change, for example IT, cross organisational operational policy that 'conflict', referral processes. Leaders who make doing the right thing easier to do and feedback about the improvements delivered will motivate staff.**
- **Create short-term wins. The challenge for the LLR system is the extent of sceptics and 'historians' who have 'heard it all before' and place a 'brake' on opportunities for improvement. Empowered people, feeling a sense of urgency and guided by the vision and strategies, focus their actions on achieving a continuing series of visible and unambiguous successes, starting as quickly as possible. With visibility to as many people as possible, and with a lack of ambiguity that makes it difficult to argue whether these are real successes on the journey to the vision.**
- **Maintain momentum. Early successes, while desirable, also create the danger of complacency. Since a few successes never take you the distance to achieve a vision of significant change, such complacency must be avoided at all costs. In successful large-scale change efforts, that problem is anticipated and effort is directed to keeping urgency up, keeping the wins coming, and never letting up until all the necessary**

changes have been made. Only when the organization has achieved the change vision, and only after its success is clear to all, does effort shift to the last step.

- **Make change stick. A new order of operating is always fragile at first. Sustainable delivery of a new model of care across a system needs to be in place for as minimum of 3 years for there to be the potential of having achieved sustainable change.**

Developing a Suite of Metrics

Developing meaningful metrics understood by clinical teams and managerial teams alike which tell the journey through the system assists in supporting the improvement programme. As a guide, consideration of the following order of metrics:

- Outcome/Impact – the expected gains from the improvements, thus mortality, harm, re-admission/re-attendance, new institutionalisations from hospital, complaints etc. These should always be presented first to re-enforce the message of what the organisation is trying to achieve. 'Hard red lines' of improvement goals will need to be clearly visible. There should be SMART (specific, measurable, attainable, relevant and time-bound) aim statements attached to the programme that set out clearly how you will measure success. However, not everything that is important can be measured – qualitative feedback from patients and staff is just as important.
- Demand – volume and time profile of the demand. The demand dictates the profile of the capacity.
- Capacity – in Primary Care the capacity is the number of available appointments, better still is the 'bookable minutes' for each demand profile, in ED and assessment areas capacity is defined by senior decision maker available time and the 'processing' time for each patient by this senior decision maker. For admitted patients, capacity is defined by flow i.e. journey time profiles. Capacity can be 'consumed' by added value processes and non-added value processes.
- Flow – linked to the relevant streams be that in Primary care or Secondary care, e.g. admitted vs. non-admitted in ED, short stay + ambulatory emergency care (daily run charts of zero LOS discharges and discharges with LOS 2 days or less) vs. sick mono-organ specialty vs. acute frailty (beds occupied – not discharges) by patients aged 75 and over with LOS 10 or 14 days or more) as defined in the work-stream profiles above. Total beds occupied by emergency admissions across all specialties are an outcome and a flow metric as well as 'work in progress'.
- Processes – the inputs required to deliver the outputs which in turn deliver the outcomes. For example, call to GP visit, GP request for transfer to arrival at ED, door to nurse, door to doctor, door to Consultant times for assessment units.
- Balancing – the unintended consequences of any changes. The commonest will be re-admissions or re-attendances.

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Wherever possible these metrics should be available in real time with appropriate historical data to ensure that seasonal and cyclical changes are not misinterpreted as improvement/deterioration. This data then provides the in-day position for operational management. In addition, forward projection using 6 week rolling averages or more sophisticated models to provide for tactical management of the system.

Without re-describing all the metrics in the BCT and BCF frameworks, there are some key principles to be considered to ensure that the expected benefits are realised and are focussed on quality rather than just finance:

i. Ensure that there are appropriate measures of demand, capacity, activity and flow across the system.
ii. Consider using the Institute of Healthcare Improvement's 'Triple Aim' framework as a guide to the metrics strategy as described in the IHI Guide to Measuring the Triple Aim White paper (http://www.ihi.org/resources/Pages/IHIWhitePapers/AGuidetoMeasuringTripleAim.aspx):

Dimension	Measure
Population Health	1. Health/Functional Status: single-question (e.g. from CDC HRQOL-4) or multi-domain (e.g. SF-12, EuroQol)
	2. Risk Status: composite health risk appraisal (HRA) score
	3. Disease Burden: Incidence (yearly rate of onset, avg. age of onset) and/or prevalence of major chronic conditions; summary of predictive model scores
	4. Mortality: life expectancy; years of potential life lost; standardized mortality rates. *Note: Healthy Life Expectancy (HLE) combines life expectancy and health status into a single measure, reflecting remaining years of life in good health. See http://reves.site.ined.fr/en/DFLE/definition/*
Patient Experience	1. Standard questions from patient surveys, for example: -Global questions from US CAHPS or How's Your Health surveys -Experience questions from NHS World Class Commissioning or CareQuality Commission -Likelihood to recommend
	2. Set of measures based on key dimensions (e.g., US IOM Quality Chasm aims: Safe, Effective, Timely, Efficient, Equitable and Patient-centered)
Per Capita Cost	1. Total cost per member of the population per month
	2. Hospital and ED utilization rate

iii. The metrics need to be defined as outcome, process or balancing metrics. The IHI white paper talks of the first two; however, there has been recognition that measurement of the unintended consequences is always necessary with change.
iv. Outcome metrics being described use the 'aim statement' structure of 'how much improvement by when by how measured'.
v. The importance of ensuring that the 6 domains of quality described by the Institute of Medicine, see table above, are represented within the metrics suite.

Outlined here are some measures the system may wish to consider in addition to those described by NHS England (http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf):

a. **Outcome Metrics**

- Reducing Mortality:

  Moving towards recording all deaths within 30 days of an 'urgent care' contact' rather than just for those who are admitted to hospital. As well as the potential years of life lost as per the NHS England Outcomes Benchmarking Support Pack. In the first instance, as a consequence of data capture difficulties in Primary Care, this could be recorded for all contacts with 111, Out of Hours and East Midlands Ambulance Service contacts.

- Reducing Harm

  Measuring harm across systems is not well done in the NHS despite there being many tools to assist in the identification of harm e.g. the NHS Institute's Trigger Tool for Primary Care (http://www.institute.nhs.uk/safer_care/primary_care_2/introductiontoprimarycaretriggertool.html). The evidence from the Health Foundation is that approximately 1-2% of consultations in Primary Care result in harm (http://www.health.org.uk/public/cms/75/76/313/3079/Levels%20of%20harm%20in%20primary%20care.pdf?realName=Hc6Loc.pdf).

- Increasing Independence

  The BCF plans all include an increase in the number of people remaining at home 91 days after a discharge from hospital in to a re-ablement/rehabilitation service. It would be better to have this mirrored with the proportion of all patients who are discharged from Hospital aged 65 and over who remain at home 91 days after discharge. Both figures need to improve and again the 'Home First' principle will support this priority. The increases described in the BCF in independent living after re-ablement/rehabilitation are relatively small.

- Reducing long term care placements.

  BCF National Metric 1. Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population. The reductions identified within the BCF are relatively small and not very ambitious.

  In parallel, a reduction in the rate of applications for the use of Deprivation of Liberty (DoL) is necessary. The national variation in DoL applications in 2012/13 ranges from 65.8 per 100,000 people aged 65 and over in London to 155.6 per 100,000 people aged 65 and over some 2.4 times higher in the East Midlands (http://www.cqc.org.uk/sites/default/files/documents/dols_2014.pdf). Balancing this metric, there would need to be an assurance that Deprivation of Liberty, either not authorised or not notified was not occurring.

  Driving the principle of 'Home First' across the system will assist in delivering this metric. Effective urgent and emergency care for older people with frailty is the key to preventing deconditioning which can result in functional decline with an increased risk of institutionalisation. Delivering the principles of the 'Silver Book' in acute care for older people with frailty has the potential for a dramatic impact in the LLR system. The metric for admitted frailty patients is to aim to reduce the current number of beds occupied by patients aged 75 and over who have been in-patients for 10 days or more across the total

journey, i.e. super spell, this is presented as a daily run chart. This group represents the 'stranded patient' whose functional status risks progressive deterioration the longer they remain in hospital. The aim would be to achieve a 50% reduction in this metric within 6 months

- Reducing Re-attendances and Re-Admissions
  Reducing re-attendances through appropriate navigation and case management through the system avoiding the current routine re-presentation to the ED. This re-attendance at ED is all too frequently happening, often with the description of 'failed discharge'. Re-admitted patients tend to have longer lengths of stay and poorer long term outcomes. Reducing re-admissions and re-attendances is achieved by improved interface management and sharing of information and risk. Alternatives to ED re-attendance and re-admission need to be designed in to the system to facilitate a 'semi-planned' approach.

- Reducing complaints and increasing compliments – Improving Patient Experience
  Aiming to increase the quality of experience for patients provided within an integrated manner focussing on needs and with the 'locus of control' with the person/patient. The Friends and Family Test metrics as well as other more formal assessments as described by the Health Foundation should be utilised. (http://www.health.org.uk/public/cms/75/76/313/4300/Measuring%20patient%20experience.pdf?realName=7qM8Wm.pdf).

b. **Integrated Process Metrics**

- Reducing Attendances at the Emergency Department.
  Effective alternatives to attendance at an Emergency Department (Type 1) will reduce attendance and the system needs to ensure high quality care be that through health promotion and prevention, improved long term condition management and alternative provision. It needs to be assessed whether alternative provision results in a greater risk of re-attendance within 7 days or prolonged journey times for an acceptable or unacceptable proportion of patients. These metrics needs to be described ideally as an absolute reduction rather than a relative reduction. As a subset of aiming to deliver and absolute reduction in all ED attendances (Type 1), a focussed metric around attendances (and subsequent admissions) of patients with long term conditions and/or high risk and/or those on a 'frailty register', and very specifically all attendances from Care Homes would be appropriate.

- Reducing Emergency Admissions to Hospital
  Nationally, there have been drives to reduce emergency admissions for over 15 years and yet there have been ever increasing numbers of emergency admissions. There is a need to standardise the way emergency admissions are counted. Over the last 15 years, there has been an almost continuous rise in emergency admissions, the vast majority of this increase is due to an 126% increase in short stay, less than 2 days, admissions over this time period, whilst for those admissions for patients with a length of 2 days or more has only increased 14% (http://www.nao.org.uk/wp-

content/uploads/2013/10/10288-001-Emergency-admissions.pdf). Short stay admissions comprise two groups, those admitted assessment and 'rule out' of at risk conditions and those admitted for intense early treatment. The former could be described as an 'admit to decide' group whilst the latter are a 'decide to admit' group. The former group have the potential for pathways of 'non-admitted' immediate access to diagnostics and specialist opinion, whist the latter may be amenable to 'ambulatory emergency care' with immediate access to diagnostics and interventions. Reducing admissions overall with a subdivision of reductions in short stay admissions whilst also reducing longer stay admissions, it having to be noted that a proportion of current short stay admissions where longer stay admissions in the past. A reduction in emergency bed days used across the system would provide an integrated metric of both reducing admissions and reducing length of stay. It has to be recognised that over the last 15 years despite the increase in admissions, there has been a 30% reduction in occupied bed days for emergency admissions. The evidence base for reducing emergency admissions is variable based on randomised controlled trial evidence but there are systems that have succeeded in achieving significant reductions e.g. Jonkoping County (http://www.longwoods.com/product/download/code/20144), Intermountain Health, Kaiser Permanente, and Canterbury District Health Board. A selection of the Cochrane database has reported the following:

a. Education to patients attending ED with acute asthma produces a modest reduction in future admissions (2007 http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003000.pub2/abstract).
b. Hospital at Home admission avoidance for generic cases failed to reduce emergency admissions (2008 http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007491/abstract).
c. Case management of patients with heart failure does reduce re-admissions at 6 months (2012 http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002752.pub3/abstract)
d. Hospital at home to manage patients with acute exacerbations of COPD did reduce hospital readmissions (2012 http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003573.pub2/abstract).
e. Hospital at Home: Home based end of life care did increase the rate of patients dying in their own home but did not appear to reduce hospitalisations before death (2011 http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009231/abstract).

This is achieved by a combination of processes. 60-70% of admissions are for people with long term conditions and/or frailty in which it can be assumed that an acute exacerbation constitute a 'break down' of case management control and is thus a measure of pre-hospital care. Delivering reductions in the ambulatory care sensitive conditions firstly requires clarity on what is included, the most commonly used set in the NHS being those described by the Victoria Department of Health, Australia and the variance in admission rates have been described by NHS England (http://www.england.nhs.uk/wp-

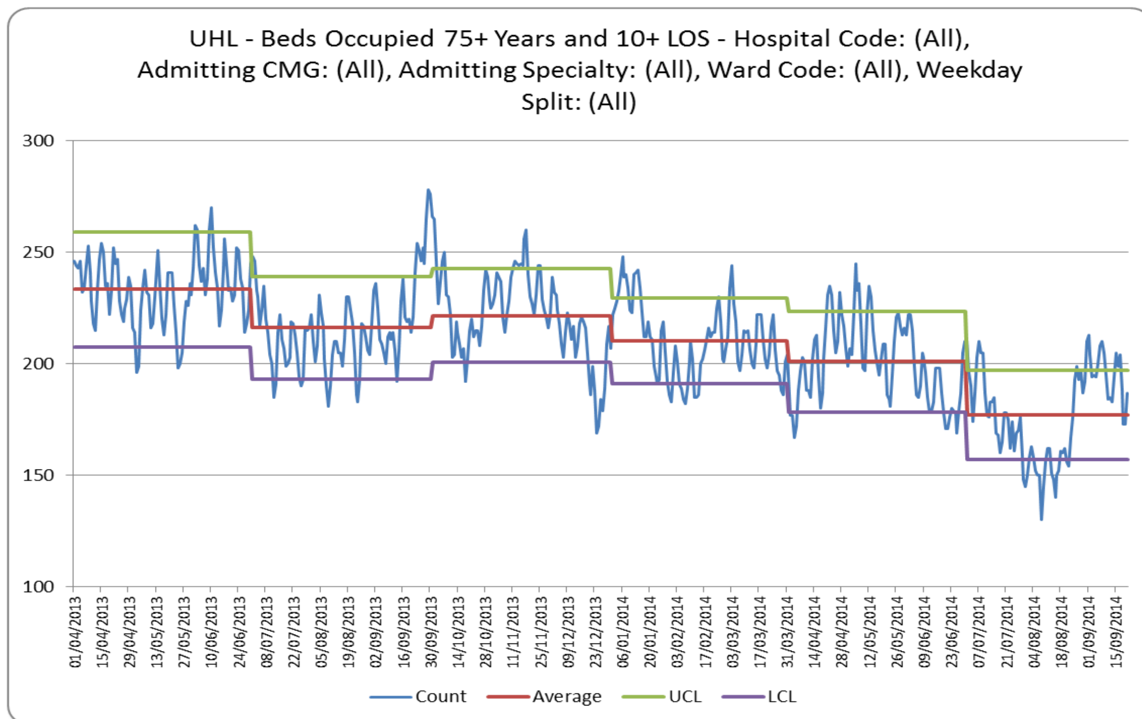
content/uploads/2014/03/red-acsc-em-admissions-2.pdf). Again, the prevention of the admission is a measure of pre-hospital care. Converting acutely ill patients who have been previously admitted overnight in to either a zero length of stay or better still in to a non-admitted same day pathway, is the basis for the Directory of Ambulatory Emergency Care for Adults (http://www.institute.nhs.uk/option,com_joomcart/Itemid,26/main_page,document_product_info/products_id,181.htm) and requires a system response. There are overlaps in the diagnoses within the two groups with ACSC having 21 diagnoses and the Directory of Ambulatory Emergency Care describing 49 clinical scenarios. However, where there is overlap, the difference in the approach is that with ACSC the aim is to prevent the patient getting ill enough to feel they need to go to an Acute Hospital, although one means of reducing admissions is early senior assessment in the ED. Whilst with Ambulatory Emergency Care (AEC) patients, currently, are deemed to require attending Hospital. Managing AEC patients without an overnight stay requires co-operation and collaboration between the acute sector and the rest of the system. A proportion of the scenarios within the Directory e.g. Care Home admissions, end of life care can be managed without attendance at Hospital. It is noted that there has been some improvement in achieving some of the Gold Standard Framework. Many of the scenarios within the Directory of AEC require same day access to senior opinion and rapid diagnostics.

- Reducing Bed Occupancy for Older people with Frailty

  Delayed Transfer of Care, although a required metric nationally, does not assist in driving alternative pathways for the management of patients with complex needs. Recognition that a significant proportion of patients who end up as ‘Delayed Transfers of Care’ have actually de-conditioned within Hospital (acute or community) because the system has not case managed them effectively to discharge to their usual address. A philosophy of ‘Home First’ as the principle for all patients admitted via the non-elective pathway will assist in driving early effective intervention for these patients to prevent in hospital deconditioning.

  As mentioned earlier in this paper, the frailty pathway is in need of considerable improvement. A better metric would be defined around a reduction in the number of beds occupied by patients aged 75 (or 65) and over who have been in hospital 10 days or more. Although only 3-5% of 65-75 year olds have frailty rising to 25-40% depending on which ‘frailty’ model is used, it is likely that patients aged 75 and over with frailty will be over represented in this metric as frailty increases the risk of a long length of stay and a poorer outcome. These represent ‘stranded’ patients who have potentially suffered and are at on-going risk of in hospital de-conditioning. The run chart below represents this metric for acute beds only, the system needs to ensure that this metric is inclusive of all ‘therapeutic beds’. For the acute sector this metric needs to rapidly reduce to less than 100 within the next 3 – 6 months and reduce further thereafter. The combined Acute and Community Hospital average for this metric is likely to exceed 300 (and considerably more if the age is adjusted to 65 and over). Again an improvement aim of reducing this metric by 50% within 3-6 months, with no or minimal increase in re-admissions and a fall in long term care placements

would indicate a system focussed on optimising independence. This would be supported by other metrics such as % of those remaining at home 91 days after discharge from Hospital and could be further supported by an appropriate PROMS.



Recommendations

- **Building a suite of metrics which describe with clarity what a 'good system' will look like at the end of the improvement programme. These could be based around the 'Triple Aim' principles in combination with those contained within the Outcomes Benchmarking Support Packs from NHS England.**
- **All measures should be seen as 'measurement for improvement' and not as 'measures for judgement'. As soon as measures are used for judgement their utility to support quality improvement is rapidly diminished.**
- **Clarity of the metrics based on whether they are outcome/impact, process or balancing metrics. Ensure outcome/impact metrics are SMART.**
- **Ensuring the ability to 'drill down' from these high level metrics to service level measures will be essential. This needs to be 'embedded' within the metrics strategy.**
- **Outcome metrics constructed around the 'aim statement principle' of 'how much, by when and how measured'.**
- **Develop a systems operations centre suite of measures based on the categories above which 'tell the story' of the system and organisation performance at a glance.**
- **Co-develop the metrics strategy with the clinical trams ensuring the utility of the metrics for the front line to manage its business.**

- **Provide visibility of key outcome and flow metrics both at system, organisational level and at team/ward/individual. Data at team/ward/individual level is of crucial importance to support change, making the variability visible between teams' supports peer to peer support and development.**
- **Train clinical and managerial leaders in the appropriate use of the metrics**
- **Aim for the use of the data at key meetings e.g. bed meetings, team briefings etc. to drive the improvements.**

c. Communicating the Vision

Crucial to the success of the improvement programme will be the need to implement an effective and continuous communication strategy. This will need to ensure that the case for the 'urgency' of the need to improvement is well received and accepted based on the quality and safety issues identified above. This will aim to achieve a compelling 'story' of the need to change, importantly including both successful and unsuccessful patient journey stories. This will link the high level objectives to the individual patient and make the story personal for all staff members. The purpose is to engender a unifying vision generating a 'social movement' for the need to change within the system which then becomes engaged in supporting the delivery of the vision. Making the 'present' uncomfortable and the 'future' appealing will be the mainstay of the communication strategy. Success of the communication strategy can be measured by the extent that peers challenge peers around the drive to the new way of working. Once improvement commences, the communication strategy will move to 'celebrating' the success stories and promoting and encouraging other to continue with their own improvement work.

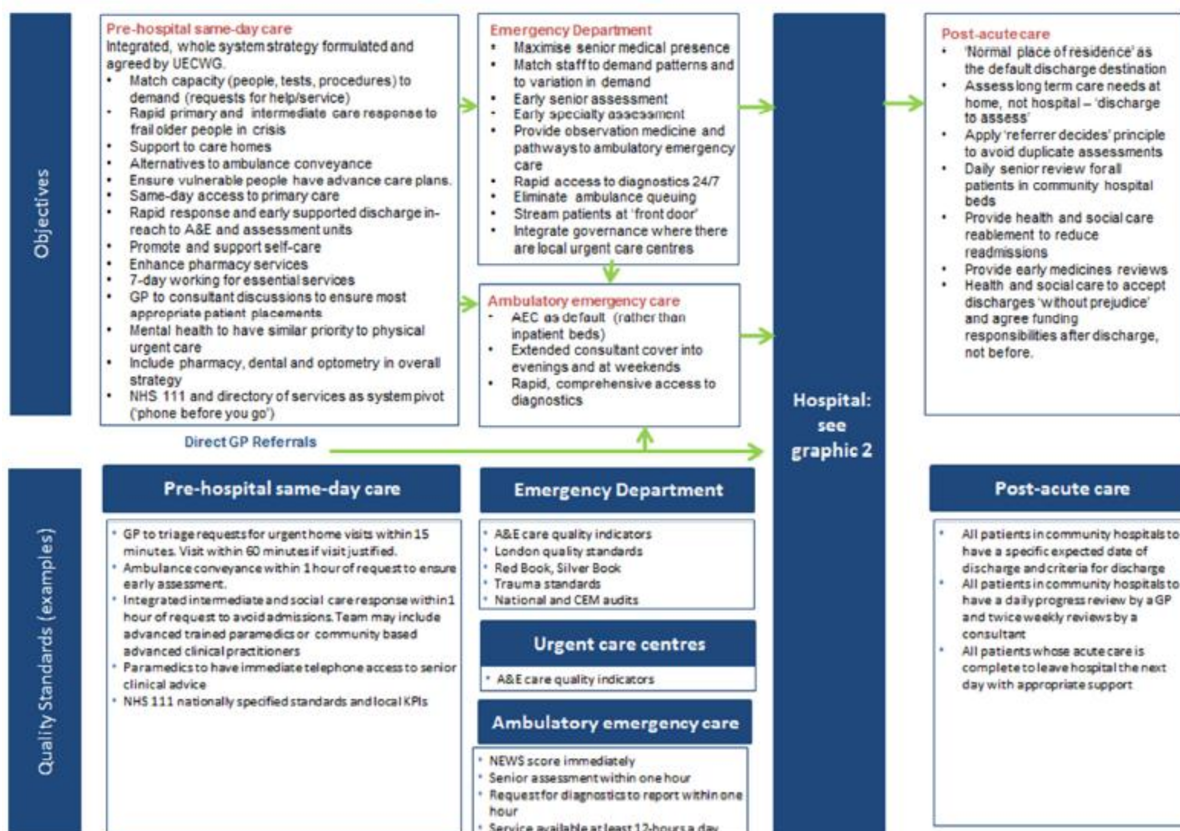
Recommendations:

- **Develop and institute a comprehensive communication strategy aiming to ensure that all staff members across the system are fully conversant with the vision for the organisation and have had the opportunity to comment and add to that vision.**
- **This will need to be embedded within the communications strategy presumably being put in place around the BCG and the Better Care Together programmes,**
- **Communicating the fact that there are no 'quick fixes' for the whole system and that progression towards the vision needs time and consistency whilst demonstrating any early wins in focussed areas and showcasing the improvement impact of 'system level teams'.**

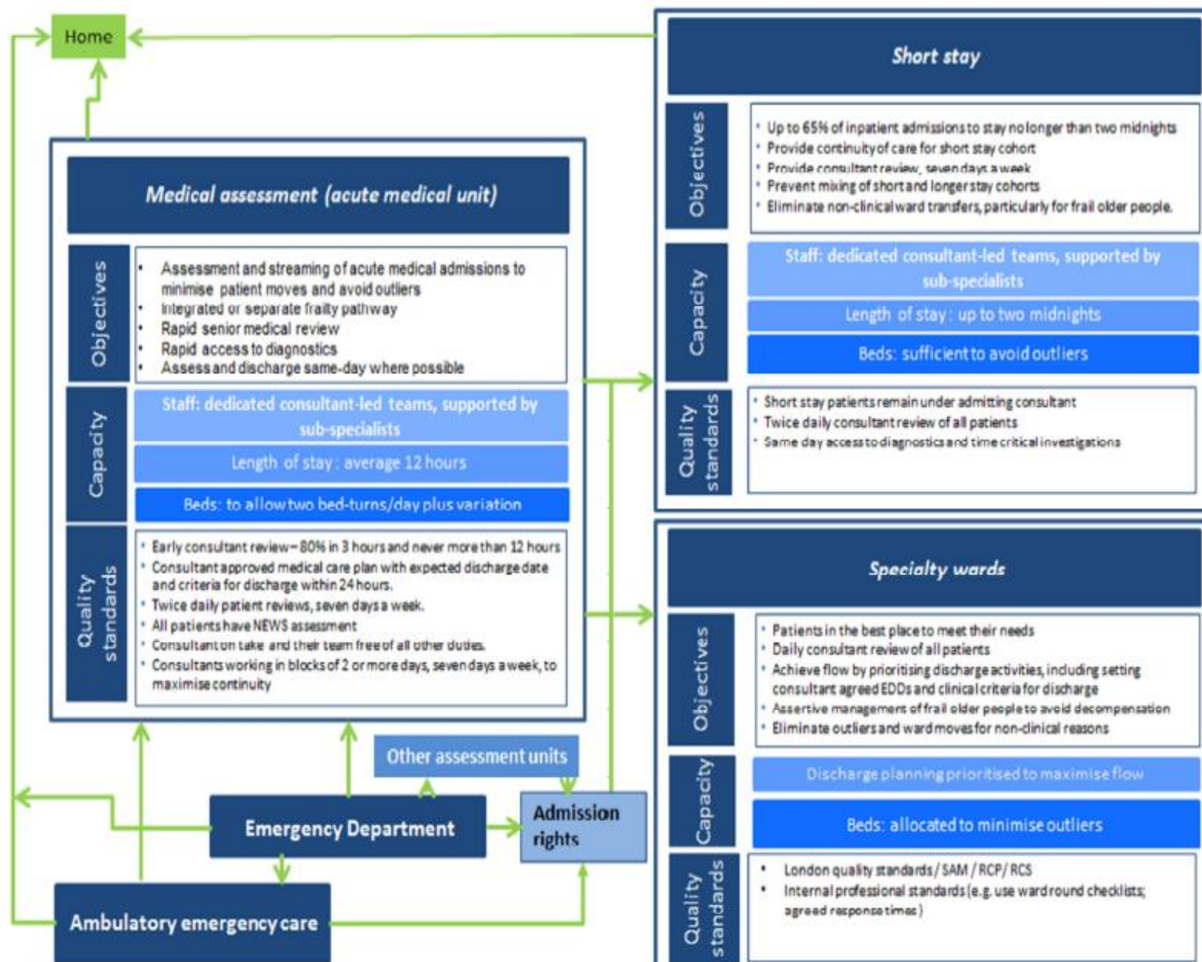
d. Governance and Leadership Behaviours

Although there have been significant improvements in the senior leadership relationships over the last 1-2 years, unanimity of vision remains relatively disjointed, although the Better Care Together and the Better Care Fund programmes could assist in resolving this issue. Moving through the organisational structures there do appear to be increasing levels of fragmentation resulting in duplication and waste across the system. This is not helping collaborative nor integrative working.

There has been an Urgent Care Board, currently undergoing re-structuring to align with the work streams within 'Better Care Together'. There has been excessive focus on the 4 hour standard with insufficient rigor of holding to account the whole system in facilitating the flows of patients across the urgent and emergency care pathway. With the re-alignment to the work streams within BCT should provide better focus for the new structure focussing on patient level and system level impact metrics rather than an access target. This group and the System Resilience Group need to ensure that the key recommendations within the Operational Resilience and Capacity Planning for 2014/15 from NHS England are in place and actively monitored and performance managed (http://www.england.nhs.uk/wp-content/uploads/2014/06/op-res-cap-plan-1415.pdf).



For those patients admitted acutely, there is guidance from NHS England on developing a demand:capacity plan linked to an improvement model:



Finally, there have been some joint case note reviews, two of which appeared to be being used as opportunities to learn across primary and secondary care as to whether there were opportunities for the development of alternative pathways. This is good practice. There have also been a series of re-coding meetings of variable value and linked to contract negotiations. These meetings had the potential to consume a considerable amount of senior clinician's time with no direct benefit for patients. Best practice in coding is by utilising the entirety of the case record for that episode, at times, coding is undertaken from the discharge summary only. Agreement on common coding practice across the system guided by an appropriate external audit might be a more appropriate way forward.

Recommendations

- **System Leaders will need to develop and communicate a unified vision of an improved system, whilst continuing to move towards a collaborative and integrated model of care with appropriate accountability across the system, recognising that there is no one part of the current system that is working optimally.**
- **Ensure that the System Resilience Group and the Urgent Care Board are aligned to the key elements within the NHS England Operational and**

Resilience Planning framework (http://www.england.nhs.uk/wp-content/uploads/2014/06/op-res-cap-plan-1415.pdf)

- **System leaders being prepared to state that the system has been perfectly designed to deliver the results it is achieving as a system not as elements within the system.**
- **System leaders accepting the responsibility that future improvements can only be achieved by collaboration and the utilisation of recognised improvement methodology focussing on relieving the constraints in the system.**
- **System leaders communicating the vision that delivery will not be a 'quick fix' but will require the re-building of improved pathways of care focussed around the patient and not the individual services.**
- **Discontinuation of re-coding exercises whilst encouraging joint notes reviews to promote the opportunities of developing alternative care pathways. Consider an external audit of coding practice.**
- **For UHL, developing an 'action based' programme board, this behaves more like a process rather than a structure. Work-streams should be encouraged to be frequent and brief focussing on actions for the next few days e.g. further rapid cycle tests of change, spread and adoption, peer to peer support/challenge processes etc. These work-streams will work to achieve specific impact goals which collectively will achieve the high level outcome metrics. An over-arching steering group should be focussed on the high level outcome and integrated process metrics with reports on actions with impact effect from each of the work-stream groups. The Work stream Groups comprise:**

  1. Organisational – covering communication strategy, high level metrics, organisational development, customer service processes (both internal and external customer relationships). This group will also be the group to which the other work-streams would refer cross boundary (internal) issues for first level arbitration – within one week of an issue being defined and not resolved by the work stream. If this Group is unable to resolve the issue the issue is escalated to the Steering Group for resolution.

  2. Assessment, initial investigation, decision making, referral and short stay. This comprises the Emergency, medical and surgical assessment units and any other acute/emergency assessment areas, short stay including EDU (http://www.aomrc.org.uk/doc_view/9450-the-benefits-of-consultant-delivered-care). The product of this group will be to 'assess once, investigate once and decide once'. Expected improvements from this group will be a 5-10% reduction in ED referrals for admission from the non-GP referred stream (http://www.londonhp.nhs.uk/wp-content/uploads/2013/03/ED-Case-for-change_FINAL-Feb2013.pdf). For the admitting specialties, for medicine for example, the aim of this work-stream with earlier senior review (https://www.rcplondon.ac.uk/sites/default/files/documents/acute-care-toolkit-4.pdf) will be to achieve 30% of discharges within 12 hrs of referral, with a further 40% discharged with a length of stay of 2 midnights or less. The delivery of effective ambulatory emergency care

will be a key process for this group. Key outcome metrics will be deaths and harm events within the first 48 hours and re-admission numbers/rates.

3. Base Wards/Mono-organ Specialty. This work-stream will be responsible for designing and delivering effective case management delivery for non-short stay admissions, minimising the impact of handover between the assessing team and the base ward team (https://www.rcplondon.ac.uk/sites/default/files/acute-care-toolkit-1-handover.pdf), and ensuring that all internal 'waits' are abolished, e.g. delays for writing up discharge summaries and drugs to take home (https://www.rcplondon.ac.uk/sites/default/files/acute-care-toolkit-2-high-quality-acute-care.pdf). The two key processes to optimise within this group will be the effective delivery of the 'board round' and the 'one stop ward round'. Effective case management delivery will improve patient outcomes and experience and the impact metric for flow will be the demonstration of a reduction in beds occupied by patients aged under 75 with the aim to reduce this by 10-20. Key outcome metrics will be deaths and harm events after the first 48 hours, re-admissions and new long term care placements.

4. Frailty Stream. The fastest growth in admissions in the UK is of the older people with frailty population. There is an overlap between this group and the assessment and base ward groups but this group will be tasked with optimising inputs and flow for all older patients with frailty admitted to any specialty in the emergency pathway. The main purpose of this group will be to reduce the 'deconditioning' impact of hospitalisation by early and assertive management of patients with frailty. (https://www.rcplondon.ac.uk/sites/default/files/acute-care-toolkit-3.pdf and http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf) The overall impact of this group will be a marked reduction in the number of 'stranded' patients, defined as the number of beds occupied by patients aged 75 and over who have been in hospital 10 (or 14) days or more, with an aim to reduce this by 25-50% within 3-6 months. Key outcome metrics will be deaths and harm events after the first 48 hours, re-admissions and new long term care placements.

e. Building capacity and capability in Improvement Methodology in the System

For a variety of reasons a number of 'quick fixes' have been put in place across the system which have actually created perturbations of the system with negative consequences. Journey times for patients across pathways have been increased and as a consequence patient and system level outcomes have been compromised. This has taken place over many years and requires a systematic approach to unravel the problems. For example, a bed bureau process that facilitates GP referrals for 'admission' does significantly reduce the time GPs spend on the phone making referrals, perversely, since this route is comparatively easy it will have the potential risk of increasing admissions when alternatives may be more appropriate. The process by which a Consultant Physician now takes these calls during 9am to

5pm has assisted in streaming to alternatives but is not robustly in place in any other specialty nor is it matched to the demand profile. The 'discharge to assess' beds spot purchased in Care Homes for ongoing assessments, particularly for CHS Decision Support Tool assessments, may appear to be logical. The end result has been a process that has assisted in perversely impacting on the Nursing Home market whilst generating a 'queue for a queue' of patient's waiting transfer, which has been as high as 15 patients, when a proportion of these 'discharge to assess' processes can be delivered in the patient's own home. A final example, is the generic re-direction of all ambulant patients without overt injury to the Urgent Care Centre based at the LRI, this was aimed at reducing 'foot fall' at the ED which it achieved for a period of time, however, this process has resulted in an unacceptable transfer rate of between 15-30% back to the ED at the LRI. One of the key issues in LLLR has been the failure to apply systematically known improvement methodology techniques across the system to ensure that changes put in place actually bring about the benefits intended. The starting point for any improvement work is a joint analysis of actually where the problems are both by the utilisation of effective metrics but also by 'walking the patients journey' and observing processes and asking those providing care what are the 'blocks' to the processes of care. The risk is always in the creation of assumptions based on 'old think' that re-enforces silo mentality across a system.

The systematic application of improvement methodology does bring about significant improvements in flow and outcomes across urgent and emergency care systems. System leaders who focus on building capability and capacity and ensuring the routine application of improvement methodology has been key to the success of organisations such as Salford Royal NHS Foundation Trust, Intermountain Health in Utah, Jonkoping County in Sweden and Canterbury District Health Board in New Zealand. There are no quick fixes to bringing about sustained high quality change across systems. The Kings Fund paper 'Reforming the NHS from within: Beyond hierarchy, inspection and markets' (http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/reforming-the-nhs-from-within-kingsfund-jun14.pdf) highlights some of the benefits achieved amongst many of these high performing systems. It requires a long term vision of what the future needs to look like with 'investment' in time and effort in building capability and capacity in improvement methodology. In the early 1990's Leicester had some of the leading national expertise in Quality Improvement Methodology but over the years appeared to lose its way. In LLR currently there are pockets of expertise in Quality Improvement Methodology in which there is an opportunity to coalesce in to a Leicester Improvement Academy to provide the training and development across the system to support ongoing improvement.

The impact of building capacity and capability in improvement science applied to urgent and emergency care has been highlighted by the Health Foundation's 'Flow Cost Quality' programme (http://www.health.org.uk/public/cms/75/76/313/4196/Improving%20patient%20flow.pdf?realName=T67pC0.pdf). Of particular note, in view of the challenges faced by the frailty pathway is the specific programme from Sheffield which resulted in marked improvements in flow and quality for older people (http://www.health.org.uk/media_manager/public/75/publications_pdfs/Improving%20the%20flow%20of%20older%20people.pdf).

Recommendations

- **Build capability and capacity in improvement methodology, coalesce the pockets of improvement teams and align to clinical work streams of improvement.**
- **Invest in developing an improvement structure across the system. There is an opportunity to link with NHS Improving Quality, the Universities and regional and national industries with expertise in quality improvement to build a 'Leicester Improvement Academy'. This would aim to build improvement methodology skills amongst health and social care staff as well as equipping graduates in health and social care with these skills for the future.**

2. Observations and Recommendations

General Recommendations

- **In all steps of the patients journey, quality improvement work needs to be aiming to ensure that patients are able to answer the 4 key questions of:**
    - **What is wrong with me or what are you trying to rule out?**
    - **What is going to happen to me now, today and tomorrow to get me better?**
    - **What do I need to achieve to be able to return to my usual self?**
    - **How long will this take?**

2.1 Primary Care

- This cannot be an exhaustive review of the entirety of primary care. Only a small number of Practices have been visited along with Locality meetings. The focus of the visits has been on urgent care processes within Primary care.
- Primary Care in Leicester City is under particular pressure with a significant number of single handed Practices and problems with some Practice estate and recruitment. In Leicester County, the 'health' of Primary Care is better.
- Variability of the quality of care in Primary care is as great as that in Secondary care.
- The Primary Care Patient management System in LLR is Systmone or EMIS.
- An understanding of the 'streams' of patient groups presenting to primary care needs to be considered. There are many descriptions of these streams within the literature and these can be summarised as; children, adults with single issues, adults with long term conditions and/or frailty, children and adults with mental health issues. From any one of these groups urgent care needs may arise.
- In response to these 'streams' of patients there are a limited array of primary care responses with standard appointments, long term condition clinics and a small range of other alternatives.
- The Quality Outcomes Framework (QoF) for Primary Care was intended to incentivise improvements, unfortunately QoF is in effect an 'inputs framework' not an outcomes framework. Nationally, there is evidence that QoF has not delivered the potential gains to the system that were perceived (http://www.kingsfund.org.uk/sites/files/kf/Impact-Quality-Outcomes-Framework-health-inequalities-April-2011-Kings-Fund.pdf)
- LLR had extensive input from the Primary Care Foundation within the last 5 years specifically examining urgent care responsiveness. It was reported by the Practices visited that the extent of delivery of the recommendations from that work has been variable.
- Booking of appointments differed across every Practice varying from a development of 'Advanced Access', through full telephone triage, through to a process equivalent too 'first come, first served' booking. In all Practices the same day appointments were invariably booked within 30 minutes to an hour of the lines opening. Some Practices have 'own list' booking for a named GP for every patient. This results in significant loss

of capacity of appointments. The evidence base for reducing admissions with continuity of GP is predominately in patients with long term conditions and/or frailty.

- Identification of patients with frailty is not well done across the system and can be improved.
- There is a plan to review 2% patients who have been identified as at high risk of admission to hospital. It was not exactly clear how the risk stratification has been carried out. Of the review meetings observed, there did not appear to be any means of identifying whether the interventions where going to have any impact. With small volumes in each practice it is likely that Federations of Practices with total list sizes of at least 30,000 and probably closer to 60, 000 would be required before any meaningful impact was measurable.
- There is variability in the 'offer' from Primary Care for those at risk of admissions with some having clear 'red flag' identification, advanced care planning and rapid response to these patient's needs. Although there is the roll out of advanced care plans, their utility and impact is variable and some reviewed have been somewhat simplistic. However, it is difficult for very busy GPs to provide extensive input in to ACPs as well as delivering everything else that is needed of them. This is yet another example of the potential for federation to support this type of work.
- None of the Practices visited were recording 'dropped call' rates, which is the missed demand which may 'escalate' to another level of care.
- The review of information provided to Practices on a daily basis on HERA is variably utilised. This system, amongst other information, provides Practices, via a dashboard similar to that developed in Bolton, with information on that Practices patients use of Out of Hours services, Urgent Care Centre, the Emergency Department and emergency admissions. This provides an opportunity for information sharing across the system as well as feedback opportunities to inform patient choices.
- Practice response to urgent care need is also variable for those unable to come to the Practice. Ranging from a GPs in a Practice providing all visiting cover during the day aiming to provide early review for those patients who cannot get to the Practice. Others have utilised a 'paramedic' rapid response service, originally provided by EMAS but 'degraded' due to need to respond but this has been set up again. Finally, through to a 'standard' response of visits after morning and afternoon 'surgery'. There is a need to obtain robust data on impact on the system of the various non-traditional schemes.
- There is also the 'GP in a Car' service (Clinical Response Team CRT) in Leicester City which has not been directly reviewed but has been discussed with both EMAS and Leicester City CCG. The aim has been to take Green 3 and 4 calls and currently this has been delivering a 70% non-conveyance rate. The volume expected to be seen was 16 per day, since inception the numbers have never been higher than an average of 2 per day. There is a move to start to take more R2 to G4 calls as well as calls from Care Homes and this is due to begin in November. It has to be noted that South Central ECPs are reported as delivering a non-conveyance rate in excess of 70% for all Green calls and this has been replicated in other Ambulance Services.

- There is a need for significant investment in Primary Care, particularly in the City. This is both capital and revenue investment, which in these cash constrained years can only come about by significant shifts in patient flows and activity with re-alignment of resources with improved outcomes for patients delivered through better integration.

Recommendations

- **Re-evaluate the input from the Primary Care Foundation as to urgent care booking processes in Primary Care to ensure that 'demand' is met appropriately and consistently across the system.**
- **SystmOne provides an opportunity to link to the electronic Frailty Index (eFI) which has been developed from research from Bradford and Leeds and has support from Professor John Young (http://www.tpp-uk.com/wp-content/uploads/2014/06/ResearchOne-Document-Frailty.pdf). The eFI is being externally validated using the THIN database which uses data from a different clinical management system, Vision from INPS Ltd. If this is not utilised then the Edmonton Frail Scale has been reasonably well validated in the Primary Care/Community setting. See NHS England's document 'Safe, Compassionate Care for frail older people using and integrated care pathway' (http://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf).**
- **Building a register of older people with frailty then provides the opportunity to test models of care to provide care closer to home rather than transfer to Hospital.**
- **Co-develop with community services, out of Hours providers, EMAS and Specialist Geriatric Medicine services a much more comprehensive approach to Care Homes appropriately minimising transfers in to secondary care. This same process would be applied to patients in Community Hospitals.**
- **Sharing of clinical information above that of 'special notes' and the core items of a summary record are required across the system to allow the 'unheralded' patient to become a 'heralded' patient no matter how they present to the system.**
- **The formation of federation of Practices to a cumulative list size of at least 30,000 but more usefully 60,000 needs to be considered. There is a Toolkit to support the development of primary care federations from the Kings Fund, Nuffield Trust and Hempson's Solicitors provides some guidance (http://www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/19A1F84B41A04DFE8AAAF2F65FD3D757.ashx). The opportunity from Federations are highlighted in this paper and on the RCGP website. What could be considered is a means of managing the streams of patients, children adults with single issues, adults with LTC or Frailty etc. could be managed by specific teams within the federation with opportunities to link with Secondary Care Specialists and the wider community services to provide better integration of care focussed around the patient,**

rather than the patient 'traversing' the system to obtain the necessary inputs.

- **The NHS England '5 Year Forward View' has made similar recommendations :**
- ***'One new option will permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care - the Multispecialty Community Provider. Early versions of these models are emerging in different parts of the country, but they generally do not yet employ hospital consultants, have admitting rights to hospital beds, run community hospitals or take delegated control of the NHS budget.'*** **This option would be more appropriate for Leicestershire County/Rutland in view of the rurality.**
- ***'A further new option will be the integrated hospital and primary care provider - Primary and Acute Care Systems - combining for the first time general practice and hospital services, similar to the Accountable Care Organisations now developing in other countries too.'*** **This option may be more appropriate for Leicester City.**
- **The formation of federations of practices would make alignment and integration of community health and social care teams to a population served very much easier. The development of skill mix within this much larger team of GPs, Practice Nurses, Specialist Nurses, Planned and Unscheduled Teams and the Social care teams has the potential to extend the capacity of the 'local' system to manage the streams of patients presenting to primary care as well as the opportunities for health promotion.**
- **Since nationally QoF is not delivering the outcome benefits expected, create integrated long term care/frailty stream programmes with appropriate standardisation, feedback loops, and patient information systems. These integrated models have been shown to have a significant impact on outcomes be that admissions, beds occupied and progression of disease burden. The operational evidence from Intermountain Health, Canterbury District Health Board, Jonkoping County and others is that outcomes for these long term conditions can be improved with fewer bed days and admissions.**
- **Ensure that call rates are monitored and the call answer capacity is matched to the demand to ensure 'capture' of all demand be that 'urgent' or 'routine'.**
- **Ensure that same day capacity for true 'urgent care need' is mapped appropriately to that demand. It would be worth refreshing the work carried out by the Primary Care Foundation.**
- **Align Primary Care response to urgent care need in older people with frailty to the standards set out in the 'Silver Book', that is a visit if required within 30-60 minutes of request. The sooner such patients are assessed, have necessary treatment initiated or are transferred to hospital for necessary specialist assessment and**

initiation of treatment the higher the likelihood of avoidance of deconditioning.
- **From 0800 to 2200 hrs, GP to Consultant discussion of all urgent/emergency referrals (unless immediately life threatening) to consider alternative non-admitted pathways.**
- **Care Home non-life threatening 999 calls to be supported by a clinical response co-ordinated by the EMAS clinical desk to ensure 'advanced care plans' are activated.**
- **Review the cost effectiveness of the CRT system for the City of Leicester.**

2.2 NHS 111/Out of Hours

- NHS III for Leicester is provided by Derbyshire Health United Ltd which provides this service to Derby/Derbyshire, Northampton/Northamptonshire Leicester/Leicestershire and Nottingham/Nottinghamshire, serving a population of approximately 4 million. DHU Ltd also provides the Out of Hours Primary Medical Services for Derby/Derbyshire.
- The information system used by DHU Ltd is ADASTRA and as with all NHS 111 services, and as with all NHS 111 providers the clinical assessment system is NHS Pathways.
- Adastra has an alert process for patients with 'special notes' to which provides additional information usually from the patient's own GP which may assist in case management out of hours. All calls for the Out of Hours Service go via 111, in Derby/Derbyshire since there is an integrated service, this allows the NHS 111 provider to directly book what is necessary, whilst with all other Out of Hours providers, there is a secondary call to manage the provision of service be that telephone advice, appointment etc.
- NHS 111 has been live for Derbyshire for almost 3 years, approximately 18 months for Nottingham and Northampton and just under a year for Leicester. The Leicester launch was delayed due to the national concerns regarding some of the implementation of NHS 111.
- On handover from NHS Direct, it is reported that there was little in the way of operational performance data provided to NHS III to be able to model likely capacity needs. Although now reasonably well resolved, this is a lesson for when any significant changes in provider are being considered.
- At the outset of the service the Directory of Service (DoS) was an issue around extent and type, availability and free capacity. DHU Ltd have their own DoS Leads to continuously update and develop the DoS, however, available capacity is still an issue for the DoS.
- With some modifications of NHS Pathways and ongoing development of staff ambulance activation rate has fallen from 11% and is now down at 8% which was reported as the best in the country.
- Between 23 and 27% of the LLR population will ring NHS 111 in a year which is at the contract volumes but not at the target volume which is aimed at 30%.
- Although not 'usual business' there has been some re-classifying/re-triage of calls with EMAS using their Advanced Medical Priority Dispatch System (AMPDS). From discussions with EMAS, this appeared to be an

agreed process, with discussion with DHU Ltd, it appeared that this was part of REAP escalation when call levels reach CRP3 level, with re-direction of calls either back to NHS 111, the website or even to make their own way to an Urgent care Centre or the Emergency Department (East Midlands Ambulance Service 'Capacity Management and Escalation Plan' Sept 2013). A possible solution to this latter problem would be a two way link for re-direction aiming to optimise capacity across the two providers.

- For Primary Care Practice Education Days, in Northampton NHS 111 has the contract to take the calls on the afternoons all the practices have education sessions. For LLR, Nottingham and Derby, there are separate private call handling providers before 6 pm but after 6 pm calls revert to NHS 111. However, since patients find remembering NHS 111 easier than the alternative providers, NHS 111 frequently receives the calls despite not having the contract to do so.
- During the day NHS 111/Out of Hours response vehicles remain relatively idle. Notwithstanding the insurance and equipment issues, is this not an opportunity for EMAS to use available vehicle capacity during the day, particularly in the morning.
- The Out of Hours Primary Medical Services for Leicester/Leicestershire/Rutland is provided by Central Nottingham Clinical Services. Out of Hours Primary Medical Services are provided from the following localities Leicester Royal Infirmary – Clinic 1, Loughborough Urgent Care Centre, Hinckley & Bosworth Community Hospital, Lutterworth Community Hospital and Rutland Memorial Hospital in Oakham. These require appointments to be made via the Communications Centre at Fosse House. Minor injuries at both Loughborough UCC and Oakham Minor Injuries Unit can arrive without an appointment.
- There are at times significant volumes of patients referred by the Out of Hours Service in the Clinic 1 area to the Emergency Department, particularly specialty referrals when the bed holding specialty do not respond to accept the patient.
- When and if the Urgent Care Centre has overload, there is no process for mutual aid and support from the Out of Hours provider. This will almost certainly be down to contract or governance reasons, both of which do not make sense to patients who are waiting.
- The OOH service provides cover for the Community Hospitals and it has been reported every Community Hospital visit that the response to any acute problem is to recommend transfer back to the Acute sector. A significant proportion of these transfers could be managed without transfer with forward planning and appropriate skill sets co-located with the Community Hospitals.

Recommendations

- **NHS 111 and EMAS continue to work together to reduce the impact of escalation in isolation on the operational performance of each other.**
- **EMAS considers the opportunity, notwithstanding the insurance issues, of using NHS 111 vehicles which are not utilised during the day.**

- **Increase the joint training and development across NHS 111 and EMAS to increase the level of mutual understanding and to explore further opportunities of operational support.**
- **LLR to consider commissioning intent with regard to NHS 111 and OOH Provider or to consider facilitating NHS 111 having direct booking to OOH appointments.**
- **LLR in conjunction with providers to ensure that the Directory of Services provides real time information on capacity within the system, even if this is just a 'yes/no' flag for being 'open' for new referrals.**
- **OOH services to provide face to face contact with patients in Community Hospitals and Care Homes before requesting transfer to UHL, providing that LPT ensures that all patients have a 'what if plan' recorded for the OOH team to operate against. If this is not achievable then an alternative process of medical cover is provided for these inpatients.**

2.3 Ambulance Service

- There can only be a brief overview of the ambulance service from this review, however, there continue to be opportunities for improvements and better integrated working especially with NHS 111.
- As with the rest of the UK East Midlands Ambulance Service operates on the 'Anglo-American' model as opposed to the 'Franco-German' model of Emergency Medical Services. In essence the difference between these two models is that in the former the patient is taken to the Hospital whilst in the latter the 'Hospital' is taken to the patient. There is little evidence of any significant difference in outcomes between these two models of care, yet there are fewer transfers to Hospital in the Franco-German model. Differences between the two models are becoming more blurred with the rise in the development of pre-hospital medical care in the UK and US.
- Notwithstanding consistency of offer by the Urgent Care Centres not co-located at the Leicester Royal Infirmary, there are opportunities for an increase lower category calls to be conveyed to these units rather than the main Emergency Department, if they cannot be managed at scene. Particularly stark is for this opportunity at Loughborough, which as a locality generates the 2nd largest number of calls after Leicester City within LLR. With an Ambulance station directly opposite the Urgent Care Centre, there is a significant opportunity to increase conveyance of appropriate level calls to that unit. As a consequence there would be a significant reduction in journey and turnaround times releasing response vehicle time back in to the system to respond to R8 and R19 calls more rapidly.
- It was reported that 90% of calls are responded to within 5 seconds, this is a significant improvement over previously.
- There is an average 32 second dispatch time which needs to be improved further. Fortunately the demise of call connect dispatch has reduced the extent of multiple activations of vehicles.
- There have been significant improvements in East Midlands Ambulance Service response times although they are not resilient. Releasing more

resource back in to the ‘response vehicle pool’ after handover is one of the key improvement aims.

- Ambulance turnaround times are not consistently measured across the East Midlands system where there are some areas with RFID activation of the clock start for turnaround but this is not the case in LLR. For this to be consistent RFID activation must be achievable whether there is a queue of ambulances attempting to access the ED. Standardisation is the key to turnaround times following the principles of the Emergency Care Intensive Support Teams paper on turnaround time (http://www.england.nhs.uk/wp-content/uploads/2013/08/amb-hand.pdf) and the guidance from NHS Confederation ‘ Zero Tolerance’ (http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Zero_tolerance061212.pdf).
- The Clinical Desk at EMAS takes Green 3 and 4 calls re-directed to them to attempt to manage as ‘hear and treat’. This team is currently being augmented and there has been an increase in the ‘hear and treat’ closure of calls.
- A very significant impact on operational performance is the number of calls for falls including from Care Homes, where ‘no lift’ policies are in place. There have even been occasional calls from Community Hospitals when there has not been significant injury.
- There does appear to be some batching of ambulance arrivals at the ED the underlying cause of which is not immediately clear and occurs on a variable basis. Likewise, GP referred patients, although on average the arrival times peak at around 2 pm, there are times when these patients arrive in a batch late afternoon. This appears to be the case in particular when the EMAS is under pressure from volume of calls. The EMAS Capacity Management and Escalation Plan Sept 2013, but still live on the EMAS website as of July 2014 (http://www.google.co.uk/url?sa=t&rct=j&q=emas%20capacity%20managament%20action%20plan%202014&source=web&cd=1&cad=rja&uact=8&ved=0CCYQFjAA&url=http%3A%2F%2Fwww.emas.nhs.uk%2FEasysiteWeb%2Fgetresource.axd%3FAssetID%3D56627%26type%3DFull%26servicetype%3DAttachment&ei=J08-VMrZFZWtacLogfgM&usg=AFQjCNHBEoNDLn9wbo0PwuqHF2b_4KkMJg&bvm=bv.77412846,d.d2s), does indicate that GP calls requiring transfer to hospital may well state to the GP that unless they deem the call a 999 status may result in a standard 4 hour response time rather than a 2 hour response at certain levels of escalation. Inevitably, this will result in batching of some GP requested transfers to Hospital.

Recommendations

- **The system needs to ensure that turnaround time data collection and reporting are effectively monitored. To this end a formal review of turnaround times by ECIST or by Dr Anthony Marsh, CEO WMAS, is recommended.**
- **Direct transfer of patients to Urgent Care Centres with appropriate handover minimum data sets is an easy win across a system working effectively as an integrated system e.g. 24 hour surgery and St John’s Ambulance in Christchurch, New Zealand. With**

Loughborough being the second largest ambulance callout locality within LLR and with an ambulance station just opposite the UCC, there is a clear opportunity for improved flows to this UCC as opposed to conveyancing to the LRI.

- **Patients with long term conditions with clear case management plans can be transferred to their own GP during normal working hours, again this is evidenced from the COPD and CHF pathway management in Christchurch, New Zealand.**
- **The LLR system urgently needs to consider an integrated falls response process to minimise the impact of falls on EMAS. This needs to consider a 'lifting' service to Care Homes.**
- **Further development of pre-hospital medical care with a reduction in conveyance to the Acute sector needs to be further developed. This requires improved integration between the Ambulance service, primary care, community providers, and pre-hospital emergency medicine specialty services.**
- **As a strategic intent, GP referred patients to UHL need to arrive at the Hospital as soon after the referral as possible since there is the potential for up to 40-60% of these patients to be managed as a zero length of stay having had appropriate diagnostics and senior review with a definitive case management plan. Late arrival significantly increases the risk of an overnight stay. This is particularly important for older people with frailty who should be conveyed to Hospital within 60 minutes of a GP request.**

2.4 Urgent Care Centres

- There are significant variances across the Urgent Care Centres (UCC) within LLR, that have been visited during this review, which were those based at Loughborough Hospital, the LRI and Rutland Memorial Hospital. The extent of the variance makes some of these services not fit for purpose. There are, however, good examples of provision but these are actually away from the central service based at the LRI, most notably at Loughborough.
- It appears that the basis for the contract shift to the Urgent Care Centre at the LRI was based on an attempt at 'local optimisation' to reduce 'foot fall' at the LRI ED. This was considered to be a safety imperative and is an area of 'local optimisation' that has had a perverse impact.
- There are issues with the UCC model at LRI which are predominately down to its non-alignment with the key quality indicators described by the Primary Care Foundation's report 'Urgent Care Centres – What works best' http://www.primarycarefoundation.co.uk/images/PrimaryCareFoundation/Downloading_Reports/Reports_and_Articles/Urgent_Care_Centres/Urgent_Care_Centres.pdf. The reporting of key performance indicators from the UCC are relatively opaque.
- The contract stipulates that all 'ambulant non-injury patients' be directed to the UCC without their being a joint front door 'initial assessment process'. As a consequence a significant number of patients walk down from the ED to the UCC only to walk back up again an hour or two later. This is

fundamentally flawed and is indicative of a process redesign without understanding of patient flows. The re-direct rate of patients from the UCC to the ED at the LRI varies between 15-30% some of which are due to failures of specialties accepting referrals from the UCC GPs.

- There are issues with the 'triage process' within the UCC which is protracted, fails to identify patients who should be in the ED and there have been a number of clinical incidents reported of potential risks. There are a significant proportion of patients re-directed from the UCC after 'triage' that are transferred late, and a proportion very late i.e. beyond 90-120 minutes. A re-direct rate of <2.5% from the UCC is an acceptable goal.
- The UCC process is that of a 'triage and wait' model. The 'triage' process is excessively long and adds little value to the patient's journey. In addition, it is at this step that re-direction should take place, however, all too often the patients are not re-directed until they have been seen a definitive clinician.
- There have been a number of clinical incidents of patients with significant pathology being transferred late. The model needs to change urgently focussing on safety and effective streaming at the point of access.
- On occasions the ED staff provide mutual support to the UCC if waiting times increase within the UCC. This is occurring on an increasingly frequent basis and is causing a drain on processing capacity within the ED.
- The UCC does have the facility to book in to a patient's usual GP urgent slots with practices holding up to 2 appointments per day for this function. In all the Primary Care Practices visited, they all reported that this had never been used. This is wasted Primary Care urgent care capacity.
- Filling clinician 'slots' at the UCC at the LRI has been problematic with capacity gaps occurring far too frequently resulting in protracted journey times. These capacity/staffing gaps have been reported late to the ED resulting in batches of already delayed patients beyond 2 hours arriving in the ED.
- Mutual aid from the co-located OOH service in Clinic 1 does not occur when there are clear opportunities to do so and this opportunity is highlighted in the Primary Care Foundation's report on UCC.
- The UCC at Loughborough sees approximately 45000 attendances per year of which 1500 are fractures. The service is run by CNCS. There is a GP with a special interest in injuries who provides specialist support to the UCC in Loughborough and also to the UCCs at Market Harborough and Oakham. The fracture service provided is deemed to be of high quality by the ED at the LRI. The service is dependent on this one individual and is thus vulnerable if he were to become unavailable. During the day the service aims to be predominately an injuries service re-directing minor illness back to their GP. Out of hours there is a two track service both run by CNCS to two different contract arranged by two CCGs resulting in parallel services with loss of flexibility. The UCC at Loughborough for its injuries service is dependent on access to radiology, which is currently available from 0900 to 1700 Monday to Friday, which does not match the demand profile. In addition the costing arrangements for radiology impact on the financial status of the model. The UCC at Loughborough provides

a high quality local service and maintaining its viability must be seen as a priority for the system in view of the volume of cases seen.

- There had been an arrangement for EMAS to bring Category 3 patients to the UCC at Loughborough but this does not appear to be occurring.

Recommendations

- **The UCC co-located at the LRI should co-develop with the ED a true joint front door as opposed to the 'single decision front door' currently in operation.**
- **This joint front door should stream patients to the appropriate clinical teams based on clinical need.**
- **An acceptable re-transfer rate is <2.5% for cases in whom there is not an attempt by the UCC to refer to an in-patient specialty.**
- **For patients in whom the UCC is attempting to refer to an in-patient specialty and there is no response within 30 minutes by that specialty, then the '30 minute rule' should be automatically invoked.**
- **The UCCs and the ED should develop a joint clinical governance framework to promote trust and mutual aid across the urgent/emergency floor.**
- **The OOH service in Clinic 1 and the UCC should be providing mutual aid and support to each other.**
- **The UCC should review demand and capacity and refresh processes to ensure that dispersal profiles achieve 90% completion by 120 minutes**
- **A minimum of data reporting as outlined in the Primary Care Foundation's report on UCC should be made available across the system with the same time availability as that of the ED. It has to be considered whether UCC should use EDIS for tracking purposes.**

2.5 Unscheduled Care Community Health Services

- Referral to community services is via the Single Point of Access (SPA). Users within the system comment that there can be extensive delays in accessing the SPA via the telephone. Referrals can be faxed but users have commented that a proportion of referrals via Fax seem to get lost. There has been recent work on building up capacity and standardisation of processes within the SPA. This has resulted in improvement in response times from SPA, however, there is still considerable room for improvement.
- The services comprise the Unscheduled Care Team and the Intensive Community Support Service (ICS). There is a Therapy team, which used to be integrated with the nursing team as an Intermediate Care Team, and it is still known as the 'Intermediate Care Team' (ICT). The first two are integrated whilst the therapy led ICT operates in a partially separate manner. It is not clear why the 'Therapy Team'/ICT have been separated from the Unscheduled Team, although there is some routine domiciliary services.
- The separation of the unscheduled and scheduled case load occurred earlier this year. In essence, the planned service is a predominately the District Nursing service providing wound management/dressings, injections e.g.

insulin and Vitamin B12 and some palliative care support. If there is an unscheduled 'event' relating to the planned case management, e.g. a wound dressing becoming saturated or becoming dislodged, then the service user contacts the Single Point of Access which is manned by non-clinical staff, who logs the call as a task for the unscheduled care team. The demand for the unscheduled care team was initially expected to be 5-6 calls per day per team. All 4 teams visited so far have reported a rate far in excess of this and not infrequently exceeding 30 calls per day. In addition, since the task is logged and there is little opportunity to 'manage the task load', each team stated that on visiting at least 50% of the visits were unnecessary and others could be managed by pro-active planning. This is reported by all the teams visited (5), and the managerial team supporting and developing these teams, to be consuming in excess of 60-80% % of the nursing team's capacity.

- In view of the excess tasks being generated for the unscheduled care team from the predictable unplanned episodes from the planned process, the Intensive Community Support is struggling to manage its virtual ward caseload. In addition, there are at times difficulties in transferring care to a less intense support teams/care packages (health or social care or both) with resultant inability to clear capacity to take on the next patient.
- The Unscheduled Care Team and ICS and Intermediate Care use SystmOne however their records are not integrated, likewise with the planned care teams. This results in the need for duplication of logins and increases the risk of wasted capacity. The unscheduled nursing team and the ICT therapy teams used to be an integrated team but are currently managed separately.
- There had been an issue with the remote working software, Briefcase, in which complete assessments were not infrequently lost and had to be re-entered on return to base. This resulted in teams' not entering information in real time but updating on return to base. The recently implemented 'mobile working' appears to be more robust with data being stored and then uploaded in to records on accessing a Wi-Fi server. However, the ability to view full community records from other teams remains limited.
- Response times for the nursing team for the unscheduled needs are measured in a few hours. For the ICT (Therapy Team) there is a 'contract' arrangement of 72 hours. This 'contract' arrangement was reported by each of the Therapy teams visited and when challenged was robustly confirmed. This is of no value and affects the utility of the team to support early discharge.
- The ICS/ICT(Therapy Team) referral form is two sides of A4 and is too long as a consequence. It includes the question, if the patient lives alone, 'Do they need assistance at night?' with the response that if yes 'refer to community hospital'. Night assessments in the strange environment of a Hospital will significantly over estimate the need for night time assistance. This question and its advisory response to the answer 'yes' will be driving bed based care and thus deconditioning.
- The referral form is faxed to the SPA and the ICS or ICT decide whether they are going to accept the referral. This adds a further delay in to the system.
- Across the teams in the community and with the interface with both the community and acute hospitals teams there are multiple re-assessments, likewise with the Social Care HART and ICRS teams. This results in considerable wasted capacity.

- Equipment delivery was reported as reasonable, i.e. the next day, but there are 'constraints' in the system as it was reported that 'nurse can't order frames' and 'physiotherapists can't order beds'. This forces multiple assessments and re-enforces silo multi-disciplinary working rather than the much more flexible inter-disciplinary working.
- All teams reported that there was an expectation that the 'virtual wards' are running at near full capacity. This has resulted in delays in step down from this service and thus reduces availability to respond to the next patient.
- In all, there appears to be a degree of inflexibility built in to the system that results in significant lost capacity, which could be as high as 50% or even more.

Recommendations

- **The SPA improvement programme needs to progress to ensure that all calls are responded to within a pre-set time limit. Secure email for referrals needs to be considered.**
- **The unscheduled aspect of planned care needs review. It is likely that a significant proportion of these 'unscheduled tasks' could be avoided with an improvement in the quality of the planned contact, anticipatory planning in the case of change, and alternative responses to the 'task' assignment via SPA.**
- **Facilitate equipment access for multi-disciplinary teams to prevent duplicate assessments.**
- **The assessment for night time needs should not be determined in a Hospital setting but once the patient has returned home which may include technological solutions.**
- **Create consistency of offer across community teams. The ICRS Leicester City social care in-reach process to pull patients back in to the community needs to be replicated across the system In addition, an integrated health and social care in-reach process could pull significantly more frail older people back home, provided an appropriate diagnosis and treatment plan has been initiated.**
- **LLR needs to consider the potential of effective operational integration. In New Zealand, Canterbury District Health Board's standardisation, improvement methodology and integration of health and social care processes has brought about significant improvements. This has resulted in no increase in ED attendance or Emergency admissions for patients aged 65 and over for over 5 years despite a greater increase in the over 65 population than the rest of New Zealand. There have been fewer long term care placements and life expectancy at 65 is growing faster than the national average. These same processes when applied to patients with COPD resulted in a 30% reduction in occupied bed days within one year of implementation of the change programme. (http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/quest-integrated-care-new-zealand-timmins-ham-sept13.pdf).**
- **Unscheduled care teams/ICS/ICT with ICRS and HART need to align with the PCC and UHL therapy teams and the Geriatricians**

to identify patients at risk of a long length of stay at the point of admission and provide daily challenge to remaining in-hospital. This requires a service/team that is integrated and prepared to provide continuity for patients as they journey through the hospital. When a similar model was implemented in Plymouth some 6-8 years ago it released 4 wards worth of beds,

2.6 Community Hospital Beds

- There are approximately 250 Community Hospital beds over 8 sites. Two of the sites have stroke rehabilitation facilities, Coalville Hospital in Coalville and St Luke's Hospital, Market Harborough. Medical cover is provided by Consultant Geriatricians with twice weekly rounds although this can be variable especially when annual leave is being taken. Day to day cover is provided by Advanced Nurse Practitioners, who also provide day to day cover for the ICS Team.
- There is a proposal to provide additional virtual supervision by a tele link to a Consultant. This is about to be trialled and is worthy of testing with regard to impact on flow.
- The vast majority of inpatients have been referred from the Acute Trust using the BB1 form. There is an option for the Community Hospitals to decline referrals.
- A significant proportion of the patients referred to the Community Hospitals could have been managed through a direct discharge home route. Direct discharge home would be the case if expected date of discharge and clinical criteria for discharge had been set, along with assertive case management from the point of arrival, along with supported discharge, on the day required for those who need it, were the processes in place for older people with frailty. For many patients, the process in place is that of delayed initiation of case management without clear EDD and CCD to prevent in-hospital deconditioning. In addition, patients who have not as yet 'achieved baseline' or who have perceived 'in-hospital' night time needs are referred for rehabilitation in the Community Hospitals when alternative home based rehabilitation is an alternative. This then creates a perceived need for rehabilitation and further deconditioning occurs. This then results in a transfer to a community hospital.
- As already mentioned under the Out of Hours Primary Care section, medical cover out of hours is provided by the OOH service. However, the main response to contact is to arrange transfer back to UHL.
- The pace at the community hospitals is slow although there has been some reduction in length of stay over the last year. Average length of stay and benchmarking against other Community Hospitals is of limited value. The flow through the Community Hospitals as with the acute sector needs to improve further. For a variety of presentations there are some guides for length of stay, for instance 32 days for patients presenting with falls. This will result in some regression to the mean and although the multi-disciplinary teams stated that they were only guides it became apparent on the visits that patients 'drifted' towards discharge in the community hospitals visited.

- It was reported at a number of Community that patients arriving on a Friday do not routinely receive a therapy assessment and can subsequently spend 3 days without effective mobilisation resulting in significant deconditioning.
- The ‘standard’ for therapy assessment is within 48 hours of arrival.
- There are daily Board rounds during the working week with the ANP, Nursing Staff and AHPs in attendance. There are multi-disciplinary meetings when the Consultant geriatricians do their rounds. The Board rounds observed did not appear to be appropriately focussed and lacked challenge to delays.
- There was one exception at one Community Hospital where a multi-disciplinary board round was observed with clear focus on clinical criteria for discharge and an expectation of discharge.
- The extent of 4 times per day double handed packages of care being stated as required by the multi-disciplinary teams reflected the same rate as that requested within the UHL. There were also high rates of plans to move to long term care placements either Discharge to Assess, CHC or Fast Track.
- In a number of Community Hospitals there were observed a number of patients who were mobile either independently or with minimal assistance who in other systems would have been discharged home.
- The most risk averse to discharge within the Community Hospitals appeared to be the Therapy Teams. As with UHL Therapists there were considerable instances of delay in discharge because the patient was not ‘back to baseline’. At the one Community Hospital observed having an focussed ‘board round’, the therapy team were planning discharge with ICS/ICT input for patients still requiring the assistance of one on transfer. At UHL this would have triggered a referral to the Community Hospital for ongoing rehabilitation. The most frustrating issue for the team at the Community Hospital with the ‘focussed team’, with over 75% of the patients on the Board Round observed going home rather than in to care, was the delay in social care provision.
- As a consequence of the extent of de-conditioning across the frailty pathway the extent of long term placement and use of the ‘bed based Discharge to Assess’ process from the Community Hospitals as well as CHC and Fast Track placement is high.
- There are patients who are transferred to the Community Hospitals in whom the diagnosis is not clear. This then results in a further re-work up of the patients and further risks of de-conditioning. There were examples of ‘over-working up’ of patients and the problems they had had for many years. For example, one lady’s discharge was being delayed for a week whilst her house was tidied up from the ‘hoarding behaviour’ she had had for years. A better solution would have been discharge home with her home being tidied up with her consent whilst she was at home. This sort of issue was also identified at UHL. This has the potential for being a ‘deprivation of liberty’ through stealth.
- It is apparent that transfer to a Community Hospital is being used as a ‘discharge process’ rather than arranging discharge direct.
- There is a significant amount of resource tied up in the community hospitals but the closure of beds before there has been the commencement of the optimisation of the frailty pathway will result in increased over-crowding at UHL. Optimisation of the frailty pathway needs to be achieved before consideration of the future use of Community Hospital beds is being considered.

Recommendations

- **The National Audit of Intermediate Care categorises four types of (http://www.nhsbenchmarking.nhs.uk/projects/partnership-projects/National-Audit-of-Intermediate-Care/year-two.php): intermediate care: crisis response – services providing short-term care (up to 48 hours); home-based intermediate care – services provided to people in their own homes by a team with different specialities but mainly health professionals such as nurses and therapists; bed-based intermediate care – services delivered away from home, for example, in a community hospital; and reablement – services to help people live independently which are provided in the person's own home by a team of mainly care and support professionals.**
- **Ensure that there are appropriate levels of 'step up' and 'step down' in intermediate care and that there is an appropriate balance between bed based and home based levels of care. This is achieved by having system level clarity of 'how a well functioning system' should operate with clear system level outcome/impact metrics.**
- **As part of the changes required to the frailty pathway (see below) there needs to be a significant increase in flow through the Community Hospital beds.**
- **Referrals to Community Hospitals should not state a '6 week duration of stay' and referral should include a clinically determined expected date of discharge and clinical criteria for discharge. Referrals should be based on the 'Home First' principle, that is the patient and family are informed from the commencement of their journey in UHL that the discharge destination will be assumed to be their usual address.**
- **The pre-set length of stay guidance should be abandoned and expected date of discharge and clinical criteria for discharge need to be used with assertive case management to minimise wasted in-patient time. Patients should be commencing active mobilisation and rehabilitation from the day of arrival.**
- **Continue to drive the 'Home First' principle and develop a culture across the teams of home based intermediate care.**
- **Therapy plans set by the referring service should be continued by the receiving Community Hospital from the time of arrival.**
- **Whilst in-patients the clinical teams need to consider proactive planning if an acute event occurs aiming for an appropriate reduction of transfer back to UHL. This may well need to involve a discussion with the on-call Geriatrician. The 'contract' with OOH should involve a standard that patients are seen and examined by the OOH service, with criteria for immediate 999 calls if necessary. If patients are to be transferred to UHL they should go direct to an assessment unit on the basis of the OOH clinical evaluation.**
- **Discharge planning should be a continuous process from the referring Hospital and based around the EDD and CCD set prior to transfer and refreshed purely on clinical need.**

- **Geriatrician cover for the Community Hospital beds needs to be more robust with a focus on driving to discharge. Virtual supervision, which is being tested, is one option to provide this level of cover.**
- **It is likely that with the drive to minimise harm from deconditioning during a hospital stay the need for Community Hospital beds by patients will fall. A large resource would then be available to further align with the 'Home First' principle.**

2.7 Mental Health

- The observations contained here are based around the interface between mental health and urgent and emergency care services.
- There are considerable concerns regarding mental health both in hours and out of hours and in addition there are particular waits for CAMHS for ED referrals. There is considerable confusion as to how the service operates. Mental health presentations for a considerable amount of workload for the ED and improving the mental health responsiveness will be of considerable benefit. This is for both in-patients and within the ED at UHL.
- From 0800 to 2300 hrs there is a Mental Health Triage team based within the ED who take referrals up to 2215 hrs. They provide a brief assessment and support direct discharge of a significant proportion of referrals. However, if a more detailed assessment is required then this team refer the patient to the Deliberate Self Harm Team, part of the Crisis Intervention Team, who are available from 0800 to 00:00 hrs and take referrals up to 2300 hrs. The DSH team will assess all patients with mental health problems in the ED and EDU and not just deliberate self harm.
- In-patient acute wards are only covered by the DSH team, who access this service through the Crisis Team Single Point of Access with variable response rates.
- After 2300/00:00 hrs, all mental health referrals go to a Junior Doctor who is part of a 'central duty roster' held by Liaison Psychiatry. This Junior Doctor is rarely of sufficient capability to be a decision maker and if further assessment and decision making is required, there is then a referral to the Crisis Team.
- These processes result in considerable delays for patients with duplication of assessments and delays in definitive decision making.
- There are recruitment issues within the CAMHS team.
- There are long delays in waiting for assessments and again if there is an in-patient bed required.
- The ED, EDU and Paediatric ED are effectively being used as holding bays for patients waiting assessments. For patients who no longer need physical interventions or monitoring, these environments are not conducive to good mental health outcomes, in particular for children.
- From a Primary Care perspective the service is perceived as of poor quality being transferred via SPA to Crisis Team. The response times from these teams are described as delayed and at times 'executive decision making' being made have at times been of concern to GPs. There is a concern that there are limited opportunities for direct discussions with Psychiatrists. The end result is that some GPs have reported that they and patient's carers can

be left ‘holding the risk’ for patients with quite severe acute mental health problems.

- The ED is an identified Place of Safety Assessment Unit and there is a Place of Safety Assessment Unit at Glenfield Hospital for patients requiring assessments under Section 136 of the Mental Health Act. Ensuring the correct patients go to the appropriate Place of Safety setting is crucial. ED should only be used where there is a need to assess an urgent physical co-morbidity.
- An innovative approach has been the ‘triage car’ with a mental health professional from LPT ad a Police Officer. It is reported that this has reduced detentions under Section 136 by around 40%.
- FOPAL provides an in-patient mental health for older people liaison service to assist in the management of challenging behaviour, delirium, older patients with psychosis and also, on occasion, for expert evaluation of capacity when there is doubt or difference of opinion. This service is well received but is only available 5 days per week.
- Applications under Deprivation of Liberty safeguarding have increased significantly this year due to clarification in the legislation after a Supreme Court Judgement. This Judgement is a highly supportive instrument for the delivery of the ‘Home First’ principle. In an emergency, the management of the hospital may grant itself an urgent authorisation, but must apply for a standard authorisation at the same time. This urgent authorisation is usually valid for seven days, although the supervisory body may extend this for up to another seven days in some circumstances. The DoLs Teams at Leicester County Council and Leicester City Council are currently stretched to deliver the authorisation of urgent DoLs within the 14 day time frame and this is despite utilising independent assessors.
- There have been observed high levels of supervision of patients with dementia who are wandering where there is a concern that the person may fall, this is both within UHL and Community Hospitals. This level of supervision which involves some restrictions would require a DoLs authorisation.

Recommendations

- **Commissioning of a more effective acute mental health services that integrate with other services needs to be a priority, made ever more relevant in view of the national focus on ensuring that mental health is given the same priority as physical health.**
- **Guidance on high quality liaison mental health services can be found at http://www.rcpsych.ac.uk/pdf/Standards%204th%20edition%202014.pdf**
- **The principle for patients who are presenting to the ED with mental health problems who no longer require physical health monitoring or interventions which of themselves would require them to remain in an Acute Trust should either be cleared for discharge or transferred, if necessary, to an appropriate mental health facility in 4 hours or less. This should be a system priority.**

- **Aiming for a single assessment and decision making process between the Mental Health Triage Team, DSH Team and the overnight Junior Doctor in Mental Health cover.**
- **Evaluate the impact of extending FOPAL to 7 days per week.**
- **Ensure that the ED is used appropriately for the Section 136 following the standards from the Royal College of Psychiatrists http://www.rcpsych.ac.uk/files/pdfversion/CR159x.pdf**

2.8 Social Care

- Leicester City, Leicestershire County and Rutland County will be reported together, where there are substantial differences, these will be highlighted. Adult social care will be the focus and children's services will not be discussed further other than to state that the Children's ED is not an appropriate setting for children to wait when there are safeguarding issues to be resolved.
- For each Local Authority there is a single point of contact for social care referrals. From the Hospital, Section 2 are issued via ICM.
- From this point on the process becomes increasingly complex and fragmented across the whole system, although there does appear to be greater consistency within Leicester City.
- The under-utilisation of multi-disciplinary owned Expected Date of Discharge and Clinical Criteria for Discharge (Keogh Standard 3), the frequent changes in discharge destination, the variance between the clinical teams on what the patient's needs are make planning by Social Care almost impossible. The end result is the issuance of Section 5 notifications late in the pathway with 'rushed' transfers of care resulting in re-admissions. A well designed system with effective collaborative working with a frailty focus can result in the almost complete abolition of the need for Section 5 notifications
- There is a high level of risk averse behaviour and requesting of excessive levels of care packages by the Hospital Teams. Clinical teams are also making recommendations around long term placement. There are also inappropriate statements made to families that 'care packages will be free for 6 weeks'. There appears to be a mis-understanding that request for social care are assessed against eligibility criteria.
- All Local Authorities (LA) in LLR, Rutland changing this in September 2014, have set their eligibility threshold as 'substantial' meaning those with low or moderate needs are not eligible for LA funded care although those clients will be 'sign-posted' to services for private purchase if they so wish. Substantial need is defined as:
    - There is, or will be, only partial choice and control over the immediate environment
    - Abuse or neglect has occurred or will occur
    - There is, or will be, an inability to carry out the majority of personal care or domestic routines
    - Involvement in many aspects of work, education or learning cannot or will not be sustained
    - The majority of social support systems and relationships cannot or will not be sustained

- The majority of family and other social roles and responsibilities cannot and will not be undertaken
- Eligibility criteria are guided by the DH 2010 publication 'Prioritising need in the context of *Putting People First:* A whole system approach to eligibility for social care' (http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113155.pdf).
- It has been recognised that the extent of interpretation of the guidance within this document has resulted in a post code lottery of eligibility for LA funded social care provision. As a consequence and as part of the Care Act 2014 (http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf), there will be national standards set for assessing and determining eligibility (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209595/National_Eligibility_Criteria_-_discussion_document.pdf). The Act and its guidance are due to come in to force in April 2015. This will also convert a Section 2 notice to a 'Referral Notice' and a Section 5 to a 'Discharge Notice' to simplify the terminology.
- It is likely that there will be an increase in the need for face to face assessments as a consequence of the Care Act 2014. The presence of Care manager support across the Hospital sector is variable between the City and the County, with the latter having a greater visibility, however, this is somewhat undermined by the process described in the next paragraph.
- Leicestershire has a Customer Services Team who take the referrals and will action care packages from direct recommendations from Hospital OTs. 70% of discharges within Leicestershire County are managed without face to face contact with minimal 'Discharge to Assess' home based processes in place to ensure that the care package is appropriate. This results in high resource utilisation. Some team members have reported that the implementation of the Customer Services Team has resulted in a de-personalisation of the service and a spatial separation from the rest of the multi-disciplinary team.
- For all Social Care teams, there are delays in contact back to the referring team when a Section 2 or a Section 5 is issued. This is both from Social care and the inability to contact the referring team member. There are at times slow allocation of a care manager in some areas in response to a Section 2. It was reported by the Social Care Teams that assessments are not infrequently delayed until deemed that the patient is ready for assessment. Since there is limited face to face contact this assumption of suitability for assessment is inappropriate.
- There are an excessive number of Section 2 notifications being issued almost as a routine for many older patients who were independent pre-admission and are highly likely to return to independence.
- There has become a relative degree of dis-connect between the social care teams and health for a variety of reasons. This has contributed to the extent of the break down in processes around planning for discharge. There is a greater presence of the County Social Care Team on the UHL sites, however, this is still not operationally optimised.

- This is not an exhaustive description regarding the interface between health and social care but is set out here to demonstrate the extent to which the processes have become incongruent.
- There has been a daily 'delayed transfer of care' (DTOC) tele-conference' which is supposed to resolve the issues. There has been no improvement in the DTOC metric across the system of any significant extent.
- The end result of this is that older people with frailty become 'stuck in the system' resulting in prolonged length of stay, developing 2nd and 3rd phase illness and deconditioning with an increased risk of a poor long term outcome. This is evidenced by the extent of CHC and Fast Track funded placements.
- No one part of the system is responsible for this situation, it has been designed by the system for the system and it will take collective integrated responsibility to resolve the issues.
- Moving on to services provided by Social care to support discharge:
- The City has a range of services under the banner of independent Living Services. This includes a community re-ablement service. A Hospital Discharge Holding Team is also available as part of this service; this is a bridging function whilst care packages start. However, the service is restricted to those with a Care Agency identified to take on the care. This team can take on the care of patients with high needs e.g. hoist and 4 times a day visits.
- The City also has intermediate care beds at Brookside Court (27) and Kingfisher Assessment Unit (10). This is a bed based re-ablement service.
- The City is implementing a Team of Care Navigators for people over 75 with frailty and complex home based needs. There is also a Practical Help at Home service for assistive technology, minor adaptations, and LeicesterCare (alarm service).
- Integrated with these services across the City and County are Social Care Occupational Therapists who provide adaptions, equipment and support by adapted re-housing. Also providing maintenance for major equipment and they work closely with Housing Staff and contactors.
- Integrated Crisis Response Service. This is designed to provide immediate support for patients who need care support and act as a 'bridging' support until an appropriate package of care is in place. It appears the ICRS will not take on 'bridging' unless a date has been provided for the commencement of a package of care from a Care Agency. Recently, the City ICRS has provided in-reach in to UHL to provide support for early discharge of patients. This then enables a 'Discharge to Assess' at home support. This has not been mirrored by the County Team. At times the ICRS teams across the system have insufficient capacity to take on new cases, some of which is an inability to step clients down to the next appropriate level of care.
- County Home Care Assessment and Re-ablement Teams (HART). These teams are designed to provide up to 6 weeks (up to 12 weeks for clients with dementia) of re-ablement within the patient's own home. HART comprises a series of managers, programme arrangers, Occupational Therapists, Senior Home Care Assistants and Home Care Assistants. It was reported by Therapy Team/ICT that there was a need to have a link therapist from their team to support HART. HART, like ICRS, have to hold a number of clients due to inability to step clients down. Outcomes reported by Leicestershire

were stated to be 50% discharged without any further support except may be assistive technology, 22-26% referred on a reduced care package, and 20-21% re-admitted to hospital, with either a new illness or still unwell on discharge.

- Packages of Care from Care Agencies. In Leicestershire County, there is described a 'crisis in care' due to the lack of availability of care workers and approved agencies. The extent to which packages of care are over prescribed on discharge from hospital due to risk averse hospital based assessment, concerns over re-admission and a mis-understanding of the assessment of needs rather than wants. There are a variety of other reasons financial, operational, social, etc. that have had an impact on the availability of care workers for the LLR system.

Recommendations

- **Within Social care as much as with Health care, the 'Home First' principle needs to be accepted as one of the drivers for change.**
- **Between health and social care, there needs to be a re-design of the discharge process to simplify the process and to remove the barriers to effective delivery of discharge.**
- **The minimum data set proposed is 13 pages long but is completed electronically. The vast majority of patients involved in a medium or complex discharge will already be known to the system. As such, the demography and all other pre-admission information for the minimum data set should be pre-populated.**
- **The minimum data set and the 3 stream discharges appears to contradict the 'Home First' principle. The vast majority of 'Discharge to Assess' should be back to the patient's usual residence.**
- **ICRS across LLR should emulate the in-reach process put in place by the City ICRS Team, to support 'Discharge to Assess' in the patient's usual residence.**
- **In conjunction with a 'front door frailty' team who track older people with frailty through Hospital to ensure near immediate delivery of discharge as soon as the patient is ready and supporting them at home through a 'Discharge to Assess' process. This is a very brief description of the discharge process developed in Sheffield (http://www.health.org.uk/media_manager/public/75/publications_pdfs/Improving%20the%20flow%20of%20older%20people.pdf) and there is a need to emulate this in Leicester.**
- **There is a need for LLR to consider how the different Social care teams and the LPT unscheduled care and ICS/Therapy Team (ICT) can operate in an operationally integrated manner to deliver the above.**
- **There is a very wide range of services across both Social Care and Community Health where there are clear examples of overlap and the risk of duplicate assessments. Simplification of structures and rules and merger of these teams has the potential for significantly improving the capacity in the ability of these services to rapidly support older people with frailty at home during a crisis and provide**

very early supported discharge for patients having completed their in-hospital treatment.

- **The further development of creative models of 'care worker' provision, tele-monitoring, tele-health and other assistive technology to support people to live in their own homes is required.**

2.9 Primary Care Co-Ordinators

- The Primary care co-ordinators (PCC) have been in place since 2005. They are based solely at LRI and comprise a Band 7 (30hrs) and 20 WTE Band 6 of which 3 are out for recruitment and 3 are for secondments.
- They did cover Glenfield Hospital for a period of time but were only being referred 6-7 patients per week for assessment which was non-viable to base a service on that site.
- This is a 7/7 365 day 0800 to 1830 hrs service for the assessment of frail older people presenting to ED, EDU, AFU (Ward 33) and Short Stay (Ward 34). There was an attempt to offer a service to 20:00 hrs; however, due to lack of availability of therapists and Social Care, this was not productive at that time.
- Note Occupational Therapy at UHL take their last referral at 15:30 and Physiotherapy take their last referral at 16:00 hrs as does Social Care. Thus discharge critical support expertise is not available when the majority of patients will be arriving or having had their initial medical and nursing assessments. This scheduling of last referral times will cause an overnight stays that are unnecessary and will result in deconditioning. It has been suggested that later presence of therapists has been attempted but did not add value, however, in view of the risk averse nature of therapy services in LLR; this might not be a surprise. What is required is a clear focus on balanced risk early discharge of older people with frailty to prevent deconditioning.
- For September 2014 the PCC saw 587 patients of which 329 were on AFU (Ward 33) and 67 on Short Stay (Ward 34). There were 153 seen in EDU (Observation Ward in ED) and the rest were seen within ED. 564 were seen between 4 and 24 hrs after arrival at the LRI. 325 went home with minor support or advice. However, only 14 went home with ICS/ICT whilst 62 went to a bed based facility.
- The PCCs do not cover Wards 15/16 or the Surgical Assessment Unit. These units have 2 'acute admissions specialist' nurses. These patients are in effect being denied access to a specialist frailty.

Recommendations

- **In conjunction with a 'frailty strategy' the PCCs, Therapists, relevant matrons and the Geriatricians formulate and test a process of rapid identification of ALL patients with frailty and thus at risk of decompensation and prolonged length of stay. This identification needs to take place at the point of access for patients being considered for referral for admission.**
- **If the patient cannot be discharged home on the day of first contact then the 'team' need to follow the patient through their**

journey aiming to maximise the opportunity for early discharge home using the 'home first' principle.

- **Work in partnership with the ICS/Therapy Team (ICT) from Leicester Partnership Trust and ICRS and HART from Social Care to plan and test new ways of working to deliver very much earlier supported discharge aiming to prevent in hospital deconditioning.**

3. University Hospitals Leicester – General Recommendations

- **In all steps of the patients journey, quality improvement work needs to be aiming to ensure that patients are able to answer the 4 key questions of:**
    - **What is wrong with me or what are you trying to rule out?**
    - **What is going to happen to me now, today and tomorrow to get me better?**
    - **What do I need to achieve to be able to leave hospital?**
    - **When am I leaving?**
- **At all steps of the patients journey, Internal Professional Standards are set which are aspirational (i.e. cannot be delivered immediately but can be achieved by continuous improvement) and are monitored. These ISPs should be simple sets of rules for optimal performance at that step.**
- **Provide written roles and responsibilities for team members, again simply articulated, at each of the step.**
- **Of particular concern is the pace of response to 'discharge critical' internal specialty referrals for in-patients (this excludes ED referrals which should have a 30 minute response time) not including radiology. The current 12 hour standard for registrar to registrar referral and 24 hours for Consultant referral is not fit for purpose. The only acceptable standard is one which states for life/limb critical response is immediate or at worst <1 hour, for all other discharge critical (referring Consultant determined not Specialist registrar) the response time should be 4 hours.**
- **Measurement against ISPs by individuals, teams and services should be visible and used as 'supportive challenge' to improve and not used for judgement.**
- **Understanding the admitted flow streams:**
    - **Short Stay Stream: all potential short stay patients, with an anticipated length of stay of two midnights or less, should be streamed to this pathway. Continuity and consistency are key to delivering high quality patient care for this group. Short stay patients should have twice daily senior review to account for rapid clinical changes, results of investigations and specialty opinions. It is to be expected that at least 65% of acute medicine patients can be discharged within 56 hours (or two midnights) if the principles of high quality care are applied.**
    - **Sick Specialty/General Stream: this stream is for patients requiring sub-specialist care for more than two midnights. Segregating these patients from those requiring short stays is essential when optimising length of stay (LOS). The specialty should be expected to create capacity on the specialist ward to allow patients to move to the ward where on-going care can best be delivered (i.e. there should be a 'pull' system). The specialist team should ensure that the patient is reviewed at the weekend by a senior doctor (good practice is that this is a consultant).**

- **Frailty Stream: This is for older people with multiple co-morbidities, including dementia, who often have fragile social support. This cohort requires early identification and the implementation of assertive case management plans. We recommend that you develop an 'in-take' process direct to the assessment unit and/or the ED to identify frail elderly patients on arrival and put in place pro-active comprehensive geriatric assessment and assertive case management as close to the time of access as possible. There is an increasing body of evidence in relation to frailty pathways (including *The Silver Book – Quality Care for Older People with Urgent and Emergency Care Needs*) that sets out the principles and recognised good practice in this area.**

3.1 Bed Meeting

- Attendance – site managers, specialty business managers and some nursing staff. The only consistent presence of senior Medical staff comes from the CD for the General Medicine and Emergency Department CMG.
- Executive sponsor is the COO.
- Predicted admissions for that day only so no forward tactical view.
- Planned admissions or transfers are passively accepted without structure or challenge.
- No use of performance data e.g. ED admit breaches by specialty and then holding the Division to account
- This meeting appears to be mostly transactional and is well structured and driven by the Senior Site Manager.
- Data is used to drive action on that day alone and not tactically across the week.

Recommendations

- **Implementation of a Gold:Silver:Bronze operational and tactical management process to support appropriate standardisation and delivery.**
- **Attendance at the bed meeting should include key senior clinical leaders from the organisation.**
- **Operationally and tactically, Divisions need to have their previous day and week performance visible for all to see and then these Divisions held to account for improvement in performance both in-day and tactically for the next week.**
- **Data regarding demand, flow, bed occupancy and 4 hour performance, with forward prediction, needs to be visible daily and used daily to drive change.**
- **The data provided to the Operations Centre should be visible to all via the intranet and as a 'pop up'/screensaver function.**

3.2 Breach Analysis

- There is little new learning from the breach analysis. The 'allocation' to ED process, bed availability etc. is crude.

- There is little in the way of collating themes to inform and improvement programme.
- A number of the 'clinical breaches' are not appropriately categorised as such being either ED process, decision making, specialty decision making etc.
- Opportunities or learning are being lost by not undertaking reviews of patient journeys where the 'system got it right', this can assist in identifying what needs to be replicated.

Recommendations

- **The setting up of a weekly Journey Meeting which should be attended by senior clinical leaders which examines both 'successful journeys' as well as 'protracted journeys' to gather learning from both.**
- **Admitted vs. non-admitted processes should be reported and examined**

3.3 Emergency Department

- There are a small number of streams of patients coming to Emergency Departments who can be identified very early in their journey , these are:
  - Going home after a brief intervention.
  - Going home after a one or two treatment cycles e.g. nebulised broncho-dilators, one or two doses of IV antibiotics, etc – mostly within the 4 hour timeline and a proportion through an ED Observation Unit. A small proportion of these 5-10% will end up being admitted as they have not improved sufficiently in the timeframe needed..
  - Definite admission and physiologically stable, early transfer to admitting specialty bed without duplication of assessment (mostly done by the admitting specialty).
  - Definite admission but physiologically unstable, early co-management between ED and admitting specialty within the Emergency Department, transfer when stable to do so.
  - Remain undifferentiated after initial rapid assessment, need ED work up and decision.
- The Emergency Department functionality is being compromised by processes and behaviours outside of its control, predominately from Departments and Specialties within UHL, which includes directing GP referrals to the ED rather than direct to specialty, specialty 'ping pong' and some inter-departmental behaviours that have the potential to breach GMC Guidance. There are also 're-directs' from the Urgent Care Centre which result in a 2nd delayed queue of patients awaiting assessment in the ED. The extent of compromise by these non-ED processes and behaviours is far more extensive than previously seen in many other Emergency Departments across the country.
- There are some 'immature' assumptions around 'conversion rates' from the ED to admission. ED conversion rate without reference to standardised admission ratios etc. is a meaningless concept.
- There is a relative lack of standardisation between the Consultant and Nurse Shift co-ordinator with marked variability between team members.

- There is variability in the way in which the EPIC (Doctor in Charge) role is undertaken. This sometimes compromises the effectiveness of the department even when there is good flow to the assessment units.
- There has been mapping of Consultant time to demand profile but this should be refreshed by reviewing the 6 week rolling profile of attends on a regular basis and used to map all staff rosters.
- There has also been an extensive paper on demand:capacity mapping which is an excellent piece of work and has made assumptions about an uplift in 'productivity' of the ED team members by between 10-20%.
- This paper then provides a gap analysis between the demand based on an 80th centile and the capacity assuming the 10-20% 'productivity gain'. Without any changes in processes including better collaborative working this would require a very significant uplift in staffing levels for the ED.
- However, a workforce plan in isolation of the necessary improvements in the total patient journey would re-enforce silo thinking.
- Ensuring Bed Bureau/GP arranged referrals for assessment to admitting specialties never or only rarely (other than those with physiological instability) went through an ED process, better collaborative working from the admitting bed holding specialties and the ED with a marked reduction in re-work (duplicate assessments, over investigation etc.) with much earlier co-management and pull through from the ED by admitting Specialties would dramatically reduce the need for additional ED staff.
- A joint clinical governance and better pathway management between the Urgent Care Centre and the ED can be expected to result in a marked reduction (<90% reduction) of the re-directs to ED after the extensive triage assessment process and others after the GP assessment process (http://www.primarycarefoundation.co.uk/images/PrimaryCareFoundation/Downloading_Reports/Reports_and_Articles/Urgent_Care_Centres/Urgent_Care_Centres.pdf). For the former, the joint governance process would ensure these patients completed their episode within the UCC rather than being re-directed to the ED. In the latter group after GP assessment, the main issue appears to be onward referral to specialty. These referrals should be managed in the same way as GP Bed Bureau patients, i.e. not going to ED but being seen direct by the specialty. Again this
- There are two periods of 'timeout' for the teams, one is at approximately 6-7pm for breaks and the other is at 9pm for handover. During both time periods there is marked reduction in 'decision making capacity' on the floor.
- There is a relative lack of standardisation between the Consultant and Nurse Shift co-ordinator with variability between team members.
- There is incomplete separation of the Urgent Care Centre stream with, variably reported, up to 15% (or even up to 30%) re-directs from the UCC to the main ED. Not infrequently these are late transfers with waits of already over 2 hours by the time they are re-directed.
- The ED majors assessment area has become the common pathway for the vast majority of patients, with flow streams that should be managed elsewhere, that is UCC re-directs, GP arranged via specialty, minors identified by paramedic crews (in the last two weeks these are now being

directed straight to Minors), GP direct to Emergency without discussion with a Specialty and some arriving as their discharge letter states 'if you have any problems either contact your GP or come to Emergency'.

- The Assessment Bay (7 trolleys) aims to provide Early Senior Assessment (ESA), however, there is variability amongst the Consultants of how this is delivered. In addition, the 'takt' time does not appear to have been factored in to how the process should be set up. If including all GP referrals (currently predominately attending via Emergency rather than direct to assessment units) the reported 85th centile of assessment attendances is 14 per hour. This equates to a Takt time of 4 minutes meaning a single senior decision maker would need to process a patient every 4 minutes to prevent a queue forming (assuming egress from the area is not blocked), two senior decision makers would need to process a patient every 8 minutes, and 3 would need to process every 12 minutes. Consultant led ESA must add value to the patient and not just be a streaming process, the latter can be utilised if ESA is not feasible and can be performed by a Senior Emergency Nurse streaming to 'definite admit' and 'probable discharge' streams.
- Referral standardisation – i.e. discussion with Consultant until Consultant shift end or ST4 and above after that of all requests for transfer or opinion. There is a degree of this but this could be tightened up.
- Response process from admitting teams. There is relative lip service to this response standard. There are multiple examples of 'specialty Ping-Pong' with poor response times to ED requests. **This consumes a huge amount of senior decision maker time within the ED.**
- Specialty 'visibility' in the ED is very limited apart from the 'funded' sessions to cover gaps in the shifts by Medical Consultants. This latter process is at very high cost. The reasons for the lack of specialty visibility are variably reported but some of this has been as a consequence of the 4 hour standard being seen as an ED problem.
- There is a 'watershed' policy for managing the referral process for scenarios where there is perceived doubt as to which specialty ED should refer some of these 'watershed conditions'. This is an extensive document, whereas in most other organisations it is a very brief set, and creates a significant number of 'complex rules' in its own right. It is not infrequently ignored by Specialties and of particular note and frequently contested is the statement within the 'policy' that the ED Senior clinical decision maker managing the floor has the final decision.
- The ED EDU should only have patients entering these beds on a protocoled pathway allowing discharge when certain criteria are met. There are opportunities to expand the range of ED managed cases going through the ED EDU e.g. cellulitis needing IV antibiotics whilst community IV therapy is being set up, low risk pneumonia, etc. many of these clinical scenarios are identified within the Directory of Ambulatory Emergency Care for Adults. The second group of patients in the ED EDU are the 'remnants' of the Emergency Frailty Unit prior to its move up to the Acute Frailty Unit on the 5th Floor. The functionality of the EFU is well received amongst the ED Team, although impact metrics based on beds occupied and patient level outcomes have not been robustly put in place.

Recommendations

- **For the admitted flows from ED, 90-95% of the improvements in the system are out with the ED.**
- **ED will be unable to maintain improvements in its own processes until there is a 4-6 week period of zero or absolutely minimal bed delays, specialty 'Ping-Pong' and delivery of all (unless physiologically unstable) GP/Bed Bureau/UCC patients to the relevant assessing specialty. For Medicine and Surgery this means direct admission to the relevant assessment areas, utilising the relevant Emergency Care Standards of 'time to initial assessment, time to treatment as well as time to Consultant review.**
- **The critical metric to reduce hospital over-crowding (www.collemergencymed.ac.uk/code/document.asp?ID=6296) and the associated risk is to reduce bed occupancy by improving processes on base wards and assessment units, ensuring that the short stay, sick mono-organ specialty/general and frailty admitted flow streams are optimised.**
- **ED is provided with data sets on a daily basis (constructed in conjunction with the Emergency) to assist in its understanding of demand, capacity, and flow ideally split by admitted vs. non admitted.**
- **An ED quality improvement metric would be to reduce ED conversion to admission downstream of the ED Short Stay Unit by 10% (http://www.aomrc.org.uk/doc_view/9450-the-benefits-of-consultant-delivered-care), possibly more, by implementation of standardised floor management, standardised Consultant review of referrals, RAT/ESA process and improved ED use of the ED Short Stay Unit. This would be further facilitated by specialty in-reach in to the ED by the relevant high volume admitting specialties of Medicine, General Surgery and Trauma and Orthopaedics.**
- **ED refreshes the capacity mapping of decision makers by reviewing the hour of arrival demand profile for the ED on a six week rolling average data set to assist in capacity planning. This should be provided to ED daily.**
- **ED tests and implements an ESA process mapped to the demand profile and Takt time. The output from ESA needs to be defined e.g.:**
  - Bundle 1 – Diagnosis/differential, investigation (necessary for immediate management) and treatment.
  - Bundle 2 – dispersal plan:
    - Immediate home
    - Probably home after treatment and observation of improvement after <4 hrs. in main ED or maximum one overnight stay in the ED EDU on a protocoled pathway.
    - Definite admit – stable – direct to admitting specialty – no need for further ED work up.
    - Definite admit – unstable – stabilisation in ED in partnership with admitting team.

  - Unsure of diagnosis or dispersal – needs work up.

- **ED standardises floor management with a written roles and responsibilities paper for both the Nurse co-ordinator and the Consultant in charge of the floor.**
- **ED considers enhancing the range of ED short stay pathways to improve utilisation of the ED EDU.**
- **ED standardises referral management. Patients assessed by grades of Doctor of below ST4 are to discuss patients with the Consultant on the floor or the ST4 after midnight. The decision is for referral for 'advice' to assist discharge or 'request for transfer'. This standardisation of senior review (not re-assessment as in most cases this will be dealt with by a discussion) will assist in demand control, for admissions. The referral process should ideally be based on an RSVP or SBAR communication tool. The response from the referred to specialty will be 'yes' 100% of the time with abolition of 'specialty ping pong'.**
- **As a general rule, ED is <u>NOT</u> to be used by other specialties as an admission route for patients from outpatients or community services unless the patients clinical situation would of itself trigger a 999 call in the community.**
- **If the ED referral is a 'request for transfer' approved by an Consultant/SR then bed holding specialties have 30 minutes to respond with either a bed available or a review in ED. If the admitting team reviewing doctor does not arrive, this constitutes 'permission to transfer' after the 30 minutes has lapsed. With the proviso that there has been a safety confirmation step which will include a full set of observations prior to transfer, adequate pain relief, appropriate iv fluids commenced. Physiologically unstable patients will not be transferred. This policy would have to be endorsed by CMG Clinical Directors and the receiving specialties all made aware that the clinical governance responsibility lies with them since they have not responded in a timely manner. Every delayed response by a receiving team is to be considered a breach of clinical governance and the organisation will need to consider how these breaches of governance are to be investigated.**
- **With the locus of control for patients not admitted from ED being predominately within the ED, the ED should be aiming for 99%+ of these patients being discharged in 4 hrs. or less. The ED is predominately responsible for this standard, although investigation wait times and waiting for advice prior to discharge does have an impact.**
- **For admitted patients, if the ED has seen and assessed and a decision formulated within 140 minutes (Emergency Services Collaborative metric), the locus of control is with the admitting specialties. The admitting specialties are responsible for delivering 95% admissions within the total 4 hour time frame. Recognising that some 5% of referrals may be late from ED due to an attempt to get the patient home but insufficient improvement occurred or considerable time has been needed to stabilise the**

patient (joint management should be occurring in this situation) and the request for a bed is thus delayed.

- **Once the whole of pathway improvements have occurred, i.e. no GP bed bureau patients via ED, collaborative co-management with admitting specialties, no waiting for bed or specialty delays etc., as well as those elements specific to ED, 10-20% productivity improvement, standardised floor management and ESA, then the demand:capacity gap analysis needs to be repeated to evaluate any staffing needs.**

3.4 Rapid Assessment Unit/Acute Medical Unit/Acute Frailty Unit

- Medicine, from Assessment Units to Base Wards, at the LRI is significantly compromised with multiple handovers, variable delivery of some of the standards for assessment, decision making and lack of formalised handover and case management. There is confusion of admitted flow stream management.
- As a result, the patient pathway across Medicine at the LRI are at risk of generating the potential for significant harm and excess mortality due to clinical processes and behaviours.
- Having the 3 Assessment Units for Medicine on the 5th Floor albeit in the same Block as the ED risks creating an ‘admitting’ culture rather than an assessment culture. The proposed relocation to behind a new ED, along with very significant changes in processes, is very logical. The Assessment Units are effectively bed based with a small clinic area, rather than a mixture of beds, chairs and trolleys, which would give an impression of fast turnaround for the less sick.
- Notwithstanding the above, there are clinical leaders within Medicine who are totally focussed on quality outcomes for the patients and are keen to bring about the necessary changes to the clinical processes. There is however, passive and even some active resistance to improvement.
- These three assessment areas essentially should run the process of assessment and decision making with the latter specifically designed to capture frail older people to optimise early management via comprehensive geriatric assessment. However, the functionality of these units is variable and impeded by the working processes on the Units and excessive variability amongst the senior medical staff on how the process should run. The units are tending to operate more like admission units rather than the expected pace of assessment and decision making units.
- Not infrequently there are beds in the Base Wards but no beds on the assessment units with delayed decision making and little in the way of pull from the Base wards. This is compounded by the ‘batch processing’ by ward rounding rather than continuous roving senior assessments and decision making.
- Many assessment unit ward rounds take all day starting at the beginning and going to the end rather than targeting the very sick first, then the discharges/transfers. The routine process is for Consultants only to review patients who have been clerked by Junior Doctors, whereas the RCP Standard is very clear that all patients referred to Medicine are to be reviewed by a Consultant before going off shift whether they have been

formally clerked or not (RCP Acute Medicine Task Force Report 2007 https://www.rcplondon.ac.uk/sites/default/files/documents/acute_medical_care_final_for_web.pdf) and whether they are on the Assessment Unit or still in the Emergency Department awaiting transfer to the Assessment Units..

- Consultant presence on the assessment units when they are rostered to be present is variable with some in the evening leaving the site before the 9pm currently set and some being absent during the afternoon of their rostered sessions on The AMU. This is totally unacceptable.
- The Acute Frailty Unit provides input in to those patients who can access the unit whilst there are as many again who are unable to access the skills of this unit.
- Patients who are on the AFU who need the Primary Care Co-Ordinator team to assist in discharge can only receive this if they remain on the AFU, rather than the PCC process following the patient to the Short Stay Unit
- There is a structured clerking proforma with Consultant first review which requires the completion of a case management plan including EDD, however, the Expected Date of Discharge is variably completed.
- Review processes are predominately by ward rounds which can last all day without roving reviews with delayed decision making as a consequence.
- There are no written roles and responsibilities for the Consultant covering the Assessment Unit delineating clearly the function of the Consultant with regard to rolling reviews, ensuring flow and decision making etc.
- There is a Consultant taking the calls from GPs to access the Acute Clinic. It does need to be considered whether this clinic has become a ‘supply side’ driver of outpatient activity rather than the intended pure acute process. Some Consultants consider it necessary for patients to be clerked before they can be seen in the clinic.
- There is relatively little development, as yet, of some of the key Ambulatory Emergency care pathways beyond cellulitis, TIA, DVT and pulmonary embolism.
- Consultants on the Acute Medicine rota work in blocks of 5/2 days although there is some swapping of this process. Patients with short stay potential are being moved to Base wards rather than the short stay unit with the likelihood of increased length of stay. In addition, there are multiple hand overs along the patient’s journey with one patient being assessed 7 times medically before a definitive case management plan was put in place.
- The 1700 to 2100 hrs rostered presence of a Consultant Physician on the Assessment Units has been variably delivered, although this appears to be changing.
- The understanding is that the 1700 to 2100 Consultant is also the overnight on-call, but rarely reviews their admissions the next day, resulting in a completely new assessment by another Consultant the next day.
- Likewise the weekend on-call Consultant does not review the patients they have seen over the weekend on the Monday morning, with a second Consultant re-assessing these patients on their Acute Assessment Unit session on the Monday morning.
- Even when running the 2 and 5 day split week there are frequent handovers of patients between Consultants on the assessment units.

- This frequent handover of short stay patients between Consultants is particularly deleterious to flow, let alone the risk associated with handover of seriously ill patients between Consultants.
- Handover of patients to Base wards, and thus almost invariably to another team, is based solely around 'arrival' on the Base ward rather than a structured 'pull' process which ensures the case management 'baton' is not dropped.
- The 'Acute Care Beds' (ACB) on Ward 16 have been developed by Medicine to cater for physiologically unstable patients who need close monitoring. It does not meet the requirements of a Level 2 Critical care facility. There are a number of patients transferred back from Base Wards to this facility whose level of care needs ought to be met by a Base Ward alone and in some with input from Critical Care Outreach. This 'back flow' in to the ACB results in a significant consumption of assessment team capacity.
- There is effectively no Level 2 Critical Care provision for Medical patients at the LRI with access to the Level 2 and 3 Critical Care Beds in the ITU perceived by the Physicians as problematic.
- On Friday 13th June 2014, the Clinical Leaders within Medicine called an extra-ordinary Physicians meeting to set and agree a series of quality standards across the patient journey which were aspirational but needed to be worked towards. These standards included door to nurse time, door to doctor time, door to Consultant time, the construct of the Consultant decision to ensure that EDD and CCD are captured. In addition, they agreed that all patients referred to service would be reviewed by a Consultant before they went off 'shift' even if still in the Emergency Department.
- In addition, two Consultants volunteered to run a test of a 'new process' for short stay patients ensuring that these patients remained under the care of the admitting Consultant. This is a crucial improvement.
- On one ward, there has been an early trial of the 'ticket' home including the four key questions patients should be able to answer.
- In addition, Medicine instituted a series of governance processes which need to be embedded and continuously delivered. These are, senior leader rota of the assessment unit floor at 2000 hrs linked to a re-enforcement of the role of the Consultant on the 'floor', a long LOS review process (which requires more robustness and then adaptation), and an early form of a Board round review process. The Heads of Service and the CD for the CMG now meet weekly to discuss actions to deliver improvements. These actions are good practice and must be developed further. These are not short term processes but are to be embedded in the system for a minimum of two years of delivery of the quality improvements required.

Recommendations

- **Monitor the improvement towards the internal standards of 4 hours to Consultant review and setting of EDD and CCD by Consultants. Ideally aiming to report performance daily at handover.**

- **All patients leaving the assessment units moving to downstream wards must have a complete end to end (i.e. to discharge) case management plan with EDD and CCD (Keogh Standard 3 - http://www.england.nhs.uk/wp-content/uploads/2013/12/brd-dec-13.pdf).**
- **Ensure that all patients 'referred to service' who are in the Hospital but who have not been assessed by a Junior Doctor receive a 'rapid review' assessment by the Consultant before they leave including those referred but not yet transferred from ED. (See RCP Acute Medicine Task Force Report - https://www.rcplondon.ac.uk/sites/default/files/documents/acute_medical_care_final_for_web.pdf).**
- **Consider making the GP call management by Consultants more robust and not dependent on a single individual and extended to 2200 hrs.**
- **Ensure that Consultant presence on the Assessment Units is continuous with roving rounds and decision making, which includes streaming to the relevant flow pathway, i.e. immediate discharge, discharge in 12 hrs, discharge with short LOS (2 midnights or less) and those for Base Wards. Breaks for 'comfort' and mealtimes (30 minutes maximum) are acceptable. If all patients have been reviewed and no-one in ED awaiting referral, then a 'downtime' for 'administration' can be taken, with the proviso that if 2 or more patients are referred to the area covered by that Consultant, they return immediately.**
- **Consultant presence on the Assessment Units should match the demand profile of 80% of admissions from 0800 hrs, currently this requires Consultant presence until 2300 hrs.**
- **The evening on-call Physicians should return to the Assessment Units/Short Stay unit at 0800 hrs to review those of their patients who have remained on the units overnight to facilitate early discharge.**
- **Aim for 15-20 empty beds across Wards 15/16/AFU every morning including Monday morning.**
- **Develop an Ambulatory Emergency Care (Ambulatory Emergency Care) strategy which sets AEC as the default (https://www.rcplondon.ac.uk/sites/default/files/acute_care_toolkit_10_-_ambulatory_emergency_care.pdf and http://www.institute.nhs.uk/option,com_joomcart/Itemid,26/main_page,document_product_info/products_id,181.htm) for the Assessment Units and monitor AEC delivery. The aim should be for 25%-30% of medical acute admissions being resolved and discharged home within 12 hours.**
- **Test and implement a process whereby patients identified as short stay where by a further 40-45% of the acute medical admissions are discharged with a length of stay of 2 midnights or less (http://www.institute.nhs.uk/option,com_joomcart/Itemid,26/main_page,document_product_info/products_id,192.html) and are managed and reviewed by the admitting Consultant until discharge.**

- **ACB should only take 'incoming patients from ED or GP referrals and not accept patients from Base Wards, to deliver this will require re-skilling of Base Wards in some areas, ensuring sufficient Critical care Outreach to support Level 1 care on the wards and the consideration of developing more Level 2 Critical Care (http://www.ics.ac.uk/ics-homepage/guidelines-and-standards/), from a combination of improved step down from the current Level 2 (reduced bed occupancy on Base wards), and possibly coalescing current so-called 'level1/2' facilities in to a single unit meeting the necessary criteria.**
- **Progress the acute frailty pathway (https://www.rcplondon.ac.uk/sites/default/files/acute-care-toolkit-3.pdf and http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf) aiming to include all patients with frailty, initially admitted through Medicine and then surgical specialties. The key outcome metric is a 25-50% reduction in beds occupied by patients aged 75 and over who have been in-hospital 10 days or more.**
- **Test and implement the Primary Care Co-ordinator process following the patient linking to a 'front door frailty team'.**
- **Metrics provision for Medicine (General Medicine and all sub-specialties combined with drill down) : daily demand run chart with forward prediction for 7 days (based on 6 week rolling average as a minimum), 4 or 6 week rolling average of demand by hour of day (based on arrival time of primary care referrals and time of referral from ED), capacity (available time of senior decision makers X process time), flow (daily zero LOS discharges for ambulatory care, discharges with LOS 2 days or less for short stay, all beds occupied by Medicine (all specialties), beds occupied (not discharges) by Medicine (all specialties) aged 75 and over to represent potentially stranded frail older people.**

3.5 Base Wards

- Board Rounding is 'structurally' in place on a number of wards, but the process varies markedly between wards with some areas focussing on discharge and the key actions to deliver this effectively as well as highlighting unnecessary internal waits. Board rounding is an effective process if delivered well and supported by all the Consultants, simply put, if board rounding is not resulting in a reduction in bed occupancy it is not being done effectively. It does require clearly constructed case management plans with clinical criteria for discharge and expected dates of discharge.
- There has recently been discussion on the implementation of the 'ticket home' concept around the 4 patient questions. This should not be considered a general medicine initiative but an organisational initiative and supports the concept of 'enhanced recovery' for the acute care pathway.
- Referral timelines are far too loose with 12 hours for a Registrar to Registrar review and 24 hours for a Consultant review. There is a degree of over referral.

- New patients arrive on Base wards every day yet there is no standardised process to have a senior review either before the end of the working day for those who have arrived on the ward before 1700 hrs or early the next morning for those who have arrived after 1700 hrs.
- There is variable delivery of the 'one stop' ward round concept, where all tasks are completed (except major procedures) during the round rather than Junior Doctors writing lists of tasks to be performed. The aim is to 'deliver this hour's work this hour'. Successful implementation of one stop ward rounds results in nursing staff rarely if ever having to call Junior Doctors back to complete discharge summaries/drugs to take home.
- It has been reported and observed that there are issues around the functionality of the Computer on Wheels, both battery life and Wi-Fi connectivity as well as 'boot' up speed of relevant software.
- There does not appear to be a process of peer to peer review of 'long length of stay' reviews using a structured proforma to be placed in the patients notes.
- Gastro-enterology are not on the acute medicine rota and are not within the same Clinical management Group. They are within the CHUGS CMT, however, even here, there alignment is less than optimal with the Gastro-enterology base wards at the LRI not co-located with the upper and lower gastro-intestinal surgical teams. Gastro-enterology HRGs are usually the 3rd or 4th most common acute admitting diagnoses after respiratory, cardiology and poisoning (deliberate self harm). There is, as with other medical specialties e.g. neurology, no 'attending principle with direct 'pull' of specialty patients from ED and the Medical assessment Units. The process of accessing these specialties is via referrals, with barriers to access, approximately 5-10 years out of date of modern practice.
- The Gastro-enterologists operate a 'bleeding rota' for emergency access to therapeutic endoscopy. The 'pathway' for the referral requires a very significant number of steps before the Gastro-enterologists become involved in the care of these patients. In their own published data set over a 6 month period, only 18 out of hours (1700 to 0800 hrs) emergency endoscopies were performed.

Recommendations

- **Standardise the Board Round process, using a script if necessary and other training opportunities. It is understood the there was a video made 3 years ago of an effective Board Round but this has not been used as a training instrument.**
- **Aim to spread the 'assertive board rounding' principle across all specialties.**
- **Implement one stop ward rounds based on the RCP guidance (https://www.rcplondon.ac.uk/sites/default/files/documents/ward-rounds-in-medicine-web.pdf)**
- **Once robustly in place for 5 days per week, consider how this might be achieved across 7 days per week to support 7 day discharges.**
- **Capture unnecessary delays (commencing with internal delays) at these Board rounds and resolve them at the Board Round, if they**

can not be resolved escalate the same morning for resolution by the afternoon and then design these out of the pathway.

- **Rapidly test and implement the ticket home in one or two clinical areas with a spread and adoption strategy.**
- **Implement a standardised process to review new patients on Base wards by a Consultant including an 0800 start, the 'golden hour' review (https://www.rcplondon.ac.uk/sites/default/files/acute-care-toolkit-2-high-quality-acute-care.pdf)**
- **Implement the 'long length of stay' review process which ensures a formalised review of patients who are 'stranded' within the system. In essence, this process should answer two questions –**
  1. What is being done now to resolve the issues preventing this patient leaving hospital?
  2. What could and should have been done both pre-hospital and in the first few hours and days of admission to prevent this patient becoming stranded.
  This initiative will need to have an escalation process embedded within it, e.g. first review at X days with a fellow Consultant and charge nurse, second review at Y days with the clinical lead and nurse manager, third review at Z days with Divisional lead and Director of Nursing. This process should start at day 6 of an admission. This process, when delivered robustly at St Thomas Hospital, London, resulted in considerable improvements in flow. Again, this strategy is not specific for general medicine and should be tested followed by a spread and adoption programme.
- **For medical specialties not on the acute medicine rota e.g. Gastro-enterology, Neurology, rapid (within 1-2 months) implementation of an 'attending' Consultant input to the assessment units on a daily basis and to see referrals within 30 minutes of referral from these units to facilitate flow. Cardiology and Respiratory Medicine from the Glenfield will likewise need to consider a referral management process for the LRI site which is equally responsive and for Diabetes and Endocrinology, Geriatric Medicine and other LRI centralised Medical Specialties, a similar process is required for the Glenfield site. Multiple transfers of patients for non-interventional fixed equipment dependent consults is not an efficient use of resources.**
  - **The upper GI bleeding pathway needs to be altered to ensure early Gastro-enterology specialist input (http://www.nice.org.uk/guidance/cg141/resources/guidance-acute-upper-gastrointestinal-bleeding-management-pdf) for any patient with a modified Blatchford score greater than zero.**

3.6 Surgical Assessment Unit

- The SAU is based on the 3rd Floor of the Balmoral Wing. It is based on ward with beds, although there is a chair and trolleyed area at the entrance to the unit.
- There are three surgical teams using this unit, upper GI surgery team, lower GI surgical Team and the Vascular team. The first two work as a

fixed pair team and cross cover providing a high level of Consultant visibility on the SAU particularly in the morning.

- There are Consultant rounds in the morning such that all upper and lower GI and Vascular patients both on the SAU and on the Surgical wards are reviewed every day by a Consultant
- The overnight on-call is shared between the upper and lower GI surgeons for the general surgery take and the vascular surgeons have, appropriately, an independent rota.
- At the Leicester General Hospital, there is a general Surgical take, run by a lower GI team, and a Hepato-Biliary take, although sick unstable hepato-biliary patients arriving via ED are admitted to the LRI SAU and transferred, at a variable time, to the LGH.
- There are delays in obtaining ultrasounds at weekends but much less so in the week.
- There are delays in obtaining ERCPs for patients at the LRI as these are only carried out at the LGH after an appropriate centralisation of this service to one site. Patients on the LRI SAU were seen awaiting transfer to the LGH for ERCP. However, the processes for ERCP need to be improved to ensure no unnecessary in-patient delays, this could include discharge home of patients with painless obstructive jaundice without high risk markers until ERCP is performed within 1 week.
- The trolley and chair based area is used as Registrar and senior nurse led Surgical triage. – which has reduced admissions at the LRI site by 30%. A build of two consulting rooms earlier this year occurred to support the implementation of an 'Ambulatory Surgical Emergency Care', currently named Surgical Triage, for abscesses, abdominal pain ? cause, groin pain, low volume rectal bleeds etc. The process would have been Consultant delivered with the Consultant taking the GP calls, focussed on rapid assessment with rapid diagnostics supporting early decision making with the potential for same or next day procedures. The process was due to be launched earlier this year after much debate and general agreement but this was postponed as it appears one surgical team felt they could not contribute. It is currently being operated on same days of the week, when there are two Registrars on-call for upper and lower GI surgery. This is not in-place at weekends
- The concept of the 'Ambulatory Surgical Emergency care' service is absolutely correct and results in significantly improved patient experience as well has having the potential to reduce non-elective surgical bed occupancy by up to 20-30%. However, with the current Registrar triage the extent of this improvement may not be as extensive, but still very worth exploring. In addition, the presence of a Consultant on the SAU running the ambulatory service also provides opportunities for Consultant decision making on the Unit if the on-call Consultant is, quite rightly, in theatre.
- There is one emergency theatre (NCEPOD list) available all day and this is utilised by multiple surgical specialties. Theatre utilisation of this NCEPOD list is likely to be sub-optimal but has not been directly observed. There are frequent overnight if not two overnight delays for access to this list for the Upper and Lower GI Surgical Teams

Recommendations

- **Through a rapid cycle test of change process, implement the 'Ambulatory Surgical Emergency Care' service, commencing with the enthusiasts. The ASGBI and RCS 2014 Commissioning Guide Emergency General Surgery (acute abdominal pain - https://www.rcseng.ac.uk/healthcare-bodies/docs/emergency-general-surgery-commissioning-guide), states that up to 30% of the general surgical take can be managed in this way**
- **Review the obstructive jaundice/pancreatitis pathway to minimise/remove delays in hospital to ERCP and arrange to manage some patients with low risk factors on an ambulatory basis.**
- **Collaborate with radiology on how access to ultrasound scans at weekends can be improved to facilitate flow.**
- **Collaborate with ED to facilitate the pathway for co-management and transfer of ED identified surgical referrals, some of whom could also go through the ambulatory process above.**
- **Review the NCEPOD theatre utilisation and increase capacity either by optimising utilisation of the single theatre or by having a second theatre available for emergency cases. The only acceptable rate of delayed time to theatre of one additional overnight stay (never two) is for this to happen no more frequently than once every two weeks for all specialties**

3.6 Surgical Base Wards and Kinmonth Unit

- There are daily wards rounds of all upper and lower GI surgical and vascular inpatients by a Consultant 13/14 days, with the 14th day being delivered by a Registrar. For the GI Surgeons this is a large volume of patients with an average 'process time' of 3 minutes. This makes one-stop ward rounding for TTOs impossible to deliver as the processing time for the TTOs is between 4-6 times longer than the patient:surgeon contact time.
- ENT, Ophthalmology, Maxillo-facial surgery and Plastic surgery do not have daily Consultant led rounding on their in-patients including their 'high risk' patients on Kinmonth ward. This is a potential clinical risk.
- Tissue viability Team response times for complex wounds appears to be sub-optimal with at times significant delays.
- Responses from other specialties for 'discharge critical' opinions is measured in days rather than hours and is totally unacceptable for an emergency care pathway. Life and limb critical referrals should be responded to immediately and all others that are discharge critical should be responded to in less than 4 hours. Notable exceptions to this are the well-received response times from the Acute Oncology Service and the Palliative care Service.

- Patient transfers to other sites for opinions without any specific 'kit' required are occurring, this is a waste of resource and patients time and wherever possible the specialty should go to the patient unless non-transportable specialist kit is required.
- There are a number of external constraints to discharge that the wider system needs to resolve.
- The Vascular ward has a clear set of rules to prevent graft sepsis and the over-crowding of the hospital with the placement of potentially 'infected' patients on this unit is a safety risk
- Elective and non-elective patients are mixed on a number of surgical wards, in some this is appropriate, e.g. Vascular, in others this has an impact on both pathways.
- Level 1 and Level 2 critical care as a process has not been strategically implemented and there are a variety of 'work-arounds' to this issue.
- The 'Rapid' bed cleaning service for contaminated areas, i.e. after a patient with diarrhoea has been discharged, is anything but Rapid. Side-rooms are a premium and the turnaround of the cleaning of these beds should be less than 30 minutes of the bed being vacated.

Recommendations

- **The surgical team have suggested a parallel team of a pharmacist along with the development of 'physician assistant' from amongst the nursing team to deliver TTO prescriptions. This is very worthy of rapid cycle tests of change. There are in essence on three types of TTO's, same drugs as admission with, maybe, one or two additions, a significant change in medication and finally complex regimes.**
- **As stated in the General recommendations section, the response times to 'discharge critical' referrals to other specialties should be set at 4 hours maximum for non-limb/life threatening referrals.**
- **As stated under the Medicine section, there is a need to move towards a Level 1 and Level 2 critical care strategic implementation plan**
- **The Vascular Ward rules for outliers are to be honoured 100% of the time by ensuring a fall in overall bed occupancy across the Trust. This will also facilitate ITU step down.**
- **Through Rapid Cycle tests of change a 30 minute turnaround time for 'contaminated bed space cleaning' needs to be implemented.**
- **Processes at the Leicester General Hospital in both General Surgery and Hepato-biliary surgery have not been reviewed as yet, it is, however, extremely likely that there will be as much opportunity to optimise processes there as at the LRI.**

3.7 Oncology

Many of the solutions being proposed here are in absolute alignment with the RCP RCR document 'Cancer patients in crisis: responding to urgent needs' 2012 (https://www.rcplondon.ac.uk/sites/default/files/documents/cancer-patients-in-crisis-report.pdf) and the RCP 'Acute Care Toolkit 7' 'Acute oncology on the acute medical

unit' October 2013 (http://www.londonhp.nhs.uk/wp-content/uploads/2013/03/ED-Case-for-change_FINAL-Feb2013.pdf).

- In Oncology, the vast majority of chemotherapy is delivered on an ambulatory basis, this is good practice, with only the rare high dose methotrexate with critical timing of folinic acid rescue – although in the US there are centres that are delivering this on an ambulatory basis.
- The Oncology Assessment Unit has a 'chaired area' for rapid assessments and interventions with early discharge home in as short a time as 2-4 hours. This is good practice although the area is not ideal for patient confidentiality/privacy whilst receiving infusions etc.
- You have attempted to introduce an 'ambulatory neutropaenic sepsis' pathway based on the internationally evidenced based MASCC risk stratification instrument. This risk stratification allows same day discharge of a small proportion of patients with neutropaenic sepsis based on a score >21 which identifies them as low risk. This process has been introduced cautiously, with a single overnight stay being the default for this low risk group. Despite some enthusiasts this process has not been widely adopted and there is now a need to accelerate the implementation of this evidence based practice over the next few months.
- The acute oncology service (AOS) which constitutes a senior specialist Oncology nurse backed up a number of hours per week by a Consultant Oncologist. This service also comprises the Consultant of the day covering the Oncology Assessment Unit. The AOS thus provides a reviewing service for the oncology acute assessment unit and will see up to 8-10 'consults' on other wards throughout the LRI of broadly 4 groups of patients.
    - Patients with cancer who have stable or progressive cancer but who have been admitted with another acute medical/surgical problem. Their 'oncology need' would be met on an ambulatory basis. These patients do not require repatriation to Oncology.
    - Patients with cancer whose disease progression has resulted in them entering an End of Life phase of their illness in whom planning of this phase of their illness is required. The vast majority of these patients do not need repatriation to Oncology, although some may e.g. those requiring very rapid palliative radiotherapy may need repatriation, although in other systems these patients remain under their admitting specialty also, with everyone focussed on what absolutely needs to be done today and tomorrow so that there is 'no wasting of the patients time'.
    - Those patients with acute oncology emergencies who are still in a treatment phase, this includes patients already known to service who present acutely with acute physiological or functional change due to disease progression and some patients whose first diagnosis of cancer is during their 'incident' acute admission and have a need for immediate/near immediate oncological intervention e.g. acute cord compression, or newly diagnosed lung cancer with rapidly progressive Superior Vena Caval obstruction and a risk of airway compromise. These may well need repatriation to oncology, but there are services nationally where the intervention is co-ordinated

in partnership with the admitting specialty – with the simple rule that if the admitting specialty wishes to discharge the patient, they are discharged but if the Oncology service feels they must remain, then Oncology repatriate. This means that Oncology can not 'use up' another services bed days.
  - Finally a group of patients whose cancer is diagnosed during their acute admission BUT in whom there is no immediate or near immediate need for oncological intervention. In this scenario, the acute need is resolved by the admitting specialty who discharge the patient and the oncological service carries out the necessary processes in parallel (but not adding any days/hours to the LOS) and after discharge.
- GCSF use in parallel to chemotherapy to reduce the potential for neutropaenic sepsis. The practice is that for the first cycles you do not use GCSF but if a patient in the treatment phase develops a single episode of neutropaenic sepsis, then subsequent cycles are 'covered by GCSF'. If the patient enters a palliative phase then the GCSF cover is stepped down. This seems an appropriate balance between the cost of the GCSF (high cost medication) and the mitigation of the risk of neutropaenic sepsis as a consequence of high dose chemotherapy aimed at 'cure'. It was not clear if this approach is 'standardised' or if there is variability in the approach between different Oncologists.
- Oncology have considered 'hot clinics' or just adding additional patients to clinics for patients with an urgent need but who can be managed away from the in-patient service. The recommendation would be for the latter rather than the former in the first instance with 'control' of access with your community oncology nursing team to start with and then for GPs. The reason for this is that a 'hot clinic' without a control mechanism will create a supply side driver and patients will attend this clinic who should have gone through a more appropriate pathway.
- On the in-patient wards, there are 'boards' amenable to 'assertive 'board rounding', however, the effectiveness of the 'board rounding' is variable. All patients do have an EDD but clinical criteria for discharge, which allows patient triggered discharge, are not routinely in place.
- One stop ward rounding on the Oncology Base ward is not the norm with Junior Doctors storing up lists of tasks to complete and the nursing staff then having to chase for TTOs etc. This is not an efficient ward process. It was reported that the Computers on Wheels are working well with good WiFi signal and battery life, this should facilitate one-stop ward rounding.

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Recommendations

- **On the Oncology Assessment Unit there is a Junior Doctor and an SpR . There is a 'door to doctor' principle measured in % achieved within 2-4 hours, reported at 92% achievement. The national ED Quality Indicators are for a Door to Treatment (assessment commencing by a doctor of decision making capability) is 1 hour and this is the same if the patient is for admission or not, the latter being not very sick. For patients being admitted as an emergency, we have to accept that these patients should be at the 'sick/very sick end of**

the scale' and as such a measure for improvement of % patients commencing medical assessment within 30 minutes is an appropriate timescale. This will not be achievable immediately and is a standard to be improved towards. Medicine have agreed this standard also for their emergency admissions. This metric is not a 'measure for judgement' and is not to be used as such, but demonstrating variance (in a non judgemental manner) is part of the improvement methodology.

- **The consultants variably round in the morning and equally, or even more variably, round in the evening. There is insufficient 'demand' based on the 85% centile of the admissions (16 per day – which is inflated by patients who can be admitted elsewhere) to require a continuous presence of a Consultant within the Oncology Assessment Unit, however, as a minimum twice daily ward rounds delivered consistently across the Consultant body covering the Unit is a process you ought to move towards. The function of the SpR during the day is to maintain safety and some definitive decisions whilst the function of the Consultant is to ensure that there are definitive decisions (including an end to end case management plan along with clinical criteria for discharge and an expected date of discharge) on all admissions and to further ensure safety.**
- **Accelerate the implementation of the MASCC risk assessed process for low risk patients with neutropaenic sepsis (http://www.ncbi.nlm.nih.gov/pubmed/20596732?dopt=Abstract).**
- **Standardise wherever possible the utilisation of GCSF across oncology taking the same risk:cost:benefit approach outlined above.**
- **Implement, through rapid cycle tests of change 'urgent' 'over-booking' in outpatients for patients with urgent need but in whom ambulatory care is feasible.**
- **On the in-patient wards, implement, through rapid cycle tests of change, effective Board Rounding.**
- **On the in-patient wards implement, through rapid cycle tests of change, the principle of the 'one stop ward round', where all tasks, including discharge letters and TTOs, are completed at the bedside except for major procedures.**
- **There are 15 Oncologists and technically it is feasible to have 15 different Consultants attempting to round on a few patients each. There are a number of specialist services that have moved to an 'attending model' where day to day case management (i.e. not the very sub-specialist highly complex processes) is carried out by one or two Consultants which rotates through the team (weekly or monthly). The hyper-specialist input is delivered through a co-management process with good MDT working and communication.**
- **The current default appears to be that patients with known cancer who develop an acute illness are admitted by Oncology, however in a number of these patients the cancer may be relatively incidental to the current acute illness in whom for example an admission for a patient with an exacerbation of COPD who has a 'stable' lung cancer on treatment may well have a shorter length of stay and a better outcome if admitted under Respiratory medicine. This requires a**

process of pathway re-design and identification of patients along their 'cancer' journey in whom a medical admission to the relevant specialty would be more appropriate than admission under Oncology.

3.8 Haematology

- There has been only a limited review of Haematology encompassing the Assessment Unit and the Day Unit.
- The vast majority of lymphoma patients are receiving their chemotherapy on an ambulatory basis.
- For reduced intensity Bone Marrow Transplantation (BMT) patients, who constitute the majority of patients receiving BMT, in-patient treatment is the norm despite there being well established international evidence for ambulatory care being feasible for a significant proportion of these patients. There appears to be a centralised process for day case transfusions in patients who are transfusion dependent, for example, patients with myelo-dysplasia. In many centres, these groups of patients receive their transfusion sin Day Units based within Community Hospitals. This process of centralised transfusion is resulting in 'loss of capacity' within the Day unit to move even more in-patient activity to an ambulatory setting.
- The emergency haematology admissions through the assessment unit vary between 2 and 6 daily with on a few occasions this being higher. There is variability of the extent of early consultant review with it being reported that this may be the next day or even up to two days later. If this is the case, this is not acceptable practice. The volume of admissions to Haematology does not require the continuous presence of a Consultant on the Unit.

Recommendations

- **Rapid implementation of a transfusion service for routine transfusions based within the Community Hospitals. There is no reason why safe and effective delivery for transfusion dependent patients cannot be organised to be delivered in some of the Community Hospitals within 8 weeks. This will require effective collaboration with LPT.**
- **As with Oncology, there is the opportunity for Community based chemotherapy, be that at home with a Community Chemotherapy Nursing Team or in Community Hospitals, especially for Lymphoma patients. This is the norm in many areas and is distinctly under-developed in Leicester.**
- **There are clear opportunities to deliver reduced intensity BMT on an ambulatory basis as there is a large amount of evidence to support its efficacy and safety. This will need careful planning. It is to be understood that a 'rush' to ambulatory care is neither feasible nor safe but a planned implementation is certainly feasible with optimised ambulatory care being delivered within 6-12 months for this group of patients.**
- **On the Assessment Unit, it is not acceptable to have the level of variability of Consultant review of new patients. As a minimum, it will**

be feasible within present Job plans to have a brief twice daily Consultant review of the new admissions to this unit to optimise flow and safety.

- **For both Oncology and Haematology, before re-direction of admissions to more appropriate specialties, it is feasible to reduce bed occupancy on the Haemato-oncology unit by up to 25%, as a conservative estimate, with early senior review of acute admissions, optimised ambulatory care of both acute admissions and for 'semi-elective' patients (e.g. reduced intensity BMT) whilst optimising the release of capacity within the Day unit by re-locating routine transfusions to the Community Hospitals, likewise with patients receiving many forms of chemo-therapy, some of whom could receive their treatment at home with 'community chemotherapy teams'.**

3.9 Glenfield Hospital – Cardio-Respiratory – CDU/CCU

- There are 26 beds on the CDU and a mixture of chairs, monitored trolleys and unmonitored trolleys at the initial assessment step.
- The nursing team attempt to identify likely discharges and definite admits as well as the 'very ill' at the point of access to facilitate stream management.
- The 'take' is a cardio-respiratory take with approximately a 50:50 split through the CDU, there are a small number of direct cardiac admissions to the Coronary care Unit daily.
- The 'take' is serviced by a single Consultant in respiratory medicine supported by a team of SpRs and other Juniors.
- The 'take' varies from a mean of approximately 48 per day to an 85th centile of approximately 60-64 per day. This requires a minimum of two Consultants to maintain decision making and safety.
- The Friends and Family Test indicates high degree of patient dis-satisfaction with the waits in the chair and trolley areas.
- The chair and trolley areas are in effect 'sit-rep' reportable areas as they do not constitute a bed and receive a mixture of heralded and unheralded patients. The clinical risk of an unassessed queue of patients is akin to that in the ED.
- There is a degree of variability of the use of clinical criteria for discharge (CCD) and expected date of discharge (EDD).
- The specialty take is sensibly restricted to under 85 years old although this will still include a considerable cohort of frail older people in whom their 'specialty' issue is not the main problem.
- If beds are tight on the LRI site, the escalation process pushes the 85 year age limit upwards. This may give some short term 'relief' but risks complex frail patients being stranded on the Glenfield site with no frailty expertise available.
- The Respiratory Consultants cover the CDU in a mixture of blocks of a few days with some doing single days. Their presence on the unit is near continuous with roving reviews.
- The pulmonary embolism and pleural effusion ambulatory pathway appears well constructed.

- There are opportunities for further optimisation of the short stay pathway including ambulatory pathways.
- There has been a trial of a Consultant cardiologist supporting the take directly, this needs to be further developed.

Recommendations

- **Embed the use of CCD and EDD as a function of the Consultant generated case management plan.**
- **Test and re-test through rapid cycle tests of change the implementation of a second Consultant (Cardiology) covering the CDU to provide further decision making and quality improvements.**
- **Cardiology has a reasonable tertiary workload and there are opportunities for some optimisation of the secondary workload from within current resources.**
- **Consider a front of house rapid turnaround process for potential ambulatory patients to extend beyond pulmonary embolism and pleural effusions.**
- **Test and re-test a process whereby short stay patients are not handed over, although within single specialty takes a team approach may be sufficient particularly if the person covering the short stay process is particularly effective.**
- **There is the need to consider how 'frailty expertise input' can be achieved at the Glenfield site. When bed occupancy falls at both sites, the need to escalate the take to include over 85 year old patients should disappear.**

3.10 Glenfield Hospital – Cardio-Respiratory Base Wards

- There has been limited time to review the base wards at Glenfield in detail. Currently bed occupancy has been at a reasonable level, although there will always be opportunities to optimise this further.
- There is variability of the presence and efficacy of Consultant Board/Ward rounding on a daily basis at the Glenfield site as at the LRI .
- One stop[ward rounding is also variable as with the LRI site.

Recommendations

- **Ensure robustness of the daily Board rounding process, with Peer to Peer review of the process to ensure focus on delivery of the case management plan and timely discharge.**
- **Implement one-stop ward rounds to end the need for 'call back' for generation of TTOs.**

3.11 Discharge Lounges

- On both sites the discharge lounges are relatively under-utilised before 10am indicating lack of criteria led discharge from the Base wards.
- There is no list generated for the Discharge lounge from the wards 1800 to 2000 hrs for the next day for them to pull patients.
- The Discharge lounge teams do 'trawl' the wards to try and pull patients.

- On the LRI site, there have been occasions where patients have been sent down without TTOs being completed. This is a workaround, or 'Borderline Tolerate Condition of Use', which has potential negative safety implications. A discharge lounge provides one function, a safe place for patients to wait for pre-booked transport or relatives to pick them up. It should have no other function.
- Re-bedding from the Discharge lounge is a 'Leicester phenomenon' and is due to a combination of factors, late preparation, late booking and transport performance against contract.

Recommendations

- **Wards to generate a list of next morning discharges (who can not be discharged that evening) by 2000 hrs.**
- **Wards generate a 2 by 10 and 2 by 12 process for discharges each day and utilise the Discharge Lounge accordingly.**
- **Set the acceptable re-bedding rate as zero and root out and correct all reasons for its occurrence.**

3.12 Diagnostics

- There is a high demand on the diagnostic services from the Emergency care pathway.
- There is clear evidence of excessive pathology requesting and even 2nd and 3rd phase requesting of pathology within the ED, not infrequently requested by bed holding specialties.
- There is near patient testing in the ED with the facility for blood gas analysis including a lactate, blood sugar, calcium, urea, electrolytes but not a creatinine or eGFR and a full blood count including differential count. The Quality Assurance of this service is maintained by Pathology.
- Turnaround time for ED pathology for tests above those offered by near patient testing is reported as slow taking up to 1- 2 hours, this has an impact in particular on the assessment units.
- Radiological requesting appears at times to be less than targeted and is sometimes used as 'hurdle' for ED to overcome before a referral is accepted.
- There do appear to be a number of 'carve outs' and other capacity constraints generated within Radiology with resultant delays in in-patient Ultrasound especially at weekends, Doppler for in-patient rule out of DVT, and CT scanning with multiple phases within CT which delay turnaround time.
- Scan acquisition time for 64 slice CT scanners should not be the rate limiting step, the rate limiting steps are in 'patient changeover time' and reporting. All CT scanner rooms have only one entry/exit point which automatically. The Department my wish to seek advice from the Army Medical Services on how, for instance, poly-trauma contrast enhanced whole body CT scans turnaround times were dramatically reduced in Afghanistan, the principles would apply to all contrast Ct scans and not just poly-trauma. Other units have considered support from Formula Pit

Stop Teams or logistics improvement experts such as Unipart to assist in process re-design.

- On-call radiology appears to be predominately managed by Radiology SpRs and not by Consultants and the routine day appears to be 9am to 5pm 5 days per week. There are examples of 0800 to 2000 hrs 7 day per week routine working accommodating emergency imaging around the country.
- There are successful joint agreed pathways, an audit 2 years ago of CTPA/VQ scan requesting for rule in rule out of pulmonary embolism revealed a 23% positivity rate. The British Thoracic Society guidance on Pulmonary Embolism suggests an appropriate positivity rate of 25%, very significantly below this suggests over requesting and significantly above this suggests under detection of this important and potential fatal condition.
- Radiology in particular and endoscopy services also are an extremely valuable resource and a referral is for a clinical opinion not a demand for a test to be done. Over utilisation of these opinions will result in longer delays for those patients who actually need them.

Recommendations

- **Jointly develop diagnostic algorithms for key presentations and these should follow national guidance.**
- **Consider restricting cross sectional requesting (CT and MRI) to Consultants, ST4 and above from all specialties and to Advanced Nurse Practitioners who have demonstrated the appropriate competencies.**
- **ED requesting of diagnostics must only be relevant for the immediate management and decision making for the patient and never for referral management alone.**

3.13 Hospital Discharge/Transfer of Care

- Placing Transfer of Care as a topic within the wider system feedback report rather than solely within the initial interim draft feedback to UHL has been deliberate. 60-70% of patients who are admitted as an emergency have either long term conditions or frailty or both. As such they should be known to the system, yet the system appears to behave as though it is 'surprised' when a patient with LTC/frailty is admitted to Hospital. The system then goes on to behave that the potential for Transfer of Care of such patients is equally a 'surprise'. The consequence of the multiple delays in the processes results in protracted length of stay with resultant significant deconditioning, these have been highlighted as key national issues within the Kings Fund (http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf) and Health Foundation (http://www.health.org.uk/public/cms/75/76/313/4196/Improving%20patient%20flow.pdf?realName=T67pC0.pdf) Reports.
- The use of the term 'discharge' tends to re-enforce the thinking that this process is separate from case management and it is better to use the term transfer of care. It appears that a significant proportion of medical teams

consider their role completed when they declare the patient 'medically fit for discharge'. This term is of little value and planning transfer of care is an integral part of case management delivery.

- There is an 'integrated team' at UHL which comprises a Discharge Team who link with ward based Discharge co-ordinators. The latter are a member of the nursing team given the specific responsibility to plan and deliver discharge. This has re-enforced the dis-location of planning transfer of care from case management delivery. If the ward based Discharge Co-ordinator is on leave or not on shift, there can be a delay in implementing the transfer of care processes as other members of the team do not see this as their primary role.
- There is a heavy reliance on the formal use of Section 2 and Section 5 notifications which has become excessively bureaucratic with resultant retractions and/or changes in information being provided. There is an almost automatic issuance of Section 2 notifications when it is clear that the individual has been previously independent and has not suffered an acute event which is likely to result in care needs requiring Local Authority support. In addition, not infrequently on contacting the ward teams, community or acute, the Transfer of Care destination has been changed.
- There is a perception that Continuing Health Care (CHC) checklists are mandatory before a Section 2 is issued. Far too many CHC checklists are being completed at a time when the patient remains acutely unwell. The national guidance is clear 'In an acute hospital setting, the Checklist should not be completed until the individual's needs on Transfer of Care are clear' (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213138/NHS-CHC-Checklist-FINAL.pdf).
- It appears that if the CHC checklist triggers positive then in some areas the Therapy Teams dis-engage from assessing and rehabilitating the patient. This appears to directly contradict the guidance where it has to be considered whether on-going NHS or NHS rehabilitation/re-ablement/packages of care/short term placement in a Care Home may allow improvement in the individual's status.
- The guidance relating to consent or involving family members are involved for those lacking capacity before commencing a CHC checklist is not infrequently breached.
- The process for carrying out discharge assessment and thus the use of Section 2 and 5 was set out in the Community Care (Delayed Discharges etc.) Act 2003 and there has been clear guidance on when this process should commence and who should be involved. This has been set out in the guidance Health Service Circular/Local Authority Circular HSC 2003/009 LAC (2003) (http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4064939.pdf) which states that 'The multi-disciplinary team, including representatives from social services, should be involved in the discharge planning process as early as possible. It is not necessary to wait for a clinical decision of 'medically fit' before referring for assessment of needs and most appropriate care options for patients after leaving acute care. However judgement will be needed about the most appropriate time to begin the assessment'. This document also states 'Hospital is not the ideal place to be while waiting for arrangements for care to be put into place. Hospitals make

people more dependent; there is also an increased risk of them acquiring an infection. Whilst they are away from home, older people's care networks can break down.' As has been identified throughout this paper, there are many patients suffering inordinate delays within the system because of a lack of effective joint working.

- There are team members who feel that assessments or even discussions regarding assessments cannot take place before a patient is medically fit. This is in clear contradiction to the guidance.
- There is a 'non-weight bearing (NWB) pathway' for patients with fractures which is invoked at a high rate and when triggered by the ward team results in the patient being kept in bed until reviewed by Orthopaedics which can take a number of days to occur. This results in significant deconditioning. The 'non-weight' bearing pathway is even triggered for upper limb fractures when there are clear opportunities to continue mobilisation. The Discharge Team run the co-ordination of the NWB pathway with transfer of care options to home with ICT and/or ICRS or a care package. If the patient has dementia on the NWB pathway, interim care home beds are utilised.
- It appears that a 'bed based' 'Discharge to Assess' in local care homes has been implemented to allow for assessment of patients utilising the 'Decision Support Tool' for those patients who have triggered positive on the CHC.
- If care packages are not immediately available there is a culture of requesting interim placement in a care home until a care package is in place. When an interim placement is offered and if the patient turns the offer down, then a 'choice letter' detailing the charges for the costs of remaining in UHL is provided to the patient and/or family. A more appropriate response from the system would be to ensure a 'bridging' process within the person's own home until a care agency can cover the care needs.
- Clinical teams are making recommendations regarding placement and extensive packages of care despite only making assessments of a patient in a hospital setting. Hospital based assessments very frequently underestimate patient's capabilities at home and assessments performed after transfer home with an interim support structure in place, that is home based 'discharge to assess' provide better information on a person's capabilities.
- Fast Track assessments for CHC funding have been reported as 4 times the national average with between 55 and 60% of these patients dying within 3 months. The fees paid to care Homes relating to CHC placement, Fast Track placement and Discharge to Assess have so distorted the market that a number of Care Homes no longer take Local Authority funded clients since the fees for the former are almost twice the latter.
- Ward 2 at the Leicester General Hospital was opened over a year ago specifically to 'lodge' patients who are waiting external care support. This results in yet another move for patients and has resulted in patients' under-going additional assessments and at times patients being transferred in whom the discharge destination is not clear.
- During this disjointed process, patients with frailty are moved from Ward to Ward causing more de-conditioning and it is this de-conditioning, which is preventable to a significant extent, that results in high rates of dependency and ultimately worse as a direct impact of the hospitalisation.

Recommendations

- **Implement across LLR the principle that all patients admitted to hospital will return to their usual place of residence, that is the 'Home First' principle. In parallel to this principle will be the process of 'Discharge to Assess' occurring within that usual residence if that is deemed necessary.**
- **All patients must have an Expected Date of Discharge and Clinical Criteria for Discharge (the latter including functional status as well as physiological parameters) set at the point of admission and there to be clear documentation within the medical notes that the multi-disciplinary team are assertively case managing to achieve the criteria for discharge and are highlighting any internal and external constraints and resolving them on a day to day basis. It needs to be considered that failure to demonstrate effective case management towards a discharge plan in this way will allocate all delays to health and not to social care.**
- **Simplify the transfer of care process and design three routes, simple, moderate and complex as per the minimum data set plan. Ensure the simple and moderate transfers of care are delivered effectively, these account for the vast majority of transfers of care out of hospital.**
- **Close Ward 2 at the Leicester General Hospital.**
- **Re-create the principle that the named Consultant and named nurse along with the named therapists are responsible for delivery transfer of care. In view of the extensive de-skilling that has occurred, this will require a period of re-training and a phased implementation strategy, before dis-banding the ward based 'discharge co-ordinator' function.**
- **Ensure that CHC checklists are only carried out at the appropriate time and ensure that consent is obtained or advocacy for those who lack capacity.**
- **For clarity on this issue, the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care *November 2012 (Revised)* (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf) states:**
- **Hospital Discharge**
  62. In a hospital setting, before an NHS trust, NHS foundation trust or other provider organisation gives notice of an individual's case to an LA, in accordance with section 2(2) of the Community Care (Delayed Discharges etc.) Act 2003, it must take reasonable steps to ensure that an assessment for NHS continuing healthcare is carried out in all cases where it appears to the body that the patient may have a need for such care. This should be in consultation, as appropriate, with the relevant LA.
  63. CCGs should ensure that local protocols are developed between themselves, other NHS bodies, LAs and other relevant partners. These should set out each organisation's role and how responsibilities are to be exercised in relation to delayed discharge and NHS continuing healthcare, including responsibilities with regard to the decision-making on eligibility. There should be

processes in place to identify those individuals for whom it is appropriate to use the Checklist and, where the Checklist indicates that they may have needs that would make them eligible for NHS continuing healthcare, for full assessment of eligibility to then take place.

64. Assessment of eligibility for NHS continuing healthcare can take place in either hospital or non-hospital settings. It should always be borne in mind that assessment of eligibility that takes place in an acute hospital may not always reflect an individual's capacity to maximise their potential. This could be because, with appropriate support, that individual has the potential to recover further in the near future. It could also be because it is difficult to make an accurate assessment of an individual's needs while they are in an acute services environment. Anyone who carries out an assessment of eligibility for NHS continuing healthcare should always consider whether there is further potential for rehabilitation and for independence to be regained, and how the outcome of any treatment or medication may affect ongoing needs.

65. In order to address this issue and ensure that unnecessary stays on acute wards are avoided, there should be consideration of whether the provision of further NHS-funded services is appropriate. This might include therapy and/or rehabilitation, if that could make a difference to the potential of the individual in the following few months. It might also include intermediate care or an interim package of support in an individual's own home or in a care home. In such situations, assessment of eligibility for NHS continuing healthcare should usually be deferred until an accurate assessment of future needs can be made. The interim services (or appropriate alternative interim services if needs change) should continue in place until the determination of eligibility for NHS continuing healthcare has taken place. There must be no gap in the provision of appropriate support to meet the individual's needs.

- **In essence Paragraph 62 above does not make it mandatory to have a CHC checklist before a Section 2 is issued, this mis-interpretation by the system needs to be resolved. Paragraph 64 and 65 however, do make it mandatory to consider the potential for a person to regain function with ongoing interventions after discharge from Hospital, recognising that assessments in the acute setting may not always reflect the individual's capacity to achieve their maximal potential. This latter point is crucial.**
- **The Social Care Act 2014 guidance (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf) is very clear, re-affirming the guidance above and states that *'Local authorities and CCGs in each local area must agree a local disputes resolution process to resolve cases where there is a dispute between them about eligibility for NHS CHC, about the apportionment of funding in joint funded care and support packages, or about the operation of refunds guidance. Disputes should not delay the provision of the care package, and the protocol should make clear how funding will be***

***provided pending resolution of the dispute'*. In essence, no delays to transfer of care with resolution of funding arrangements taking place after joint care packages have been put in place.**

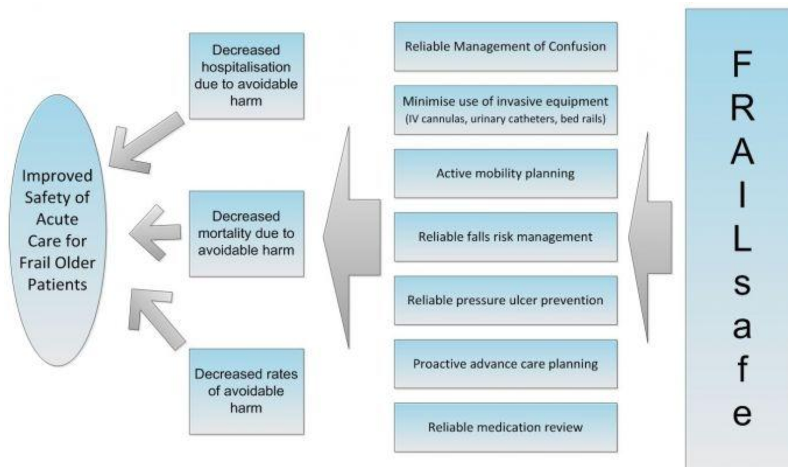
- **Work with social care and the 'frailty tracking' team described below to manage transfer of care of older people with frailty in a balanced risk manner recognising that frequently the opportunity for discharge for these patients is fairly early in the pathway and fairly brief.**
- **For those patients awaiting a 'care package' rather than arranging an interim placement, a more appropriate response from the system would be to ensure a 'bridging' process within the person's own home until a care agency can cover the care needs.**
- **With the embedding of the 'Home First' principle, 'Discharge to Assess' in the person's usual residence, an 'older person with frailty' pathway aimed at minimising decompensation with effective collaborative working across the system, the key outcomes of reducing the 'stranded patient' metric, promoting independence and reduced reliance on long term care placement will be achieved with a parallel reduction in the DTOC metric and the need to issue 'Choice Letters'.**

Older Person with Frailty Journey Through Urgent/Emergency Care

The urgent care pathway for older people with frailty in LLR is fraught with delays. There are delays in accessing assessments for home care, there are delays in primary care responses to urgent needs despite some of the processes put in place. If it is deemed that a patient needs to go to hospital having been referred by their GP, there are delays in the transfer of the patient to Hospital. When the patient arrives at Hospital there are delays through the pathway from front to back of the hospital, despite there being some services aimed at getting such people home quickly. The reason being that the system has not been designed to capture all older people with frailty who access the Hospital from the point of access through to the point of transfer of care. Once admitted a significant proportion of older people with frailty do not undergo comprehensive geriatric assessment, the setting of EDD and CCD is not universal and the 'drum beat' of case management delivery is not robustly delivered to achieve the goals. Even once a patient is moving towards the potential for transfer of care back home there are multiple delays which prolong length of stay. The impact of these delays, compounded by multiple moves, is that patients de-compensate and develop 2nd and 3rd phase illness with the end result that their functional state becomes profoundly impaired resulting in high cost health and social care provision with loss of independence, early transfer in to long term care and in a proportion a deconditioning that results in Fast Track placement.

It has to be the main priority to provide a much more patient centric process for older people with frailty that ensures there are no delays in the system for this group of patients. The development of operational integration of services aligned to the needs of older people with frailty is crucial. The system has to accept the risks of delays with resultant deconditioning and have a pathway in place that ensures that older people with frailty who develop urgent health care need are responded to very promptly and in keeping with the principles of the Silver Book. If older people with

frailty are admitted to Hospital as an emergency, then the system has to remove all delays to prevent deconditioning and deliver transfer of care back to their usual residence without delay 7 days per week. The Health Foundation 'Frail Safe' Collaborative (http://www.frailsafe.org.uk/) is currently testing a checklist akin to the Safer Surgery checklist to provide a check and challenge process for older people with frailty being admitted to Hospital. The aim being to reduce the risks of deconditioning and harm which occur in a disproportionate number of these patients.



The seven interventions highlighted within the 'frailsafe' intervention have an extensive evidence base to reduce harm and improve outcomes in older people with frailty.

Recommendations

- **The system has an opportunity for a significant 'quick win' with personal and system wide benefits by focussing on delivering highly responsive, high quality response to a significant group of patients who, if not managed effectively, have high rates of complications and poor outcomes and consequent high consumption of health and social care resources. This group is the 'older person with frailty'.**
- **Ensure that the system creates a 'register of adults at risk of frailty', provides health promotion and 'independence promoting' interventions, based around socialisation, physical activation and specific interventions for those at risk of falls etc. If these individuals develop urgent care needs, ensure the system responds to prevent deconditioning at every step.**
- **Ensure a Primary care response commensurate with the guidance within the Silver Book for Older People with Frailty and urgent care need.**
- **If older people with frailty do attend the acute sector, they receive rapid assessment by appropriate inter-disciplinary community facing teams that ensure adequate diagnosis, implementation of treatment and a community based case management plan, predominately based within their own home.**

- **If admitted to hospital, the same team track their progress to ensure transfer home occurs at the first available opportunity to prevent in-hospital deconditioning.**
- **This inter-disciplinary team ensures that the 'Frailsafe' principles are delivered to ensure minimisation of deconditioning and patient safety incidents.**
- **In the first instance, this inter-disciplinary team will comprise the integration of ICRS, HART, ICS, Therapy Team/ICT, PCC, GPs and secondary care clinicians who demonstrate the necessary competencies of managing older people with frailty with urgent care needs in a 'balanced risk' approach.**
- **Personal, population and system level benefits to be realised are with increased independent or supported living at home, reduced long term care placement, reduced carer strain and an increase in independent living life expectancy.**

Concluding Comments

The system in LLR is perfectly designed to deliver the results it is achieving. The first step in resolving this is for the system to accept that for a variety of reasons what has been designed is not providing the highest quality of urgent health and social care the population of LLR deserve. There is not a single element of the system that can say that it has 'got it right'.

There are very significant opportunities for quality improvement with reductions in mortality, harm and improvements in patient experience by improving the processes identified by robustly implementing the recommendations.

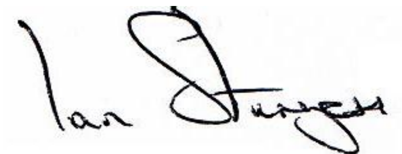
A focussed and driven improvement programme with clear governance frameworks holding each other to account, supported by managerial and Executive 'grip' to support the clinical 'grip' will bring about rapid and marked improvements in patient safety and experience. Early senior review, clear and time dependent case management delivery whilst holding each other to account to deliver the quality inputs with a focus on delivering the quality outcomes of reduced mortality and harm whilst improving the experience for the patient are easily within reach.

This improvement process needs to be clinically led supported by managerial/Executive/system alignment with as far as possible real time metrics to support continued improvement.

The 4 hour standard for emergency care just happens to be measured in the Emergency Department, it is, however, a measure of the effectiveness of the whole system's management of the urgent and emergency care pathway, and crucially of how long term conditions and frailty are managed in people who spend markedly in excess of 95% of their total life living with LTC/Frailty in the community. If they do become acutely ill enough to need to go to Hospital, it is the systems responsibility to ensure that their stay at the hospital is only as long as required to get them over the critical phase of the acute illness. Once well enough to leave Hospital, the system needs to design a process that delivers the transfer back to the community on the

day they are ready. That is the system delivers for the needs of the patient and not for the needs of the individual component parts of the system.

Yours sincerely



Dr Ian Sturgess FRCP (Lon)

Winter Urgent Care Action Plan 2014/15

Organisation	Improvement Requirement	Actions	KPI trajectory	Accountable lead	Delivery date	Operational delivery group	Partner support requirements	Contribution to Resilience Plan metrics (no.s 1-50)	Alignment to Ian Sturgess review recommendations
DEMAND (inflow)									
Leicester City CCG	**Extra capacity & improved access to General Practice**	Discuss the Area Teams Christmas and New Year Extended opening hours scheme with all practices. The aim is to have at least four hubs across the city offering consultations over the Bank Holiday period.	All schemes will contribute to: Reduction in Leicester City CCG ED attendance of 5%, 72 per week leading to a run rate of 1375 per week	Sarah Prema	24th December 2014	Primary Care Delivery Group	General Practice Area Team	UHL EM Avoidable UHL EM by GP UHL EM by bed bureau UHL AE attends 65+ UHL EM via GP/BB with 0 day LOS	1,3,4,5,6,7
		Contact all practices to ensure all patients are offered on line booking.		Sarah Prema	31st December 2014	Primary Care Delivery Group	General Practice		
		Develop and implement an awarness rising campaign aimed at practices and the public to promote the availability of on line booking and repeat prescriptions.		Sarah Prema	31st December 2014	Primary Care Delivery Group	General Practice		
		Undertake quality visits to 18 practices with highest emergency admission rates and develop a plan for improvement, 16 practices by the end of December 2014 and 2 in January 2015.		Sarah Prema	31st January 2015	Quality Review Delivery Group	General Practice		
	Community alternatives to admission	Provide additional resources to expand the capacity of the following community services: 1. Practical Support at Home 2. Assistive Techonology 3. Night Nursing (double the night time capacity) 4. Primary Care Co-Ordinators (2 additional at the Front Door of ED) 5. Additional therapy capacity	Reduction in Leicester City CCG ED admissions of 5%, 32 per week leading to a run rate of 602 per week	Sarah Prema	31st December 2014	BCF Implementation Group	UHL LPT Leicester City Council	ED occupancy over 55 UHL AE Attends UHL EM via AE EMAS non-conveyance rate UHL EM Falls 65+	1,3,4,5,6,7
		Provide a 5 day a week ICRS presence in ED to pull patients into community services.		Sarah Prema	Daily to the end of March 2015	BCF Implementation Group	Leicester City Council		
		Have the Frailty Front Door Team in place a minimum two days a week pulling frail older people into community services. Cover additional days as medical capacity allows.		Sarah Prema	Weekly to the end of March 2015	BCF Implementation Group	UHL		
		Send all practices an information summary setting out the community alternatives to admissions.		Sarah Prema	31st December 2014	BCF Implementation Group	General Practices		
		Review the Directory of Services and update as necessary.		Sarah Prema	24th December 2014	BCF Implementation Group	ELR CCG DHU		
	Care/nursing homes	Implement a revised City Care Nursing Service including the provision of a one session a week UHL Outreach Geriatric service focused on those patients most at risk of admission from Care Homes.		Sarah Prema	31st December 2014	BCF Implementation Group	UHL Care Homes	UHL EM Avoidable UHL EM by GP UHL EM by bed bureau UHL AE attends 65+ UHL EM via GP/BB with 0 day LOS	1,3,4,5,6,7,9,14
		Reissue information to care homes on community alternatives to admissions.		Sarah Prema	24th December 2014	BCF Implementation Group	Care Homes		

Organisation	Improvement Requirement	Actions	KPI trajectory	Accountable lead	Delivery date	Operational delivery group	Partner support requirements	Contribution to Resilience Plan metrics (no.s 1-50)	Alignment to Ian Sturgess review recommendations
Leicester City CCG	**Weekly clinical review and feedback**	Weekly clincial peer review of emergency attendances and admissions using real time data for Leicester City and feedback to practices on missed alternatives to admissions.		Sarah Prema	Weekly from January 2015	Primary Care Delivery Group	General Practice	UHL EM Avoidable UHL EM by GP UHL EM by bed bureau UHL AE attends 65+ UHL EM via GP/BB with 0 day LOS	1,3,4,5,6,7
		Weekly review of care home emergency attendnaces and admissions data and feedback to homes on missed alternatives to admissions.		Sarah Prema	Weekly from 15th December 2014	BCF Implementation Group	Care Homes		1,3,4,5,6,7,9,14
East Leicestershire & Rutland CCG	**Extra capacity & improved access to General Practice**	**All day weekend Access for complex patients by:** •Weekend & bank holiday routine surgeries - to support the area team LES during the period 20th December 2014 to 28th February 2015 at set periods on Saturdays and Sundays and Bank Holidays • Weekend and bank holiday extension to 7 day working pilot to run alongside the area team LES for focus on complex and high risk patients during the period 20th December 2014 to 28th February 2015 (practices being offere opp to either or both) •Urgent Home Visiting - 20 practices to provided additional home visiting service every am 8.30-12.30 for most risk of admission	All schemes will contribute to: Reduction in EL&R ED attendance of 5%, 35 per week leading to a run rate of 673 per week	Tim Sacks	20th December Week commencing 5th January 2015	Quality+Performance Committee CCG	CCG/Primary Care/Area Team	UHL EM Avoidable UHL EM by GP UHL EM by bed bureau UHL AE attends 65+ UHL EM via GP/BB with 0 day LOS	1,3,4,5,6,7,9,13
	Community alternatives to admission	**Extended Opening Hours for Oadby WIC** To extend the opening hours and access to the Oadby site from 8-Midnight (12am)		Tim Sacks	8 weeks from 5th January 2015	Quality+Performance Committee CCG	NHSE/CCG/WIC	UHL EM Avoidable UHL EM by bed bureau UHL AE attends 65+	1,3,4,5,6,7,9,13
		LTC AF Pathway Use All practices now trained to new standards NOACs now green on LMSG. Expect significant increase in prescribing/AF prevalence and reduced stroke related admissions	Reduction in EL&R CCG ED admissions of 5%, 19 per week leading to a run rate of 362 per week	Tim Sacks	Monthly	MMSG	GP/Primary Care	UHL EM by GP UHL EM by bed bureau	1,3,4,5,6,7,9,13
	Care/Nursing homes	**Care Home/EOL** GP Practice management of patients with Care Plans (100%) working to educate homes and ensure compliance of completed care plans and link with EMAS/OOH/NHS 111 if there are any identified system failures		Tim Sacks	Weekly audits at ED on care home admissions. EMAS care home conveyance rates	Quality+Performance Committee CCG	GP Primary Care/OOH/NHS 111	UHL EM Avoidable UHL EM by GP UHL EM by bed bureau UHL AE attends 65+ UHL EM via GP/BB with 0 day LOS	

Organisation	Improvement Requirement	Actions	KPI trajectory	Accountable lead	Delivery date	Operational delivery group	Partner support requirements	Contribution to Resilience Plan metrics (no.s 1-50)	Alignment to Ian Sturgess review recommendations
East Leicestershire & Rutland CCG		**3xWTE Care Home/Integrate Care Pharmacist** To undertake reviews/admission avoidance with 2% vulnerable patients. 8 care homes have been visited YTD and plans are for another 5 are to be visited upto the end of February 2014.		Tim Sacks	Ongoing from November 2015	MMSG	GP/Primary Care/LCC	UHL EM Avoidable UHL EM by bed bureau UHL AE attends 65+	
	Weekly clinical review and feedback	**Prospective Peer Review** Every practice peer reviews every patient to ensure all community options are used. This will be undertaken prior to every admission		Tim Sacks	Ongoing from November 2014	Q+P Committee CCG	GP/Primary Care	UHL EM Avoidable UHL EM by GP UHL EM by bed bureau UHL AE attends 65+ UHL EM via GP/BB with 0 day LOS	
	Director of Services (DoS)	**LLR DOS** Updated with current live information to aide practices with urgent care/alternative to admission. This will be updating of new services, review of disposition orders and implementation of the CMS.		Robin Wintle/Tim Sacks	Guide to be sent out w/c 12th January 2015	Quality+Performance Committee CCG	ELRCCG	UHL EM Avoidable UHL AE attends 65+	1,3,4,5,6,7,9,13
	Reduce readmissions to UHL from community hospital	Community Hospital Out ot Hours service (CNCS) to face to face review deteriorating patients prior to transfer (excluding 999 patients)							
West Leicestershire CCG	**Extra capacity & improved access to General Practice**	Extra in-week capacity - additional 100 general practice consultations every weekday	All schemes will contribute to: Reduction in WL ED attendance of 5%, 34 per week leading to a run rate of 644 per week	Angela Bright	12 Dec 14 Funding Decision Area Team 12th January 2015 Provisional Start date	WLCCG Out of Hospital Implementation Board	Area Team	1, 3, 4, 9, 14, 15 and 16	9,11,14, 16 and 17
		Weekend & bank holiday routine surgeries - implement LES during the period 20.12.14 to 28.02.15 for agreed times of Saturdays, Sundays and Bank Holidays		Angela Bright	20-Dec-14	WLCCG Out of Hospital Implementation Board	Area Team	1, 3, 4, 5, 6, 7, 9, 14, 15 and 16	9, 11 and 14
		7 day locality pilots - embed GP led 7 day services. Targets care homes and at risk patients. Seeing 80 per week rising to 860 patients in total by March 2015		Angela Bright	20 Dec 14	WLCCG Out of Hospital Implementation Board		1, 3, 4, 5, 6, 7, 9, 14, 15, 16 and 18	10, 11, 12, 14, 15 and 18
	Maximise Utilisation of Community alternatives to admission	Loughborough Community Hospital - Ensuring we get maximum use out of EMAS support in utilisation of Loughborough Urgent Care Centre and Older Persons' Unit through conveyance diverts to this site		Angela Bright	15 Dec 14	WLCCG Out of Hospital Implementation Board	EMAS CNCS LPT	1, 3, 4, , 6, 7, 8, 9, 12, 14, 15, 16 and 18	11, 12, 13,
		Older Persons' Unit (OPU) - Implement the new dedicated transport solution to support OPU patients back to their own homes		Caron Williams	w/c 22 Dec 14	BCF Frail Older Persons' Group	LPT St John Ambulance	1, 3, 4, 9 and 16	11, 18, 43, 75 and 76
		Acute Visiting Service - Embed use of new AVS to increase utilisation from 100 rising to 400 by March 2015		Angela Bright	w/c 22 Dec 14	WLCCG Out of Hospital Implementation Board	SSAFFA	1, 3, 4, 5, 6, 7, 9, 14, 15 and 16	11, 12 and 18
		Single Point of Access (SPA) - Task and Finish group developing the SPA, resulting in a reduction in call answering time, dropped calls and target GP calls responded to within 30 seconds		Caron Williams	w/c 26 Jan 15	BCF Step Up Step Down Board	LPT	1, 3, 4, , 6, 7, 8, 9, 12, 14, 15, 16 and 18	38, 43
		Integrated Community Health and Social Care Crisis Response Service (ICRS) - Night Nursing Assessment Service extension to established provision ensures 24/7 365 day a year crisis service within a 2 hour response time preventing an average of 15 admissions per month		Caron Williams	W/C 8 Jan 15	BCF Step Up Step Down Board	LCC LPT	1, 3, 4, , 6, 7, 8, 9, 12, 14, 15, 16 and 18	42,43 and 44

Organisation	Improvement Requirement	Actions	KPI trajectory	Accountable lead	Delivery date	Operational delivery group	Partner support requirements	Contribution to Resilience Plan metrics (no.s 1-50)	Alignment to Ian Sturgess review recommendations
West Leicestershire CCG		Effective alternatives to ED - LTC Integrated Management Care: • Maximise the capacity in the Rapid Access Heart Failure Clinic at UHL by continually promoting this service to GP's. Increase from an average of 14 - 17 a month from January to March. • Mobilise an Atrial Fibrillation Rapid Access Clinic at UHL from January – March. Reducing admission from by 3 a month from February to March, and reduce LOS from by 1.5 days. • Integrating HF Community and Secondary Care MDT – This will support the management of complex HF patients at home. This will reduce readmissions by 2 a month. • Integrating case management for Complex COPD patients (pilot) – Community Respiratory Nurse meets weekly with Respiratory Consultant. This will reduce follow-up activity for Complex COPD by 2 a month.	Reduction in EL&R CCG ED admissions of 5%, 21 per week leading to a run rate of 404 per week	Angela Bright	w/c 22 Jan 15	WLCCG CVD Delivery Group WLCCG Respiratory Delivery Group	UHL LPT	1, 3, 4, 9 and 16	15, 18
	Care/Nursing Homes	Reducing inappropriate Admissions from Care Homes - extend Acute Visiting Service to take direct referrals from care homes in hours and at weekends (see activity trajectory for 7 day pilot section 1)		Angela Bright	w/c 15 Jan 15	WLCCG Out of Hospital Implementation Board	All Care Homes SSAFFA	1, 3, 4, , 6, 7, 8, 9, 12, 14, 15, 16 and 18	11, 12, 13
	Weekly clinical review and feedback	• Weekly review of emergency attendance and admissions by GP Board Members using real time data for West patients • Identify and disseminate to practices one top tip each week based on themes from the previous week's ED data • Each practice to receive and review data with suggested alternatives to admission • Board clinical lead GP's to undertake weekly peer to peer feedback and challenge with identified practices		Angela Bright	Ongoing	WLCCG Weekly Clinical Leads Meeting	GEM CI	1, 3, 4, , 6, 7, 8, 9, 12, 14, 15, 16 and 18	13, 17
DHU - NHS 111	**Reduced Attendances and Admissions**	124.5 hours (5 heads) of call advisors to be added to the rota week commencing 8.12.14as due out of training. 550 hours (19 heads)of call advisors to be added to the rota week coming 22.12.14.	Additional hours added into the rota enabling 95% calls answered in 60 seconds	Pauline Hand	1 week 3 weeks	Collaborative Commissioning NHS 111 Group	None	95% calls answered in 60 seconds National Minimum Dataset	
EMAS	**LLR non-conveyance rate**	1. LLR Non-conveyance: Deliver Paramedic Pathfinder (EMAS wide) and Falls Assessment (LLR only) training to support access to appropriate pathways, clinical safety netting and treatment within the community.	LLR Falls Training: 25% by w/e 11/1/15 50% by w/e 18/1/15 75% by w/e 25/1/15 95% by w/e 1/2/15 EMAS Pathfinder Training: 30% by end Jan 15 60% by end Feb 15 90% by end Mar 15	Tim Slater (LLR) Adrian Healey (Falls) Andrew Mills (Pathfinder)	LLR Falls Training - scheduled to finish end January 2015 (subject to IA and REAP 4 impact) Pathfinder Training - continual programme working towards 90% of eligible EMAS staff by March 2015.	Currently providing updates on training to multiple forums including EMAS Locality Meeting, Inflow, Integration Executive, UCB and TDA weekly conference calls. This requires rationalisation to avoid duplication of reporting and performance management.	To be fully effective, this needs a consistent approach across all CCGs. We need a commitment to work to a true single point of access and seamless transition between in and out of hours provision.	EMAS LLR non-conveyance and LRI pre-handover within 15 minutes	

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EMAS	**LLR non-conveyance rate**	2. Supporting pre-hospital clinical assessment: Both Pathfinder and Falls initiatives are supported by access to a DoS or SPA type approach but there is potential to extend and integrate a practitioner helpline within EMAS's Clinical Assessment Team to reduce the steps and consolidate access routes to provide a more direct and appropriate pathway to alternative services.	Incremental increase in EMAS LLR overall non-conveyance to 50% (trajectory to be set following pilot evaluation)	Tim Slater (LLR) Joe Garcia (EMAS EOC for CAT)	The integration and enhancement of dedicated EMAS LLR CAT is at this stage an aspirational objective with no agreed timeline, but is viable during Q4 2014/15 to Q1 2015/16. This could utilise the capacity provided to support the practitioner helpline but incorporated in to the EMAS CAT provision.	Inflow	CCGs/providers to map out current available capacity to identify practitioner provision to support.	EMAS LLR non-conveyance	
	LLR conveyance rate to UCCs	3. Increase usage of Urgent Care Centres - both earlier in the access to urgent care (e.g. referrals from 111 or HCP contact) and as an outcome of EMAS Hear & Treat and See & Treat	Incremental increase in EMAS LLR overall and LE11 area non-conveyance to 50% and referrals to UCC (trajectory to be set following activity review): 48% by end Jan 15 49% by end Feb 15 50% by end Mar 15 (all data is available on a daily/weekly basis to support KPI monitoring)	Tim Slater (LLR) Ian Mursell (EMAS Consultant Paramedic for care pathway review)	End of March 2015 but supporting reduced ED conveyance through winter.	Inflow	CCGs/UCC provider to review with EMAS the current utilisation and expected levels (including referrals that lead to self-presentation). 111 provider to review DoS to ensure UCC services are correctly signposted where appropriate.	EMAS LLR non-conveyance (specifically destinations other than ED)	
George Eliot Hospital (LRI urgent Care Centre	**Reduced Attendances and Admissions**	1. rearrange clinical audit to inform pathway design. 2. Mov UCC to new premises by 24th December	1. To be determined 2. improve patient journey	Kim Wilding/Julie Dixon/ Josh Sandbach		1. UCC/ED Governance meeting 2.CCG UCC contracting Team	UHL		
LPT	**SPA:** **Improve the response rate within Single Point of Access**	1. Increase wte staff numbers within SPA to reduce healthcare professional answering times	45% of calls answered in 30 seconds (22nd Dec) and 60% by March 2015	Rachel Dewar	22nd December 2014 (40%) 30th March 2015 (60%)	Clinical Network Group		38	18, 11

Organisation	Improvement Requirement	Actions	KPI trajectory	Accountable lead	Delivery date	Operational delivery group	Partner support requirements	Contribution to Resilience Plan metrics (no.s 1-50)	Alignment to Ian Sturgess review recommendations
Leicestershire County Council	**UHL Inflow reduction/prevention: From 1 November – operational SW team based at LRI to assess and navigate patients in ED (A&E and Assessment wards) to prevent admission on Saturday and Sunday**	Weekend admissions prevented/ reduced through increased SW capacity in LRI ED	Changes in ED admission rates at weekends	Jackie Wright	1 Nov 2014 onwards	LCC Operational Delivery Group reporting to DMT	UHL ED Ind sector Providers	16, 44	68
	UHL Inflow reduction/prevention: stronger capacity in ED	Doubling of resources to assess and navigate patients in ED (A&E and Assessment wards) to prevent admission. Also, improved use of Hospital To Home service, as an alternative.	Changes in ED admission rates	Jackie Wright	1 Nov 2014 onwards	LCC Operational Delivery Group reporting to DMT	UHL ED Crisis Response	16, 44	68
	Joint work to ensure the right balance of health and social are input into cases.	LCC Crisis Response Service (step up) linked with hospital social work team and PCCs to support admission avoidance. Social Care Team also navigate patients to other appropriate services to avoid admission e.g. family/voluntary etc.	Crisis Response Service support 10 avoidable admissions per week. CRS to record number of interventions that have resulted in advoidance in addmission	Tracy Ward/Carolyn Dakin	01-Dec-14	SUSD Board	LPT UHL EMAS	3, 9, 16	42, 45
FLOW (internal)									
UHL	**Improve front door (UCC/ED) interface/alignment**	1) Continue weekly clinical meetings with UCC team	90% of patients triaged within 20 minutes	Julie Dixon	14-Dec-14	ED subgroup of EQSG	UCC/ GE	Reduce ED occupancy and time in ED	30-36
		2) UCC to triage all patients within 20 mins		UCC	14-Dec-14				30-36
		3) Ensure UCC is supported to manage the '30 min' rule		Julie Dixon	14-Dec-14				30-36
		4) Support the UCC where possible to ensure 'construction handover' date for the UCC takes place on the 19/12 and the move date is 23/12		Jane Edyvean	31-Dec-14				30-36
		5) Ensure ED is not used as an admission route by other specialities from UCC		Julie Dixon	14-Dec-14				30-36
	Improve ambulance turnaround	1) Work with EMAS and CCGs to introduce RFID as the sole data set	50% reduction in waits over 30 mins and 50% reduction in waits over one hour	Rachel Williams	31-Dec-14	ED subgroup of EQSG	EMAS and CCG commissioning team	N/A	25-29
		2) Use the new data set to agree the real scale of the problem		Rachel Williams	31-Jan-15			Reduce time in ED	25-29
		3) Continue to employ additional nurses to work in the assessment bay to minimise handover times		Rachel Williams	14-Dec-14			Reduce time in ED	25-29
	Implement the Ambulatory Emergency Care strategy	1) Cohort six member of AEC network	5% reduction in admissions (circa 4 patients per day)	Lee Walker	31-Dec-14	AMU subgroup of EQSG	CCGs	Reduce ED occupancy and admissions	80
		2) Select priority pathways for implementation		Lee Walker	31-Jan-15				80
		3) Implement priority pathways		Lee Walker	31-Mar-15				80
	Improve the resilience of ED processes	1) Implement improvements to Gold Command	70% of time ED occupancy less than	Julie Dixon	07-Dec-14	ED subgroup of EQSG	None		101-114
		2) Set up a weekly journey meeting which reviews delays in processes within the ED dept		Julie Dixon	31-Dec-14				101-114
		3) Address systematic delays identified in journey meetings (e.g. portering, transport)		Julie Dixon	15-Jan-15				101-114
		4) Ensure consistent application of floor management SOPs		Ben Teasdale	31-Dec-14				101-114
		5) Expand the use of EDU pathways		Ben Teasdale	31-Mar-15				101-114
		6) Ensure ED is not used as an admission route by other specialities		Julie Dixon	14-Dec-14				101-114
		7) Ensure ED is supported to manage the '30 min' rule		Julie Dixon	14-Dec-14				101-114
		8) Implement the 0800 'safety team'		Catherine Free	Complete				101-114
		9) Refresh ED medical staffing recruitment plan		Ben Teasdale	31-Jan-15				101-114
		10) Implement ED SOPs relating to managing activity spikes and when there is exit block		Ben Teasdale	31-Jan-15				101-114

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		11) Develop and enforce whole hospital response relating to ED exit block (i.e. poor flow)		Andrew Furlong	31-Dec-14				101-114
UHL	**Review ED staffing**	1) Review existing ED staffing to ensure optimum balance of capacity and demand	70% of time ED occupancy less than 55 and no more than one hour wait to be seen time	Julie Dixon	31-Dec-14	ED subgroup of EQSG			101-114
	Increase the proportion of GP bed referrals going directly to AMU	1) Validate and agree with CCG commissioning team that the data set is accurate	Greater than 40% in Q3 and greater than 70% in Q4 of GP referrals go directly to AMU	Rachel Williams	31-Dec-14	AMU subgroup of EQSG	CCG commissioning team	N/A	115-127
		2) Ensure senior decision maker presence within acute medical clinic between 0900 and 1700 seven days a week		Lee Walker	31-Jan-15			Improve AMU discharges	115-127
		3) Increasing bed capacity by three within the acute medical clinic (capital scheme)		Jane Edyvean	28-Feb-15				115-127
		4) Keep bed bureau clinic empty overnight enabling improved flow in the morning		Lee Walker	14-Dec-14				115-127
	Reduce the time to assessment by a consultant on the AMU	1) Validate and agree with CCG commissioning team that the data set is accurate	Greater than 40% in Q3 and greater than 70% in Q4 of patients are seen by a consultant within six hours	Rachel Williams	31-Dec-14	AMU subgroup of EQSG	CCG commissioning team	N/A	115-127
		2) Ensure consultant presence on AMU is continuous with roving ward rounds between 0800 and 2100 Monday to Friday and 0800 and 2000 at the weekend		Lee Walker	31-Dec-14			Improve AMU discharges	115-127
		3) Start ward rounds at 0800		Lee Walker	07-Dec-14				115-127
	Improve middle grade staffing resilience on AMU	1) Review remuneration rates for tempory medical staff on AMU	Greater than 40% in Q3 and greater than 70% in Q4 of GP referrals go directly to AMU	Lee Walker	31-Dec-14				115-127
		2) Develop more resilient middle grade staffing model for AMU		Lee Walker	31-Mar-15				115-127
	Reduce bed occupancy on the base wards	1) All patients leaving the assessment unit must have a main diagnosis, plan and EDD	Supports 5% (total) reduction in medical bed occupancy by	Lee Walker	31-Dec-14	Base ward subgroup of EQSG	None	Reduce bed occupancy	128- 137, 169-172 and 176-184
		2) Start base ward rounds now at 0830 and then move to 0800 start by 31/3 five days a week		Ian Lawrence	31-Mar-14				128- 137, 169-172 and 176-184
		3) Increase consultant presence on short stay and key speciality base wards (34, 37 and 38) at the weekend		Ian Lawrence	14-Dec-14				128- 137, 169-172 and 176-184
		4) Establish the manpower, rota requirements and finances and necessary support staff for further extension of weekend consultant cover (links to seven day plan)		Ian Lawrence	31-Mar-15				128- 137, 169-172 and 176-184
		5) Implement peer review of ward rounds and long stay patients		Ian Lawrence	31-Dec-14				128- 137, 169-172 and 176-184
		6) Ensure that patients 'sit out' or move to the discharge lounge asap and book ambulances when TTOs are complete		Maria McAuley	31-Dec-14				128- 137, 169-172 and 176-184
		7) Use metrics to identify high/ low achieving wards and support low achieving wards to improve		Ian Lawrence	31-Dec-14				128- 137, 169-172 and 176-184
		8) Ensure accuracy of real time bed state		Gill Staton	31-Jan-15				128- 137, 169-172 and 176-184
		9) Develop plan to implement electronic bed management system		Rachel Overfield	31-Mar-15				128- 137, 169-172 and 176-184
	Improve the discharge process in medicine and cardio-respiratory	1) Standardise the assertive MDT board round process seven days per week	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Ian Lawrence	End of March 2015	Base ward subgroup of EQSG	None		128- 137, 169-172 and 176-184
		2) Implement one stop ward rounds		Ian Lawrence	31-Jan-15				128- 137, 169-172 and 176-184
		3) Implement the long length of stay review process		Ian Lawrence	31-Dec-14				128- 137, 169-172 and 176-184
		4) Wards to generate a list of next morning discharges with TTOs written the prevous day		Maria McAuley	31-Dec-14				128- 137, 169-172 and 176-184
		5) Eliminate rebeds / failed discharges for non clinical reasons		Maria McAuley	28-Feb-15				128- 137, 169-172 and 176-184
		6) All patients to have an EDD and CCD set at first review on base wards including criteria for nurse delegated discharge		Ian Lawrence	31-Dec-14				128- 137, 169-172 and 176-184
		7) Prioritise therapy and specialist input to expediate simple discharge		Maria McAuley	15-Jan-15				128- 137, 169-172 and 176-184
		8) Reskill ward staff to facilitate simple discharges		Maria McAuley	15-Jan-15				128- 137, 169-172 and 176-184
		9) Liberate nursing time to drive discharges		Maria McAuley	15-Jan-15				128- 137, 169-172 and 176-184
	Reduce discharge delays caused by TTOs	1) Increase the volume of TTOs completed the day before discharge	Supports 5% (total) reduction in medical	Maria McAuley	31-Dec-14	Base ward subgroup of EQSG	None		128- 137, 169-172 and 176-184

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UHL		2) Prioritise pharmacy support to admission areas and base wards		Maria McAuley	31-Dec-14				128- 137, 169-172 and 176-184
DISCHARGE (outflow)									
LPT	**Improve the flow of patients to and through Comnmunity Hospitals**	Community Hospital Matron to work out of UHL to identify suitable patients for discharge	Increase number of patients refered to community hospitals by 4 per day	Nikki Beacher	W/C 26th January 2015	CHS Strategic Development Group	UHL City/County Social Services	38,39,41,42	46,47,
		City CCG - PCCs will attend board rounds on 5 wards to increase rate of discharge	Reduction in excess bed days	Nikki Beacher	w/c 13 Oct one ward/month roll out	Clinical Network Group	City CCG, UHL	38,39,41,72	72,
		The use of pre-set LoS in community hospitals will cease	Reduction in LoS by 4 days	Nikki Beacher	26th January 2015	Clinical Network Group		N/A	46,47.48,49
		The daily community hospital MDT board round process will be reviewed and SOP deployed to standardise processes and facilitate timely discharge	Reduction in LoS by 4 days	Nikki Beacher	19th January 2015	Clinical Network Group		N/A	46,47,48,49
		All community hospital in-patients patients will have an EDD and CCD	Reduction in LoS by 4 days	Nikki Beacher	19th Janaury 2015	Clinical Network Group		N/A	46,47,48,49
	Community Services: improve of patients to and through community services	Community Hospital Matron to work out of UHL to identify suitable patients for discharge	Increase number of patients referred to community services by 4 per day	Nikki Beacher	W/C 26th January 2015	CHS Strategic Development Group	UHL/City and County Social Services	38,39,41,42	41,42,43
		Community staff will follow up patients discharged from ED by PCC to prevent readmission.	100% follow up within 72 hours	Rachel Dewar	W/C 22/12/14	Clinical Network Group		48,49,50	73,41,42,43
	Community Health Services: Community Nursing	Deliver 7 day service 8am to 8pm offering contact and support for children/young people in the community (e.g. IVs, wound assessment and management etc.)	Reduction in UHL admissions of 2 per week	Helen Perfect	December 2014 to March 2015	Children's Clinical Sub Group	UHL, Primary Care		
		Expedite discharge through discharge coordinators working in CAU and the children's Hospital to community nursing service	Reduce LOS for 2 patients a week by 1 day	Helen Perfect	December 2014 to March 2015	Children's Clinical Sub Group	UHL, Primary Care		
	Community Health Services: Community Nursing; Respiratory Physiotherapy	Work with a variety of long-term conditions such as neuro-muscular weakness to reduce hospital admissions associated with winter illness	Reduce LOS for 2 patients a week by 1 day	Helen Perfect	December 2014 to March 2015	Children's Clinical Sub Group	UHL, Primary Care		
	Community Health Services: CAHMS Urgent Admissions	FYPC CAMHS operate a 24 hour on-call service to support the assessment of patients at UHL. After 10pm child/young person is admitted to a UHL paediatric bed with assessment by CAMHS the following morning to discharge, admit to CAMHS bed or remain insitu	Reduce LOS for 2 patients a week by 1 day	Helen Perfect	December 2014 to March 2016	Children's Clinical Sub Group	UHL, Primary Care		
		CAMHS inpatient beds (LPT Tier 4 inpatient unit or an out of area bed) co-ordinated by LPT.	Reduce LOS for 2 patients a week by 1 day	Helen Perfect	December 2014 to March 2016	Children's Clinical Sub Group	UHL, Primary Care		
		Where the CAMHS on-call service cannot identify a CAMHS bed then the child/young person will need to be admitted/remain in UHL bed.	Reduce LOS for 2 patients a week by 1 day	Helen Perfect	December 2014 to March 2016	Children's Clinical Sub Group	UHL, Primary Care		
	Mental Health: Reduce attendence at UCC/ED for mental health related crisis intervention	Continue with mental health Triage service in UCC/ED to redirect and improve patient flow through UCC/ED.	Reduction of referrals to MH Triage nurse in UCC/ED - 5 per week from 9 Feb 2015 10 per week from 1 March 2015	David Gilbert	09/02/2015	Acute/Low Secure Ops Group (LPT) and AMH/LD Divisional Assurance Group (LPT)	UHL, Primary Care, CCGs		55-58
		Crisis House beds, Crisis Support Telephone line and drop in centre to be fully operational 9 Feb 2015	Reduction of referrals to MH Triage nurse in UCC/ED - 5 per week from 9 Feb 2015 10 per week from 1 March 2015	David Gilbert	09/02/2015	Acute/Low Secure Ops Group (LPT) and AMH/LD Divisional Assurance Group (LPT)	UHL, Primary Care, CCGs		55-58

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LPT		Crisis team re- modelling Project Implementation Plan agreed and management of change commenced.	Reduction of referrals to MH Triage nurse in UCC/ED - 5 per week from 9 Feb 2015 10 per week from 1 March 2015	David Gilbert	09/02/2015	Acute/Low Secure Ops Group (LPT) and AMH/LD Divisional Assurance Group (LPT)	UHL, Primary Care, CCGs		55-58
LLR CCGs	**Discharge Pathway work**	Weekly monitoring and evaluate the Brookside Court (city pathway 3) pilot making any necessary changes.	Brookside Court 6 pilot beds to remain full.	Jane Taylor	6 month pilot with weekly review 1-2 wks	Discharge Steering Group	CityLA City CCG Strategy, planning and finance leads. CHC lead. LPT communitylead, UHL discharge leads	DTOC rates	No 60,62,63,65,66,
		Set up task and finish group for the implementation of the Catherine Daley (county pathway 3) pilot.		Jane Taylor	1-2 weekly meetings for pilot to start early January	Discharge Steering Group	County LA, EL&R CCG and WL CCG Strategy, planning and finance leads. CHC lead. LPT community lead, UHL discharge leads	DTOC rates	
		Commence evaluation of the D2A home first pilot (pathway 2) for the county.		Jane Taylor	20 patient pilot - evaluation and the roll out	Discharge Steering Group	County LA, EL&R CCG and WL CCG Strategy, planning and finance leads. CHC lead. LPT community lead, UHL discharge leads	Patients discharge to admission address	
		Establish task group to prepare the rutland pathway 3 pilot .		Jane Taylor	Pilot for January start	Discharge Steering Group	Rutland LA and EL&R CCG Strategy, planning and finance leads. CHC lead. LPT community lead, UHL discharge leads	DTOC rates	
	Minimum Data Set	Commense MDS implementation		Jane Taylor	1-2wks	Discharge Steering Group	City, County and Rutland LA. All 3 CCG Strategy, planning and finance leads. CHC lead. LPT community hospital lead, UHL discharge leads, IT leads at each organisation		
		Set up the MDS Cross Organisation Work Group	Electronic sharing and transfer of patient needs assessments	Jane Taylor	1-2wks	Discharge Steering Group			
	Fast Track	Monitor and review the weekly CHC data.	(Aim is to bring in line, over the next 2years to our national bench mark level)	Jane Taylor	2 wks	CHC tasks group	City, County and Rutland LA. All 3 CCG Strategy, planning and finance leads. CHC lead. LPT community lead, UHL discharge and management lead	Weekly activity data for CHC mainstream and fast track	
		Review the results of the CHC finance and quality data cleanse.	Reduce the number of packages of care	Jane Taylor	2 wks	CHC tasks group			
		Agree and implement the process for community nurses to notify the CHC team when CHC funded patients have died or have moved off their case load.	Reduction in CHC packages	Jane Taylor	2 wks	CHC tasks group			

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LLR CCGs	**Fast Track**	Develop a joint CHC and fast track action plan, incorporating the requested changes.	Reduce the number FT per week (UHL and LPT) Reduce the number of packages of care Reduce the number of hours of care Reduce the number of placements	Jane Taylor	2 wks	CHC tasks group			
		Develop a clear link to the EOL Working Group.	Reduce the number FT per week (UHL and LPT)	Jane Taylor	2ks	CHC tasks group			
		Agree and circulate a uniformed CHC consent form for all provider organisations to use.		Jane Taylor	2 wks	CHC tasks group			
Leicestershire County Council	**Targeted Early Reviews within 2 weeks of hospital discharge to independent sector provision**	All packages of care placed with independent sector providers to be reviewed within a two week timeframe. Review Officers to alert Brokers on a daily basis to capacity created, including number of hours, provider and geographical zone/area.	Reviews completed Cases maintained at same level Cases increased Cases reduced Cases ended Reduced/ended Details of hours released and the provider details to be shared with Care Brokers on a daily basis Cumulative figures to be produced monthly.	Tracey Burton	01-Dec-14	LCC Operational Delivery Group reporting to DMT	n/a	44, 45, 50	70

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Leicestershire County Council	**STOP specifying timed calls. START specifying time bands.** **Set periods for time critical call and communicate with commissioners.**	Setting time-banded POCs and allowing more felxibility for when the carers go to visit will lead to shorter time spent on the Await Care list, and service users get care quicker. The knock-on effect in HART will be released HART capacity to reable new people. Only time critical calls to be commissioned at specific times, care commissioners and HART to be reminded that calls will be in time brackets am = Morning 7am – 10am, Lunch, 11.30am – 2.00pm Tea, 4.00pm – 6.00pm and Night 7.00pm – 10.00pm. Service users to be advised of these timings and the point of the assessment for the need of care being made. This is an existing process which should be being followed. Embed cultural change and adhere to business process - messaging to service users and managing expectations. Team senior workshops to be held. Commissioning document updated	Number of time-banded vs time-specific commissioned requests. Requests for time critical calls reduced and reduction in await care list through analysis of the HC request forms and the await care list	Tracy Ward	01-Dec-14				
	UHL Outflow: increased ASC staff resources in UHL for s5 responses	Additional staff to respond to any Section 5 notification and immediate requests for discharge of patients (based on escalation levels)	s5 timescale compliance trend Compliance with requirements set by the UHL escalation level	Jackie Wright	01-Nov-14	LCC Operational Delivery Group reporting to DMT	UHL LPT	44, 45, 50	59, 62
Leicester City Council	**UHL Inflow reduction/prevention: stronger capacity in ED**	Doubling of resources to assess and navigate patients in ED (A&E and Assessment wards) to prevent admission	Changes in ED admission rates	Jackie Wright	ongoing				
	Reduced LOS , minimising lost bed days, reduced DTOC levels	Daily Liaison between ASC and UHL base wards to reduce LOS, minimise lost bed days and improve DTOC levels to include the ICRS offer.		Ruth Lake	1 Week			Sitreps	