UHL Emergency Performance

Author: Sam Leak , Director of Emergency Care and ESM **Trust Board paper G**

Executive Summary

Context

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

A refocus on high impact actions via the new AE Delivery Board and AE implementation group aims to decrease attendance, reduce admissions and improve processes, thus improving 4 hour performance. UHL continues to work with ECIP and LLR to deliver these actions and rebalance capacity and demand.

Questions

1. Does the Board agree with the action plan?
2. Are there any other actions that the Board thinks we (LLR) should be taking?

Conclusion

The RAP has been agreed by LLR, NHSE and NHSI as a credible plan to deliver change and progress is being made on delivering the actions via the AE implementation group externally and EQSG internally. UHL will focus on internal actions but will also play a key part in working with LPT, EMAS and CCGs to ensure we see reductions in attendance and improved discharge processes. If we can open ward 7 at the LRI and ward 23a at the Glenfield, they will play a significant part in the delivery of improved performance and it is essential that these wards are staffed safely to ensure opening as planned. It is acknowledged that there is a great deal of work to be done as we head into a challenging time of year with expected increase in attendances and admissions. As discussed at the recent Trust Board Thinking Day, two of the key risks are:

1. The growing imbalance between demand and capacity

The RAP highlights key actions to address this with timeframes when we should see a change in demand. The opening of ward 7 is critical to reducing the beds gap at the LRI to circa -40 beds this winter. At the moment, due to nurse vacancies, it is unclear whether ward 7 will open this winter and a verbal update will be provided at Trust Board. This risk remains.

2. The challenges in transforming a service when we are also trying to focus on the 'here and now'

Additional resource is required to ensure pace is achieved in some of the key actions. The Chief Executive, Chief Nurse, Medical Director and Chief Operating Officer have met to identify the priorities for the Trust and have begun to identify a small supernumery team to support this work. This risk remains.

Input Sought

The Board is invited to consider the issues and support the approach set out in the report.

For Reference

Edit as appropriate:

1.The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes /No /Not applicable]
Effective, integrated emergency care	[Yes /No /Not applicable]
Consistently meeting national access standards	[Yes /No /Not applicable]
Integrated care in partnership with others	[Yes /No /Not applicable]
Enhanced delivery in research, innovation & ed'	[Yes /No /Not applicable]
A caring, professional, engaged workforce	[Yes /No /Not applicable]
Clinically sustainable services with excellent facilities	[Yes /No /Not applicable]
Financially sustainable NHS organisation	[Yes /No /Not applicable]
Enabled by excellent IM&T	[Yes /No /Not applicable]

2.This matter relates to the following governance initiatives:

Organisational Risk Register	[Yes /No /Not applicable]
Board Assurance Framework	[Yes /No /Not applicable]

3.Related Patient and Public Involvement actions taken, or to be taken: [Insert here]

4.Results of any Equality Impact Assessment, relating to this matter: [Insert here]

5.Scheduled date for the next paper on this topic: 1 December 2016

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

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

REPORT TO:	**Trust Board**
REPORT FROM:	**Samantha Leak Director of Emergency Care and ESM**
REPORT SUBJECT:	**Emergency Care Performance Report**
REPORT DATE:	**3 November 2016**

Four hour performance

2016/17 YTD

- We are seeing an average of 652 patients everyday through ED at the Leicester Royal Infirmary
- 16/17 performance YTD is 79.7% and September's performance was 79.8%
- 15/16 performance YTD was 91.7% and September 2015 was 90.3%
- YTD attendance 7% up on the same period last year
- YTD total admissions are similar to last year's levels, noting we have had fewer beds open for the majority of the year to date compared to last year

October 2016

- Month to date - October 1 to 16 is 78.8%

Attendance and admissions

Month to date in October, attendance has been 7% higher than the same month last year equating to 50 more patients attending per day and is at a similar level of attendance as seen during the peak of winter 2015-16.

ED Occupancy

High attendance and variable outflow from the department has resulted in high ED occupancy. There have been seven days when ED occupancy has exceeded 100 patients in the department at the same time during the first 16 days of October and as in September there have been a number of days when we have been on critical incident in relation to poor ward capacity and high ED occupancy and inflow.

Discharges

Adult emergency admissions and discharges are slightly lower, month to date than October 2015. As forecast in our demand and capacity plan, outlying increased from an average of eight beds per day in August to 21 beds per day in September and peaked at 31 during the month. We have continued outlying throughout October. It is apparent that timely discharge remains a problem.

STF

September's STF target was not achieved and based on current performance October's will not be delivered either. In quarters three and four we are forecasting an increase in demand and further deterioration in the mismatch between demand and capacity, which will make the STF achievement more difficult. (1 – 16 October 2016 below)

	STF trajectory	Actual
Apr-16	78%	81.2%
May-16	78%	79.9%
Jun-16	79%	80.6%
Jul-16	79%	76.9%
Aug-16	80%	80.2%
Sep-16	85%	79.5%
Oct-16	85%	79.0%
Nov-16	85%	
Dec-16	85%	
Jan-17	89%	
Feb-17	89%	
Mar-17	91.2%	

AE Delivery Board (LLR)

The AE Delivery Board has now met on three occasions chaired by the UHL CEO with the most recent meeting being 19 October 2016. The RAP is attached and has been signed off by NHSI and NHSE as having the right actions focusing on:

1. Streaming at the front door – to ambulatory and primary care
2. NHS 111 – increasing the number of calls transferred for clinical advice.
3. Ambulances – decrease in conveyance and increase in 'hear and treat' and 'see and treat' to divert patients away from ED
4. Improved flow – reduce inpatient bed occupancy, deduce LOS, implement and SAFER
5. Discharge – mandating discharge to assess and 'trusted assessor' type models

The AE implementation group who are responsible for delivering the RAP first met on the 12 October 2016 to review progress on actions and ensure a confirm and challenge process against actions and deliverables is in place across the health economy. Five members of the UHL team attended that meeting.

Progress on seven key UHL actions in the RAP for October

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

1. Improved utilisation of ambulatory pathways and use of the yellow zone

Yellow zone activity

- The additional space was opened in July and is used for ambulatory query home patients.
- Consistently staffing the area remains a challenge due to the high nurse vacancies however the use of the yellow zone has increased from 379 patients in July 2016 to 588 patients in September 2016 which has supported the de-bulking of ED and a reduction in admissions.
- Our focus in November is identifying these patients earlier in the pathway to decrease the number of breaches.

GPAU Activity

- Referrals from GPs with a decision to admit are seen as ambulatory assessment (not through ED) to ensure they do not add to ED attendances, but also to deflect as many as possible (where clinically appropriate) to avoid admission.
- The use of this area has increased from 451 patients in April 2016 to 500 patients in September 2016. A consistent number of patients are discharged, demonstrating the effectiveness of the service.

	Apr 2016	May 2016	Jul 2016	Jul 2016	Aug 2016	Sep 2016
Activity	451	457	431	475	486	500
% Discharged	**70%**	**65%**	**64%**	**64%**	**65%**	**66%**

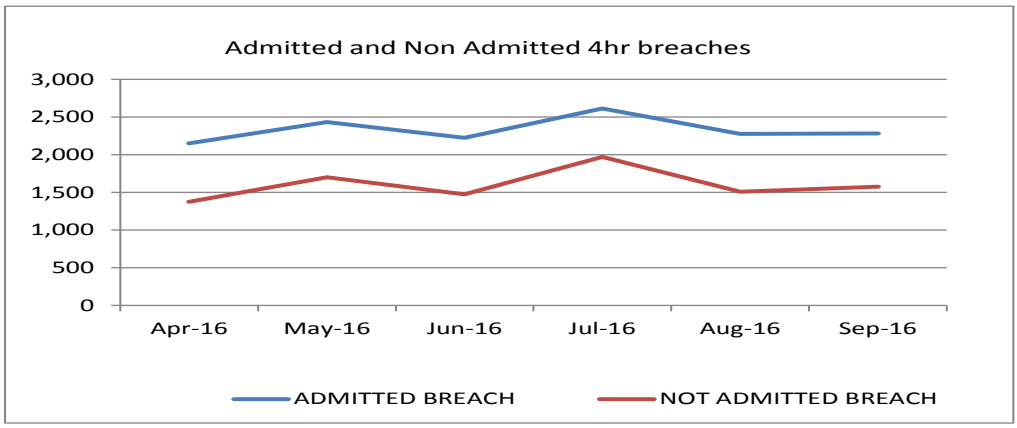
2. Reduction in out of hours breaches

- A late shift rota involving senior managers in the department until 2200 and sometimes as late as midnight was instigated in October
- Clinical matron presence has been increased to seven days per week including evenings
- Huddles have been implemented overnight which focus on department safety, function and flow
- A diagnostic to establish reasons for increased breaches overnight will be completed by the end of October
- Despite these actions, it is apparent there has been no change in breaches after midnight:

Month	ED Type 1 Attendance	All ED Type 1 Breaches	Breaches after Arriving 7pm to Midnight	% After 7pm
Apr 2016	11757	3406	1050	31%
May 2016	13247	4080	1258	31%
Jun 2016	12455	3614	1125	31%
Jul 2016	12624	4450	1477	33%
Aug 2016	12367	3716	1095	29%
Sep 2016	12963	3827	1221	32%

3. Reduction in non-admitted breaches

These have increased in September during the day as a result of limited space in ED to assess patients. The diagnostic and actions related to overnight breaches will enable this to be tackled further in November.



4. Improvements to streaming/ treating and redirection of patients from ED front door

- The number of patients treated and redirected has slightly decreased in September but we aim for it to improve in November with an increase in streaming GPs, as agreed through the extension to the contract
- The staffing model has been revised to allow timely access to streaming at peak times
- The inclusion of a nurse led triage prior to streaming will ensure medical streaming is more available to patients that require it.

Total	Apr	May	June	July	Aug	Sep	TOTAL
Treated / Redirected	48%	47%	47%	46%	44%	41%	**48%**
Admitted	7%	6%	6%	5%	6%	6%	**6%**
Majors	12%	12%	13%	12%	12%	15%	**12%**
Minors	26%	28%	26%	29%	31%	29%	**26%**
Resus	1%	1%	1%	1%	1%	1%	**1%**
Paeds	0%	0%	1%	0%	0%	1%	**0%**
Other	0%	0%	0%	0%	0%	0%	**0%**
Left before treatment	2%	3%	3%	3%	2%	3%	**2%**
Other pathway	4%	4%	4%	4%	4%	4%	**4%**
Total	100%	100%	100%	100%	100%	100%	**100%**

5. Reopening of the discharge lounge

The discharge lounge shut on Friday 14 October with estates work planned that will enable it to house more trollies and chairs:

Date	Plan
Friday 14 October	LRI Discharge Lounge Closes • Staff and kit relocate to ward 34 • DRT relocate ops room/ bed co's
Saturday 15 October	Discharge lounge reopens in ward 34's day room
Build duration	It is anticipated that the building/ works programme will take 3-4 weeks • Update Discharge operational lounge policy and take to NET • Re-launch of new lounge
Week 14 November	Re-open New Redesigned Discharge lounge

6. Roll out of rapid flow (SAFER placement)

This scheme will:

- Decrease congestion in ED
- Improve ambulance handover times
- Improve patient experience
- If we can generate earlier patient flow each day throughout the hospital, we can improve the safety of patients in ED
- Tackles the biggest challenge which is timeliness of the discharge not the number of discharges

How it works:

- Places an additional patient on every base ward at key points throughout the day
- The patient is placed on the ward against a definite or query discharge. The extra patient is not the extra patient who is the sickest, but the patient that needs to be discharged.
- The discharge is expedited quickly with focus from nursing & medical teams
- The ward team identify a suitable patient & the process of placing that patient is owned by the nurse in charge and doctor in charge of the ward

Rapid flow has been delayed on the base wards due to the limitation of space to place an extra patient on the ward safely. The team are focusing on AMU as the first area to implement the change.

7. Reduce the number of patients breaching by ten minutes or less

Month	ED Type 1 Attendance	All ED Type 1 Breaches	Breaches between 241 and 250 Minutes	% of Total
Jun-16	12455	3613	145	4%
Jul-16	12624	4450	160	4%
Aug-16	12367	3716	153	4%
Sep-16	12963	3827	143	4%

Despite lots of actions within the RAP focused on this, this metric remains static. It is important to note that activity is much higher than this time last year but this needs to be focus for the ED team, in particular the consultant in charge and is picked up in the front door and majors work stream plans in October and November.

Work streams

At EQSG on 12 October progress on the front door and base ward work streams were discussed. Key updates are in the attached.

CDU

The CDU team continue to progress their RAP actions as detailed in the attached and key actions for November include:

- Implementing the low risk ambulatory service in CDU
- An audit of EMAS conveyances to LRI which could have gone direct to the Glenfield
- The progression of the plan to open additional beds on Ward 23 in December

Ambulance handovers

Handover data (CAD+) is detailed below:

	Under 15 Mins Delays %	% Delay Over 15 mins (CAD+)	% Delay Over 20 mins (CAD+)	% Delay Over 30 mins (CAD+)	% Delay Over 45 mins (CAD+)	% Delay Over 60 mins (CAD+)	% Delay Over 120 mins (CAD+)
Dec-15	35.1%	64.9%	53.5%	37.2%	23.7%	15.6%	3.3%
Jan-16	57.4%	42.6%	35.4%	24.9%	16.3%	12.0%	3.3%
Feb-16	60.3%	39.7%	31.5%	22.4%	14.8%	9.8%	2.2%
Mar-16	56.0%	44.0%	35.3%	23.7%	15.6%	10.7%	2.7%
Apr-16	58.9%	41.1%	29.5%	17.1%	9.6%	6.0%	0.9%
May-16	57.3%	42.7%	30.4%	17.6%	9.1%	5.6%	0.8%
Jun-16	59.9%	40.1%	28.7%	16.1%	9.2%	5.7%	0.5%
Jul-16	50.7%	49.3%	38.0%	23.7%	14.1%	8.9%	1.5%
Aug-16	53.8%	46.2%	34.5%	20.6%	11.1%	6.6%	0.8%
Sep-16	51.2%	48.8%	37.8%	24.3%	15.0%	9.5%	1.4%
Oct-16	50.0%	50.0%	39.8%	25.0%	11.9%	6.9%	0.5%

The position in September deteriorated for the reasons identified earlier in the report; high inflow, limited capacity in ED, high ED occupancy and poor outflow from ED. It has been recognised in the A&E Delivery Board and EQSG that actions to speed up the handover have now been implemented and the focus needs to be on reducing the demand and improving flow out of ED.

ED Front Door / UCC

We are working with the CCG to agree the front door model to be procured from 1 April 2017 to ensure a primary care and UHL integrated service. Due to timescales for procurement there is a risk that this will not be completed prior to the start of the NFY. This concern has been shared with CCGs and we are jointly working on mitigations. The current work with Lakeside will continue from 1 November 2017 to 31 March 2017 and the plans to fund this will be part of the year end settlement.

Demand and capacity update

The planned opening of ward 7 on 1 November 2016 is dependent on safe staffing. A small cohort of staff have expressed an interest in working on the ward and the HCA recruitment drive on 17 October 2016 will enable us to identify HCAs for the ward. We are reviewing the numbers weekly to establish if we are able to open all or part of the ward. The opening of ward 23A at the GGH remains on track for 1 December 2016. With both wards open, the imbalance of capacity going into winter is circa 40 beds at the LRI.

Delayed discharges

The RAP focuses on the below key actions to ensure the number of delays are minimised:

1. **Home First approach & Discharge to Assess -** 'Home first' principle with assessment for longer-term needs and on-going assessments around decisions for further care taking place within the home environment and not a hospital bed. This includes CHC assessments and longer term Social Care support in care homes
2. **Trusted Assessment** One assessment leading to safe, effective and timely transfer of care to another provider, using an electronic document that can be shared
3. **Patient Choice** Robust patient and family choice policy and procedure that is used at the start of an in-patient stay to explain expectations, and to support timely transfer of care
4. **Redesign of discharge pathway** Amalgamating over 50 pathways into 5 main pathways

Overall in October

Attendance in October is 2% higher than the previous month and 7% higher than the year before. Previously we have had challenges just with the volumes of admissions but we now regularly see challenges with the volumes of attendance and admissions. As a way of trying to manage the competing elective, emergency and cancer demands, we have implemented a weekly winter planning meeting with all CMGs with the aim of proactively managing the hospital take and flow.

Seven key UHL actions in the RAP for November

The key improvements and actions we need to see delivered in November are:

1. Reduction in patients breaching by ten minutes

By focusing on roles and responsibilities in the team and ensuring everyone knows what they are responsible for delivering.

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

By focusing on time to be seen by a Dr and time for a plan (admit or home) in three hours which will then enable an improved non – admitted position

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

To trial using space differently in ED to ensure that every cubicle is used at all times. This requires a different approach to assessment, but does require a decrease in the number of patients waiting for beds in ED.

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

This has been agreed by the team and will be implemented on the 7 November 2016. This will allow the pull of ambulatory patients from ED and UCC. The GPAU vacated space is being assessed to determine if it can be used for four additional acute medical assessment beds.

5. Ambulance handovers

The Service managers have been moved back to supporting this function and ensuring it is as efficient as possible.

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

Opening additional medical capacity at the LRI is a key part of our winter plan. The plan was to open the ward on 1 November 2016 but despite lots of effort, this will not happen because of the underlying nurse vacancies. The ward has now opened as a discharge ward because the discharge ward has shut for refurbishment and the Chief Operating Officer, Chief Nurse and Medical Director are working with the CMG on a plan to confirm when the ward can open and what its function will be.

7. SAFER bundle and Red to Green

Learning from South Warwickshire FT, Ipswich Hospital NHS Trust and The Dudley Group FT, we are focusing on improving flow on the wards by reducing delays. We are putting a small team together within the CMG to transform two wards to become red to green exemplars and will then role this out across the rest of the CMG and Trust.

The SAFER bundle stands for:

Senior review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.

All patients will have an expected discharge date and clinical criteria for discharge. This is set assuming ideal recovery and assuming no unnecessary waiting.

Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am.

Early discharge. 33% of patients will be discharged from base inpatient wards before midday.

Review. A systematic MDT review of patients with extended length of stay > 7 days (stranded patients) with a clear home first mind set.

It is noted that a number of these key actions are extended actions from October.

Risks

As discussed previously, most recently at the Trust Board Thinking Day, the key risks remain:

1. **The growing imbalance between demand and capacity**
   The RAP highlights key actions to address this with timeframes when we should see a change in demand. The opening of ward 7 is critical to reducing the beds gap at the LRI to circa -40 beds this winter. At the

moment, due to nurse vacancies, it is unclear whether ward 7 will open this winter and a verbal update will be provided at Trust Board. This risk remains.

2. **Variable clinical engagement**
   ECIP returned on 26 October 2017 and will provide 1-2 days a week of support to the Emergency Care Pathway. Matt Metcalfe, Deputy Medical Director, will also work closely with Ian Lawrence to support the clinical engagement programme in ED and we continue to request further external support with medical leadership. This risk remains.

3. **The challenges in transforming a service when we are also trying to focus on the 'here and now'**
   Additional resource is required to ensure pace is achieved in some of the key actions. The Chief Executive, Chief Nurse, Medical Director and Chief Operating Officer have met to identify the priorities for the Trust and have begun to identify a small supernumerary team to support this work. This risk remains.

The relevant Board Assurance Framework sections are attached for reference.

Conclusion

The RAP has been agreed by LLR, NHSE and NHSI as a credible plan to deliver change and progress is being made on delivering the actions via the AE implementation group externally and EQSG internally. UHL will focus on internal actions but will also play a key part in working with LPT, EMAS and CCGs to ensure we see reductions in attendance and improved discharge processes. If we can open ward 7 at the LRI and ward 23a at the Glenfield, they will play a significant part in the delivery of improved performance and it is essential that these wards are staffed safely to ensure opening as planned. It is acknowledged that there is a great deal of work to be done as we head into a challenging time of year with expected increase in attendances and admissions.

Recommendations

- Note the contents of the report
- Note the latest high impact RAP (attached)
- Note the continuing concerns about 4 hour delays and ambulance handovers in particular and the actions in the RAP to reflect the improvements that can be made within UHL to improve performance.
- Note the continued pressure on clinical staff with increasing demand and overcrowding

Leicester, Leicestershire and Rutland Urgent Care Network
System Overview & Recovery Action Plan
Version: 11
Last updated: 18th October 2016 **By who:** Tim Slater
Approval date: **By who:**

Programme Structure

Workstream	Sub-workstream	SRO	Medical Lead	Link to National Actions	Link to SAFER bundle	SRO Update	Link to LLR Risk Register
Minimise presentations at LRI campus		Rachana Vyas	Dick Hurwood	2 (111)		14/10/16 R Vyas - Highlight	
Improve ambulance response and interface		Mark Gregory		3 (Ambulance)		Nothing received	
Improve the LRI front door	Streaming and Assessment	Lisa Gowan	Ursula Montgomery, Ffion Davies	1 (Streaming)		13/10/16 S Leak - RAP and Highlight	
	Ambulatory care	Lisa Gowan	Vivek Pillai, Lee Walker	1 (Ambulatory care)		13/10/16 S Leak - RAP and Highlight	
Improve ED flow	Adults	Julie Taylor	Vivek Pillai	4 (Flow)		13/10/16 S Leak - RAP and Highlight	
	Children	Julie Taylor	Sam Jones	4 (Flow)		13/10/16 S Leak - RAP and Highlight	
Improve Ward Flow	Assessment units	Julie Taylor	Lee Walker	4 (Flow)	**S F E**	13/10/16 S Leak - RAP and Highlight	
	Base wards	Gill Staton	Rachel Marsh	4 (Flow)	**S A F E**	13/10/16 S Leak - RAP and Highlight	
Improve CDU Flow		Sue Mason	Caroline Baxter	4 (Flow)		13/10/16 S Leak - RAP and Highlight	
Improve discharge processes		Tamsin Hooton		5 (Discharge)	**R**	15/10/16 T Hooton - RAP and Highlight	
Overall lead for UHL-led workstreams		Sam Leak	Ian Lawrence				

S Senior Review
A Expected date of discharge
F Early flow
E Early discharge
R Review >14d stays

Urgent Care - High Level Dashboard *GEM logo*

Updated: *Date*

Key Intervention Area				
1. Streaming in A&E	2. NHS 111 Calls	3. Ambulance Response Programme	4. Improving Patient Flow	5. Discharge
1	1	1	1	1
2	2	2	2	2
3	3	3	3	3
Only use if a requirement for 4th metric				
Only use if a requirement for 5th metric				
Patient Safety Incidents: *Number of PSIs in the reporting period*	**Commentary:** *GEM and Urgent Care Team to provide high level narrative*			**Significant Change:** *To highlight any metric that has changed significantly (SPC)*

Insert new format here - split by 5 key intervention areas

EMERGENCY DEPARTMENT METRICS DASHBOARD

Monthly updates

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

Key Intervention Number	National Guidance reference / detail	Action Detail	Lead Organisation	Accountable Officer	Action number	Planned activity	Expected outcome/Impact	Key milestones	Delivery date	Contribution to ED recovery	Links to Dashboard	Update (All perf. Figures are dated)	Metric			RAG rating
Key Intervention Area 1: Streaming in A&E ***(Remodel the front door to better manage patient flow - to ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service).***																
1	1.2	Increase the streaming/ treating and redirection of patients from ED front door.	UHL	Lisa Gowan	**8**	1. Model streaming service integrating Lakeside with primary care team & UHL. 2. Develop staffing model to allow increased streaming. 3. Develop clinical model to enable increased treat and redirect.	1. Reduction in late referrals to ED 2. Increase in the number of patients streamed. 3. Increase in the volume of patients treated/redirected.	1. Paper to JA confirming the service integration plans 23/9/16. 2. Continuation of the streaming service 1/11/16 3. Remodelling of the streaming service 1/12/16 4. Monthly review of the service - on-going 5. Opening of new service 1/4/17	Continuation of service 1/11/16	1. Decrease attendance in ED 2. Ensuring referrals from UCC to ED occur in a timely fashion 3. Reduction in non-admitted breaches in UCC & ED	Treat and redirect	1. Contract with Lakeside extended from November 2016 to 1st April 2017 2. Integrated model of care agreed 3. Mtg took place on 3.10.16 to operationalise the new workforce model; new model implemented from 10/10; 6 GP slots currently not filled for October - team working to fill all gaps.	44% (% pts treated and redirected)	55%	44%	**4**
1	1.4	Maximise use of ambulatory pathways to avoid ED attendance	UHL	Lisa Gowan	**11**	1. ED on the day review of utilisation of ambulatory pathways planned. 2. Develop action plan to address any gaps 3. Implement change 4. Reaudit 5. Embed a process for continual education and up skilling of all ED staff in available ambulatory pathways and how to access them.	1. Increase number of patients accessing ambulatory pathways	1. ED on the day review of utilisation of ambulatory pathways planned 28/9/16 2. Develop action plan to address any gaps 14/10/16 3. Implement change 4/11/16 4. Reaudit 25/11/16 5. Embed a process for continual education and up skilling of all ED staff in available ambulatory pathways and how to access them 7/12/16	Complete by 07/12/2016	1. Decreased ED attendances 2. Decreased non-admitted breaches	ED attendance	1. Audit of yellow zone scheduled for 28/9/16 not completed as plan due to staffing issues (further date to be arranged). 2. ECIP ambulatory audit to take place on 25.10 2. Action plan to be developed based on learning from audit.	Baseline to be established in the 'on the day' review	20%	TBC	**4**
1	NA	Review short stay capacity & demand and determine if we are going to increase the short stay capacity and reduce base ward capacity	UHL	Lisa Gowan	**13**	1. Review literature on how many AMU beds are required to match demand and capacity 2. Visit other Trusts to compare the size of their AMU capacity to ours 3. Determine if we are going to increase our short stay capacity or not	1. Improvement in flow from ED 2. Improvement in patient experience 3. More efficient way of working, leading we hope to a reduction in LOS	1. Review literature on how many AMU beds are required to match demand and capacity 9/9/16 2. Visit HEFT to compare the size of their AMU capacity to ours - 2/9/16 3. Determine if we are going to increase our short stay capacity or not - 28/9/16	Agree on whether we will increase AMU capacity or not ~~28/9/16~~ 30.11.16	1. Improvement in flow from ED resulting in a reduction in non admitted breaches	Admitted breaches	1. ECIP suggested we are 28 to 50 beds short. 2. RCT expansion of short stay being planned but requires GPAU relocation to be successful in order to free space for additional short stay bed / chairs . 3. Contact being made with HEFT to discuss their capacity and clarify numbers. 4. Task and finish meeting taking place w/c17/10 to plan rapid cycle test. 5. RCT results will then be reviewed alongside any additional resource requirements	106 short stay beds	134	106	**2**
1	NA	Develop ED internal professional standards	UHL	Lisa Gowan	**18**	Implement Rapid assessment: 1. On the day observation to identify areas of improvement 2. Develop improvement plan 3. Implement improvement plan Patients to be seen by senior decision maker in 90mins & have decision made within 180 mins: 1. Two hourly huddles implemented with senior nurse, doctor and manager; from 1 September there will be a focus on time to be seen by doctor. 2. Implement process to ensure appropriate use of escalation areas 3. Revise SOP for Majors 4. Rapid cycle test new medical model	1. Reduction in non-admitted breaches. 2. Reduced number of patients on ambulances	Implement rapid assessment: 1.Observation and plan - complete 31 Oct 2016 2. Implementation - complete 30 Nov 2016 Patients seen within 90mins/decision within 180mins: 1. Huddles began 1/9/16. 2. Implement process to ensure appropriate use of escalation areas - in place 3. Revise SOP for Majors - 30 October 4. Rapid cycle test new medical model - 30 October	All actions to be complete by ~~30 October 2016~~ 28.11.16	1. Reduction in non-admitted breaches. 2. Reduced number of patients on ambulances	non admitted breaches	1. Focus of ECIP intervention 2. Huddles now in place (not consistently) 3. Ensuring appropriate use of escalation in place (not consistently) 4. SOP revised and being reviewed by senior team prior to circulation 5. Single queue working to begin w/c 28.11.16 (as part of roles and responsibilities area of work).	48% (% patients with decision made within 180mins)	95%	54%	**2**
Key Intervention Area 2: No. of 111 calls transferred to Clinicians ***(Minimise presentations from primary and community care to LRI ED assessment services)***																

2	2.2 2.5 2.6 2.7 3.3	All phone based access points only direct patients to ED when clinically necessary	West CCG	Rachna Vyas	**1**	1. Implement Navigation hub 2.Implement new pathways for a specific clinical cohort of low risk 111 patients deemed appropriate for ED 3. Implement new pathways for a specific clinical cohort of low risk G1-4 patients deemed appropriate for ED	Decrease in ED dispositions of 5% Increased deflection to CRT/AVS or community based hubs from both EMAS CAT desk & 111 by > 5 per day Increase in pathway 0 patients being diverted to base visit rather than ED by 5 per day	1. Navigation hub go-live 2. Test 2: revised pathways for 'ED dispositions' 3. Test 1: Revised HAT pathways for G1-4 calls	1. Oct 31st 2. Pathway live (PDSA) 3. 28th September 2016	Reduction in Non-admitted breaches in minors/UCC Reduction in admitted breaches		Implementation of Navigation hub on track 111 > hub pathway live Sept 2016. Numbers monitored weekly. Test 2 will include revised booking process for ANP calls 111/G3-4 > Digital GP due to go live in Oct	Decrease in ED dispositions of 5% Baseline requested	Increased deflection to CRT/AVS or community based hubs from both EMAS CAT desk & 111 by > 5 per day Baseline: 13 calls/month from EMAS 0 calls/month from 111 (August 2016) Decrease ED attends by 11%	Increase in pathway 0 patients being diverted to base visit rather than ED by 5 per day Baseline requested	**4**
2	1.1	Ensure GP's have direct access to a Consultant for clinical discussions prior to acute referral	UHL	Rachna Vyas	**2**	1. Secure funding for pilot extension 2. Implement roll out plan to Paeds and geriatrics 3. Re-launch service to all GP's	Increase in avoided EAs in specific specialities (from 66% to c.70%) Increase in utilisation rates in Primary care from 74% to 95%	1. Agree to continue CC 2. Roll out to Paeds & Geriatrics 3. Re-launch at PLT using clinical case studies (City)	1. Complete 2. Complete 3. 21st Sept 2016	Reduction in admitted breaches		Funding secured for pilot until March 31st 2016 Comms for CC outstanding Case studies for PLT outstanding	Increase in avoided Emergency Admissions in specific specialities (from 66% to c.70%)	Increase in utilisation rates in Primary care from 74% to 95% Decrease ED attends by 11%	**TBC**	**3**
2	2.1	Instigate direct feedback loop re patients who were referred to acute care via BB but could have accessed other services	ELR CCG	Rachna Vyas	**3**	1. Audit sample of case notes 2. Implement direct and indirect feedback 3. Audit other patient pathways listed in national guidance, starting with EMAS & then 111	As per results of audit	1. Audit GP urgent calls to assess appropriateness 2. Feedback to Primary care at PLT's in Oct/Nov 3. Plan EMAS GP urgents line audit for LLR	1. September 15th 2. November 2016 3. October 2016	Reduction in non-admitted breaches		1. Audit underway 2. Slots booked at both Sept and Nov PLT 3. Audit planning started	**NA**	**NA**	**NA**	**3**
2	4.6 1.8	CCG led schemes to manage acute demand	City CCG	Rachna Vyas	**4**	1. Maximise utilisation of Hubs 2. Ensure all acute access services have embedded pathways to use most appropriate/lowest acuity care setting available including GP urgent referrals	Reduction in the number of City patients referred to UCC/ED by 111 by 5% Increase in utilisation rate at each City hub from c75% to 85% by September Reduction in avoidable admissions from LLR care homes by 10% of 15/16 outturn Reduction in conveyed module 0 patients to ED by EMAS by 5% Reduction in deep emergency admissions to commissioned plan	1. Increase use of City Primary care Hubs - Re-launch hubs with focus on reception staff in practices 2. Implement new 111 ED disposition trial to safely treat pts in the hub rather than at ED minors or UCC 3. Open up ANP slots for 111 booked pts, diverting from UCC Re-launch service with practices to ensure appropriate flow from GP to hubs, rather than GP to UCC. Will include increased presence on social media and revised answerphone messages 4. Commission additional resource to Clinical Response Team, specifically for care homes.	1. Complete by Sept 1st but part of rolling engagement plan with all practice staff 2. Pathway in place as of Sept 15th for GP and ANP 3. Complete 4. Complete	Reduction in Non-admitted breaches in minors/UCC Reduction in admitted breaches		1. Outstanding - awaiting NHSE sign off for hub services Q3-4 2. 1st test cycle being finalised - aim for end of Sept start 3. Complete - live from mid-Aug 4. Complete - car live on Aug 16th	ED attendances to commissioned plan M4 Baseline: +10% vs plan Emergency admissions to commissioned plan M4 Baseline: +2% vs plan	**Decrease ED attends by 11%**	**TBC**	**3**
2		CCG led schemes to manage acute demand	ELR CCG	Rachna Vyas	**5**	1. Maximise utilisation of UCC's 2. Ensure patients are aware of service provision via NHS NOW app	Reduction in the number of ELR patients referred to UCC/ED by 111 by 5%	. 1. Maximise the use of the ELR Urgent Care Centres in the four sites providing a seven day evening and weekend service. Oadby profile re-checked on DOS to ensure maximum diversion from 111 2. Focus use of NHS NOW App and continued promotion of service	1. Complete 2. Ongoing rollout programme	Reduction in attendances at ED and Non-admitted breaches in minors/UCC		1. Complete 2. App launched	Reduction in the number of ELR patients referred to UCC/ED by 111 by 5% Baseline requested	ED attendances to commissioned plan M4 Baseline: +10% vs plan Emergency admissions to commissioned plan M4 Baseline: +11% vs plan	**TBC**	**4**
2	4.6	CCG led schemes to manage acute demand	ELR CCG	Rachna Vyas	**6**	1. Launch Weekend AVS scheme	Reduction in avoidable admissions from LLR care homes by 10% of 15/16 outturn	1. New Weekend AVS scheme to commence in August/ September specifically for complex, elderly, EOL and Care home patients covering 3-4% of the ELR population at greatest risk of admission	Complete - service live	Reduction in attendances at ED and admitted breaches		1. Service launched. Activity and impact will be monitored	Reduction in avoidable admissions from LLR care homes by 10% of 15/16 outturn Baseline requested	**Decrease ED attends by 11%**	**TBC**	**4**
2	4.6	CCG led schemes to manage acute demand	West CCG	Rachna Vyas	**7**	1. Ensure adequate capacity in practices for non-urgent clinical presentations 2. Launch extended AVS service	Pharmacists in place as per trajectory Reduction in avoidable admissions from LLR care homes by 10% of 15/16 outturn	1. Commissioning of Pharmacists in every practice / group of practices to provide workforce capacity to focus on cost effectiveness and medicines related admissions 2. Increase AVS timings from 9-5 to 8pm	1. Rolling programme 2. Planned go-live Oct 16	Reduction in attendances at ED and admitted breaches			Reduction in avoidable admissions from LLR care homes by 10% of 15/16 outturn Baseline requested	ED attendances to commissioned plan M4 Baseline: +7% vs plan Emergency admissions to commissioned plan M4 Baseline: +5% vs plan	**TBC**	**4**

2		Identify multi-agency solution in high user postcodes across LLR - these are predominantly in East and City	EMAS	Rachana Vyas	**29**	1. Review and Share activity by post code to support a reduction in activity reaching 999 services 2. Review and share HAT/SAT activity by postcode	Reduction of 999 activations by 5% per day.	- Baseline activity captured - 14/09/2016 - CCG produced postcode analysis report shared - 30/09/2016 - Alternative care pathway planning &implementation including comms package for patients and practices - Through November/December 2016	As previous column	Reduction in attendances at ED and Non-admitted breaches in minors/UCC		Postcode data received - difficult to attribute to practice level so a generic Comms and engagement programme is being planned at community level between CCG and EMAS	Reduction of 999 activations by 5% per day. Baseline requested	**Decrease ED attends by 11%**	**TBC**	**3**
2		To ensure that patients discharged from the Acute Trust with a PARR+ score of +5 are provided with adequate community support to prevent readmission within 30 days	UHL	Rachana Vyas	**66 (new)**	1. Roll out use of PARR+ tool 2. Update nerve centre with PARR score for at risk patients 3. Identify and implement community/primary care support within 48 hours of discharge	Reduction in readmissions for patients leaving the Trust with a PARR score of +5 by 10%	1. Nerve centre updated 2. Primary/community care support secured and implemented	1. November 2016 2. November 2016	Reduction in attendances at ED and admitted breaches		Initial pilot complete. Readmissions reduced in target cohort by X%	Reduction in readmissions for patients leaving the Trust with a PARR score of +5 by 10%	**Decrease ED attends by 11%**	**TBC**	**2**
2	1.8	Increase utilisation of step up ICS capacity to prevent acute activity	LPT	Rachana Vyas	**67 (new)**	1. Develop additional guidance with GP's and circulate. This should include medical management template with pre-populated prescribing guidance and parameters 2. Improve engagement and understanding of service across General Practice through use of case studies	Increase utilisation of step up capacity by > 2 patients per day by CCG	1. Guidance, template and Comms complete 2. Rolling programme of case studies and direct feedback to GP's to be implemented using Board GP's	To be completed by October 31st 2016	Reduction in attendances at ED and admitted breaches		Team identified at City CCG to lead development of template and guidance in partnership with LPT. Includes LPT team, nursing & quality, Medicines optimisation, IT leads and lead clinician.	Increase utilisation of step up capacity by > 2 patients per day by CCG City CCG currently averages 1 patient per day Baseline requested	**Decrease ED attends by 11%**	**TBC**	**4**
2		All patients referred to UHL by GP should arrive < 4 hours from time of referral	EMAS	Rachana Vyas	**69 (new)**	1. Assess viability of limiting the number of LLR practices using the direct EOC booking function 2. Reiterate to General Practice that all appropriate referrals to UHL must go via Bed Bureau for capacity planning purposes 3. Re-launch criteria for ambulance conveyance to General Practice *Linked to actions 4-6 above - if EMAS refer more CAT-triaged patients to CRT/AVS this should release EMAS capacity to convey patients into UHL earlier*	Reduction in number of GP urgents conveyed to hospital in total All patients conveyed within 4 hours of referral	1. Ability to divert all LLR requests to EOC to BB 2. Re-launch booking criteria and pathway to practices	1. 30th September 2016 2. PLT, Locality/HNN meetings in September	Reduction in attendances at ED and admitted breaches		1. In progress - turning EOC line off completely is not viable as the line services the whole region 2. Practice-specific Comms package being put together	All patients conveyed within 4 hours of referral	Reduction in number of GP urgents conveyed to hospital in total		**3**
Key Intervention Area 3: Ambulance Response Programme ***(Improve ambulance response and interface)***																
3		Monitor and increase the use of CAD+ at the Leicester Royal Infirmary	EMAS	Mark Gregory	**30**	1.Set Current baseline 2. Working with UHL arrange for notify screen move 3. Working with EMAS PMIT, generate individual compliance report 4. Ensure consistent use by Amvale resources	90% of crews using CAD+	1. Baseline generated from UHL handover report 2. link UHL & EMAS IM&T teams re the move of the notify screen 3. PIN number report to be generated and shared with divisional managers 4. Liaise with Amvale and feedback non-compliance	1. 1st October 16 2 31st October 16 3. 31st October 16 4. 30th September 16	Accurately monitor handover times and track trends			Oct 16 - 75% Nov 16 - 77.5% Dec 16 - 82% Jan 16 - 85% Feb 16 - 87.5% Mar 16 - 90%	90% of crews using CAD plus	*TBC*	**4**
3		Implement A&E Front door Clinical Navigator	EMAS	Mark Gregory	**32**	1. Identify individuals to undertake navigator role 2. Provide Supportive development with navigators to ensure appropriate challenge etc. 3. Monitor and report against findings 4. Look towards extension to hours via Vanguard Funding	Linked across all Non conveyance metric (Reduction of 4% by 31st March 2017)	1. Clinical team Mentors identified as navigators 2. Jay Banerjee to deliver training 3. Monthly reports to be fed into the appropriate meeting structure 4. Business Case to be submitted for extension to coverage	1. 1st Sept 2016 2. 1st Nov 2016 (Complete) 3. 10th of Each Month 4. 10th Oct 2016	Reduction in A&E attendances		1. Team identified and Briefed 1. Soft launch of confirm and challenge commenced 2. Dr Jay Banerjee contacted and dates for trailing being developed	Oct 16 Clinical Navigator role on site 3 x per week for >4 hours per day	Percentage of EMAS attendances where an alternative should have been used not to exceed 15% per month (Nov 16 Onwards)	TBC	**3**
3		Implement and enhance the use of Mobile Directory of Service	EMAS	Mark Gregory	**33**	1. Ensure registration of all eligible staff to MDoS (50% by March 16) 2. Train Staff in the use of MDoS (50% by March 16) 3. Increase the number of MDoS referrals 4. gain access to mobile SystmOne enabling care plan viewing	Linked across all Non conveyance metric (Reduction of 4% by 31st March 2017)	1. Project lead to be identified 1.1 Project lead to generate project plan to increase points 1 & 2 2. Train the Trainer sessions to be held ensuring MDoS super users can support training schedule 3. Project lead to monitor use and support non compliant staff 4. Work with Commissioners to secure SystmOne access	1. 30 Sept 16 1.1 15 Oct 16 2. 31 Oct 16 3. March 17 4. Feb 17	Reduction in A&E attendances		1. Project Lead identified and in post	50% of staff registered to use MDoS (March 16)	50% staff trained to access and use MDoS (March 16)	TBC	**3**

3		Implementation of Dispatch on Disposition	EMAS	Mark Gregory	**34**	1. Trust identified as adopter site 2. Timescales for implementation Negotiated with NHSE 3. NHSE assurance review and sign off 4. Mobilisation 5. Secure exec lead for ARP/DoD at the delivery board 6. Map Nature of Call list against current keyword flows	Reduction of Resources to scene by 0.2 from 1.4 baseline Linked to above non conveyance trajectory	1. Work with NHSE to register as implementer site 2. negotiate and agree timescales for mobilisation 3. Assurance review to be arranged and undertaken 4. Mobilise scheme	1. September 16 2. September 16 3. 10th Oct 16 4. 31st October 16	Reduction in A&E attendances		1. Trust approved as implementer site 2. Timescales agreed	1.4	Oct 16 - 1.4 Nov 16 - 1.36 Dec 16 - 1.32 Jan 16 - 1.28 Feb 16 - 1.24 Mar 16 - 1.2	TBC	**4**
3		Left shift transportation of Urgent activity into UHL sites	EMAS	Mark Gregory	**34a**	1. Review current baseline 2. Scope resource availability 3. draft project and resourcing plan 4. Mobilise additional resources	Earlier attendance of HCP urgent calls	1. Working with PMiT gain average call to arrival time 2. Review current resources within LLR EMAS Pool 3. Liaise with Commissioners to plan additional commissioned resources 4. communicate launch and mobilise additional resources	1. 15 Oct 16 2. 20 Oct 16 3. 1 Nov 16 4. 30 Nov 16	Improved Flow			Percentage of patients arriving within their allotted timescale	TBC	TBC	**4**
3		Sustain Current High levels of Hear and Treat rates for LLR 999 calls	EMAS	Mark Gregory	**35**	1. Assess workforce capabilities to ensure robust 24/7 cover 2. Assess access for Clinical Advice Teams to the DoS 3. Communicate new access routes to Clinical Advice Hub once mobilised	Maintenance of the current baseline of 20% hear & Treat Rates for LLR generated calls	1. Workforce review undertaken and WFP generated 2. DoS access reviewed and available to CAT 3. Communication to be shared when CAH PID received	1. September 16 2. September 16 3. Nov 16				20%	20%	TBC	**4**
Key Intervention Area 4: Improved Patient Flow ***(Improve CDU, ED and Ward Flow at UHL)***																
4	NA	UHL to open additional emergency beds at the LRI to decrease bed capacity/demand mismatch	UHL	Gill Staton	**9**	1. Open and staff 28 beds on ward 7	1. Decrease outlying on non-medical wards (dependent on attendances and admissions remaining constant) 2. Decrease congestion in ED by improving flow 3. Contribute to an improved 4 hour performance 4. Improve staff experience by staffing a consistent ward therefore preventing staff moving from ward to ward	1. 10th October 2016 identified staffing to be confirmed 2. Equipment to be ordered and delivered by 22nd October 3. Planned opening 1st November 2016 4. Fortnightly progress update meeting in place with COO	Ward open 1 November 2016	1. Reduction in breaches linked to poor flow and ED occupancy	admitted breaches	1. Estates work on ward 7 started on 14/9/16 2. Communications have gone out to all staff in September 3. Equipment ordered on 25/8/16 4. Nurse staffing rosters set up and shifts sent out agency on 08/08/16 5. There is a fortnightly meeting in place chaired by COO to progress 6. On Track to open November 1st (The main risk to opening remains staffing)	0%	28 beds open on the ward	0%	**3**
4	NA	Trial senior acute physician in ED to challenge admissions	UHL	Julie Taylor	**10**	1. Three day trial in September 2. Two further trials to take place to confirm results 3. Collate results and review outcome of trials 4. If results positive review medical job plans to check if it can be staffed within existing resource. 5. Implement (if outcome positive)	1. Reduced conversion rate to admission 2. Increase bed capacity 3. Decrease congestion in ED 4. Improve patient experience with 'home-first' mentality	1. 15th August complete 1st trial 2. 29th August completed 2nd trail 3. 26th September complete 3rd trial 4. 3rd October review outcomes and confirm benefits and decision to progress	Decide by ~~14/10/2016~~ 211/10/16 if this will be fully implemented	1. Decrease congestion in ED 2. Decrease breaches 3. Improve patient experience 4. Reduction in volume and % of patients admitted	Decrease admission	1. First two trials complete- provisional data showing decreased conversion to admission 2. Third trial was not completed as planned 3. CHKS data to be used to benchmark target against peers, and develop key actions for UHL 4. Meeting to be held w/c 17.10 to define and agree next steps.	21.2% (ED conversion rate)	18.70%	21.30%	**2**
4	NA	Reduce handover times for medical team	UHL	Julie Taylor	**15 New action**	1. OD facilitated workshop with medical and nursing teams on handovers 2. Trial of suggested new format of handover 3. Embedding of newly agreed process in the department	1. Reduce handover times to maximum of 20 mins and reduce number of handovers.	1. Baseline current handover process & times - complete 27th July 2016 2. Implement bedside handover - will be complete 7 November 2016 3. Reduce number of doctors handovers - review 7 November 2016	All actions to be complete 7 November 2016	1. Reduction in wait to be seen in ED	breaches	1. Data on number of handovers obtained 2. ECIP to facilitate the required improvements	Handover time: Medical: 3 hours (out of 24)	Maximum 20 mins	3 hours	**3**

4	NA	Increase utilisation of yellow zone (ambulatory majors)	UHL	Julie Taylor	**16 New action**	1. Determine different staffing models to test 2. RCT models 3. Review outcomes 4. Develop model 5. Implement change	1. Reduce non-admitted breaches 2. Improve patient experience	1. 29.6.16 RCT an Acute physician model running this area 2. Collate results 3. If positive see if this model is viable (resources)	30.11.16	1. Reduction in breaches	breaches	1. Initial day trial (RCT) went well; needs longer trial to prove concept and collect meaningful data to support approach. LW to action. 2. Obtain data from Leeds Hospitals via ECIP re their model and criteria. 3. HOS to review criteria for local use 4. Daily reminder to clinical matrons to be responsible for ensuring patients are identified for yellow zone.	68% (Majors yellow area 4hr performance)	95%	61%	**3**
4	NA	Improve leadership and behaviours in ED.	UHL	Julie Taylor	**21**	1. Appoint OD consultant 2. Sept - Nov: delivering leadership interventions; delivering sessions with leaders and teams on behavioural competencies; integrating OD, comms, SOPS and IT. 3. Delivering coaching for key leaders within ED	Improved staff morale	1. OD consultant in post May 2016 2. Sept - Nov: delivering leadership interventions; delivering sessions with leaders and teams on behavioural competencies; integrating OD, comms, SOPS and IT. - on-going 3. Delivering coaching for key leaders (Heads of Service & Key managers) within ED - complete August 2016 4. Agreement with Exec colleagues on tackling challenging behaviour and	This is on-going work until 31 March 2017	Non specific	Breaches	1. Pulse check baseline complete July 2016 2. Follow up taking place September 2016 3. New leadership team in place 4 Twice weekly staff engagement meetings in place to update staff on progress/changes/issues-On-going 5. LiA recruitment & retention event planned Oct 16 6. Focus area for ECIP	Sickness rate: 3.9% Turnover: 9.7% Vacancies: 30%	Sickness rate:3% Turnover: 9.5% Vacancies: 10%	Sickness rate: 3.8% Turnover: 9.7% Vacancies: 28%	**4**
4	NA	Reduce overnight breaches	UHL	Julie Taylor	**22**	1. Senior leadership shift change (2pm - 10pm) over winter 2. Pro-active use of escalation areas to allow space in ED for decisions to continue to be made 3. Ensure consistent huddles over the night period 4. Open additional beds (as per previous action re ward 7)	1. Reduction in breaches 2. Improved patient experience	1. Implementation of the late shift rota (senior management 2pm -10pm) 3rd October 2. Increased clinical matron presence 7 days per week including evening 3rd October 3. Ensure safety huddles are completed during the night (SMOC or duty manager to lead) 5th September 4. Open additional ward capacity 1st November 2016	All actions to be complete 1 November 2016	1. Reduction in breaches overnight	Breaches	1. Shift change goes live 3rd October 2. Matron restructure complete 3. The opening of the ward has been pushed back to 1 November 2016 - on track 4. Matron 7 day rota now complete 5. Senior manager rota, initially planned to start on 3rd Oct, currently delayed; discussions ongoing. 6. Diagnostic to identify any other reasons for increased number of breaches overnight	Currently 29% of patients arriving between 7pm and midnight are treated within 4hrs	70%	32%	**4**
4	NA	Implement low risk ambulatory service on CDU	UHL	Sue Mason	**26**	1. Business case to be written for EQSG 2. Meeting with CCGs to discuss commissioning 3. Implement if commissioned	1. Maintain LOS on CDU achieved during pilot (July/August) 2. Average LOS in low risk ambulatory service 2 hours 3. Improve quality for patients by decreasing time in CDU	1. Business case went to EQSG on 31st August 2. Met with CCGs to discuss commissioning 6th September 3. Implement if commissioned 1st December	If commissioned, 01/12/2016	1. Decrease in frequency of CDU going on a 'stop' therefore decreasing congestion in ED and number of breaches	breaches in ED	1. Business case complete 2. Meeting with commissioners 6.9.16 3. Total BCF funding identified £105k - awaiting confirmation from commissioners 4. Further conversations with the have CCG on 16/09/16 5. For discussion at Chief Officers meeting w/c 3rd October 6. Proposed approach and funding stream agreed; scheme being implemented as	13 (Length of stay in CDU)	13 (target to achieve length of stay achieved during the pilot)	13.3	**4**
4	NA	Decrease conveyance of Cardiorespiratory patients between LRI and Glenfield to increase EMAS capacity	UHL	Lisa Gowan	**27**	1. Establish baseline activity 2. Review the criteria 3. Case note review to determine if the patient was conveyed to the right location 4. Develop action plan 5. Implement any required changes	1. Decrease conveyance of cardiorespiratory patients from LRI to Glenfield 2. Improve quality to ensure that patient gets to the right specialty first time	3. Case note review to determine if the patient was conveyed to the right location 30 September 4. Develop action plan 31st October 5. Implement high impact and short term rapid interventions 30th November	Full implementation 30 November 2016	1. Reduce attendances at ED 2. Reduce overall breach rate	breaches	2. Audit to be completed for all those patients sent direct the LRI to ascertain reasons by end of September 3. 2 FY2's have been identified to carry out audit on those patients transferred from LRI to gather evidence on process and define next steps.	107 in August (Number of pts transferred from ED LRI to Glenfield)	96 (10% reduction)	50 to date in Sept (ED LRI to GGH)	**4**

4	NA	Rename of action description: Rapid Flow (formerly - Implement Safer Patient Placement across UHL)	UHL	Julie Taylor	**36**	1. Launch communication throughout UHL 2. Project plan to be developed on how UHL roll-out on wards 3. Roll-out across Medicine 4. Full roll-out across UHL 5. Re-opening of discharge lounge	1. Increase discharges from wards before 1pm 2. Reduce breaches in ED 3. Reduce congestion in ED 4. Improve patient experience 5. Decrease use of escalation areas	1. Launch communication throughout UHL - complete 7th September 2016 2. Project plan to be developed on how UHL roll-out across wards - complete 14th July 2016 3. Roll-out across Medicine - go live 10th October 4. Full roll-out across UHL - phased roll out January to March 2017 5. Re-opening of discharge lounge - 14th November 2016	~~Go live of Safer across medicine on 10 October 2016~~ Delayed due to engagement with teams - 30.11.16	1. Reduce breaches in ED 2. Reduce time from bed request to allocation	admitted breaches	1. Rapid flow to be implemented on acute medical wards iniitially 2. Task and finish group established to look at implementation and roll-out across all wards 2. Documentation produced in standard UHL format 3. Estates work required for new discharge lounge starts 17/10, with 3 week build time.	55% of patients allocated a bed within 60 mins	75%	58%	**2**
4	4.1 4.3 4.4	Implement SAFER patient flow bundle Trustwide	UHL	Gill Staton	**37**	1. Baseline audit of wards to be completed on utilisation of the SAFER flow bundle 2. Develop actions to address gaps identified in audit 3. Re-audit once actions put in place 4. Phased roll-out across UHL	1. Increase in the number of patients discharged before 1100 2. Increase in the number of patients with EDD 3. Consistent board rounds on all wards 4. Decrease number of 'stranded' patients 5. Improve ward ownership 6. Increase patient experience by ensuring patient is part of the decision making process 7. (Percentages to be confirmed once baseline audit complete)	1. 29th August 2016 audit of 5 wards completed 2. 19th September 2016 baseline audit of 2 further wards to identify areas for improvement 3. Collation of results and feedback w/c 1st October 4. Action plan developed by 10th October 5. Implementation of plan to start 17th October on key wards 6. Start of baseline audit of remaining wards on 14th November 7. Action plan and full roll-out by mid-December	SAFER patient flow will be rolled out on two key wards by 01/11/2016	1. Improve base ward capacity for admissions from ED.	admitted breaches	1. 29th August 2016 audit of 5 wards completed 2. Week of 19th September:2 further wards audited and data being collated for baseline 3. Resource for implementation of actions being identified 4. Re roll-out of professional standards 5. Increase rigour of board rounds to create consistency	5.82 (average length of stay for Medicine)	4.67	5.82	**3**
4	NA	Glenfield to open additional beds to decrease bed capacity/demand mismatch	UHL	Sue Mason	**39**	Open 28 beds on ward 23a	1. Decrease outlying on non-medical wards (dependent on attendances and admissions remaining constant) 2. Decrease congestion in CDU 3. Contribute to an improved LOS on CDU 4. Improve staff experience by staffing a consistent ward therefore preventing staff moving from ward to ward 5. Reduced frequency of CDU going on a 'stop'	1. 18th November 2016 staffing to be confirmed 2. Equipment to be ordered and delivered by 31st October 3. Planned opening 1st December 2016	Ward is due to open on Monday 5 December 2016	1. Decrease breaches linked to better flow to GGH	admitted breaches	1. Communication to staff started 15th August 2016 2. Compiled list of equipment requirements - ordered w/c 18th Sept 3. Out to recruit for staff 4. Discussed with medical staff to provide cover 5. Funding agreed and phasing needs finalising	0	28 beds open on the ward	0	**4**
4	NA	Implement specialty in-reach of referred patients to ED	UHL	Julie Taylor Ian Lawrence Lee Walker	**40**	1. Review Trust Watershed policy 2. Benchmark against specialty in reach services in other Trusts 3. Work with HOS and CD to communicate policy to all other specialty CDs 4. Re-implement Trust watershed policy	1. Reduced wait times for ED patients by releasing ED medical staff 2. Improve patient experience	1. Review Trust Watershed policy - complete by 17/10/16 2. Benchmark against specialty in reach services in other Trusts - complete by 17/10/16 3. Work with HOS and CD to communicate policy to all other specialty CDs - complete by 17/10/16 4. Reimplement Trust watershed policy - complete by 17/10/16	All actions to be complete by ~~17/10/16~~ 30.11.16	1. Reduction in breaches 2. Improvement in time to be seen by a doctor and time for a plan 3. Reduction in conversion rate	breaches	1. Current policy under review 2. Clinical director discussed with consultant colleagues 3. Medical director to discuss further with Heads of Service	21.2% (ED conversion rate)	TBC	21.30%	**2**
4	NA	Develop hospital internal professional standards (incl speciality in-reach to ED)	UHL	Sue Mason	**43**	1. Implement UHL Better Change project to decrease Cardiology inpatient LOS pre Cath Lab 2. Implement daily review of patients on monitored beds 3. Review capacity and demand of monitors available	1. Improved LOS in Cardiology 2. Decreased delay of transfer of patients from ED to CDU	1. Baseline data collection of cath lab waits - complete 2. Implement electronic referrals for Cath lab - complete 3. Implement Hot lab Cath lab sessions - complete 4. Reaudit Cath lab waits 11th November - this has been brought forward to October	All actions to be complete by 11 November 2016	1) Reduce delay of transfer of patients from ED to CDU	ED breaches	1. Baseline data collection of cath lab waits complete 2. Implement electronic referrals for Cath lab complete 3. Implement Hot lab Cath lab sessions complete 4. Reaudit of Cath lab waits has been brought forward to October	3.1 (Cardiology LOS)	3.5	3.7	**3**
4	NA	Improve discharge from UHL by decreasing transport delays	UHL	Gill Staton	**45**	1. Meet Arriva and CCGs to establish reasons for delays 2. Implement actions to address delays 3. Implement a weekly meeting to review patients that were re-bedded and identify themes and develop actions to resolve 4. Establish process of prospectively booking discharges 5. CCG to complete procurement of NEPTS	1. Increase early discharge 2. Decrease failed discharge	1. Set up meeting with Arriva & CCGs by 1st October 2016 2. Set up weekly review to start w/c 26th September	All actions complete by end of October	1) Reduction in breaches 2) Improved flow out of ED	admitted breaches	1. CCG UHL meeting 29.9.16 to discuss contract arrangements and overbooking processes to manage demand until new contract confirmed 2. Arriva UHL meeting 30.9.16 to jointly improve processes 3. Meeting took place with Arriva; new way of working agreed, including focus on discharge from assessment areas and increase ambulance utilisation.	4.5% (discharges pre 11am) 13% (discharges pre 1pm)	33% before 12.00	4.2% (discharges pre 11am) 12.9% (discharges pre 1pm)	**5**

4	4.2 4.5	Implement Red Day / Green Day as part of SAFER	UHL	Gill Staton	**47**	1. Investigate feasibility of method of capture of Red and Green Days (white boards or electronic) 2. Develop Red and Green Day Criteria for implementation 3. Develop launch pack 4. Communicate to and educate staff 5. Roll out across ESM -audit following roll-out	1. Decrease LOS for ESM	1. Agree Nerve Centre feasibility of recording of R&G days by 1st October 2. Agree R&G Day Criteria by 29th September 3. Roll-out of launch packs on 10th October 4. Audit 14th November 2016	All actions complete by 14 November	1) Improve base ward capacity for admissions from ED.	Admitted breaches	1. Project team met 15/9/16 to plan implementation 2. Red Green criteria agreed 30.9.16 3. Red and green audit ongoing on two wards; initial feedback shows high numbers of red days 3.Launch days being planned throughout October 4. Focus of ECIP support	5.82 (average length of stay for Medicine)	4.67	5.82	**3**
4	NA	Implement direct admissions from ED to specialities	UHL	Julie Taylor	**68 (new)**	1. Develop a CMG wide clinical task and finish group to establish the type of patients that can be direct referred 2. Data analysis to determine impact change will have 3. Agree Patient criteria 4. Write SOP 5. Communicate process to teams 6. Implement 7. Feedback session to ensure the team capture any changes and improvements required	1. Decrease admitted breaches 2. Decrease overcrowding in ED 3. Improved patient experience	1. Develop a CMG wide clinical task and finish group to establish the type of patients that can be direct referred 10th Oct 2. Data analysis 31st Oct 3. Agree Patient criteria 31st Oct 4. Write SOP 11th Nov 5. Communicate process to teams 18th Nov 6. Implement 28th Nov 7. Feedback session to ensure the team capture any changes and improvements required 19th Dec	28.11.16	Decrease breaches	admitted breaches	1. Meeting planned with MD, CD to agree implementation plan 2. For discussion at EQSG	80%	77%	TBC following data analysis	**1**
Key Intervention Area 5: Improved Discharge																
5	5.6, 5.1	Additional packages of care/DRT input will need to be purchased to reduce delayed discharges from the acute trust	UHL	Tamsin Hooton	**48**	Commission extended capacity in DRT to support discharge. £155k = up to 5 beds until the end of March 2016	Increased flow, Reduced delays in discharges	Funding source to be identified. Business Case to EQSG, Discussion at AEDB 5/10	01/11/2016	Reduction in LOS	% discharges before 12pm at UHL, Patients aged 75+ with LOS >10 days at UHL, % of UHL DTOC	Review after Help to Live At Home.	TBC	increase by 5	TBC	**2**
5	5.6, 5.1	Increase OPAT provision (up to 2 beds) to provide a service that delivers IV antibiotics in the patient's own home, in order to reduce LOS	UHL	Tamsin Hooton	**49**	Expansion of the current process that will allow patients who require IV antibiotics to be treated at home rather than in a hospital bed.	Increased flow, reduced LOS	MRET funding to be utilised to March (£100K) Advertise for 3 nurses (Sept 16) Identify consultant Pas (complete)	Expansion scheduled for 1/12	Reduction in admitted breaches, reduction in LOS,	Patients discharged from UHL	TBC	current numbers of patients supported	2 bed expansion up and running (can be phased if recruitment requires)	TBC	**4**
5	5.5	ICS to provide a programme of education to hospital ward teams in order to increase the usage of ICS.	UHL/LPT	Tamsin Hooton	**50**	Share referral criteria for ICS - 10/09 Clinical ward rounds to identify suitable people (joint with LPT)	More appropriate referrals, increased utilisation of ICS	Circulate ICS criteria Communication exercise internally and on wards Ward rounds weekly - senior LPT and UHL staff - agree frequency and put in place	30/09/2016	Increased flow, reduced admitted breaches, reduction in LOS, ICS Capacity utilisation (baseline 80%, increase to 90%)	% of LPT ICS Beds used by patients	Significant progress in ward coding on ward 16. Lessons from this ward to be rolled out across other wards Requires update	Number of referrals to ICS from UHL wards. Baseline TBC	TBC	TBC	**4**
5	5.1, 5.5	Review model of ICS for opportunities to increase usage, focus on County pathways	LPT	Tamsin Hooton	**51**	Integration of ICS with county POC provision/HTLAH model	More appropriate referrals, increased utilisation of ICS	Initial paper to Integration Exec 5/10 Full Cusiness Cases 5/11 Decision on further integration to go to Integration Executive Pilot in Loughborough of inreach/joint working with ICS	5/10 for agreement on future direction with County Social Care	Reduced LOS/Reduced discharge delays, also supports 'step -up' and reduced ED admissions	% of LPT ICS Beds used by patients, % UHL DTOC	Business case to focus on integrated health and social care offer for pathway 2, plus an integrated discharge team inreaching into hospital (as per Rutland model)	Business case for social care input to work alongside ICS agreed	Business case agreed	ed initial paper, full	**3**
5	5.1, 5.5	Review future model of ICS to support discharge to assess and 'Home First' model	UHL/LPT	Tamsin Hooton	**51a**	Discharge Steering Group to agree strategic direction for **Discharge to assess,**	Better integrated discharge to assess approach across LLR, increased use of ICS	Agree future integrated discharge to assess short term model by November 2016 Trial changes to ICS model by November - March 2017 Agree Business Case with commissioners/RCT - Jan 2017	31/03/2017	Reduced admissions, reduced admitted breaches, reduced LOS, improved flow	UHL DTOC %	Some ICS capacity decommissioned. Proposal to have a multi agency ICS review	Discharge to Assess model agreed.	Reduction in numbers of patients assessed for CHC in acute setting (baseline TBC) but target only 10%	Business case for social care input to work alongside ICS agreed	**3**
5	5.1, 5.4, 5.6	Mobilise 'home first' discharge to assess model from hospital - go live 7th November 2016 for County	CCGs	Tamsin Hooton	**52**	Referral routes confirmed, UHL staff training, Use of MDS tool on key wards	Improve flow at transfer of care stage as no waits for care packages. Improved pathway of care for non weight bearing patients, those requiring further assessment to identify true care needs, reduction in number and complexity of long term care packages. Reduction in number and complexity of CHC packages (including reduction in number of patients eligible for CHC). Reduced LOS in hospital as no eligibility assessments completed during hospital stay (possibly up to 5 days)	Procurement completed. Implement pathway on November 7th 2016. Conversation with City by 30/09/16	07/11/2016	Increased flow, reduced admitted breaches, reduction in LOS	% Discharged before 12pm at UHL, Patients aged 75+ with LOS >10 days at UHL, % UHL DTOC	On track to go live November 7th 2016	Number of patients using pathway 2. Baseline: 0 cases. November 7th: 5 cases. December 7th: TBA	Number of CHC assessments completed post-transfer of care. Baseline: 0. November 7th: 5 cases. December 7th: TBA.	0	**3**
5	5.1, 5.4	Establish pathway for reablement patients (replaces D2A)	CCGs	Tamsin Hooton	**53**	1. Identify homes with spare capacity. 2. Agree referrals into spot placements 3. Agree inreach model 4. Identify in reach resource incl case managers	Improve flow at transfer of care. Improved pathway of care for non weight bearing patients, those requiring further assessment to identify true care needs, reduction in number and complexity of long term care packages. Reduction in number and complexity of CHC packages (including reduction in number of patients eligible for CHC). Reduced LOS in hospital as no eligibility assessments completed during hospital stay (possibly up to 5 days)	1. 28/09/16 complete, weekly refresh 2. Criteria agreed 30/10 3. Business case 4/10 4. Some existing staff - confirm resource 30/10	Pathway running by November	Increased flow, reduced admitted breaches, reduction in LOS	% Discharged before 12pm at UHL, Patients aged 75+ with LOS >10 days at UHL, % UHL DTOC	Procurement closed 16th September 2016 for the second time. Bids received for Therapy provision, no bids received for bed based services. Urgent meeting to agree future options/mitigations planned for 21/09	Pathway not in use (existing pathway has 50 patients)	20 cases per week	Existing D2A has 80 patients	**2**
5	5.2	Design and implement an electronic solution to support a trusted assessment upon transfer of care	CCGs	Tamsin Hooton	**55**	41. Trial of trusted assessment at UHL (using Nervecentre platform) prior to go live of pathway 2.	Reduced number of assessments by multiple people (potential LOS saving), no process delays between assessment and acceptance at onwards community service	Trial go live at UHL during August 2016	November 7th 2016	Increased flow, reduced admitted breaches, reduction in LOS	Patients aged 75+ with LOS >10 days at UHL	Update required from UHL (Julia Ball/Elizabeth Simmons)	Number of trusted assessments completed. Baseline: 0. November: 5. December: TBA	Number of accepted trusted assessments. Baseline: 0. November: 5. December: TBA	Reduced DTOC rate. Baseline UHL: 2.43% LPT: 2.85% Target 1.35% and 6.5%	**3**

5	5.2	Provide electronic means of sharing the trusted assessment with partner organisations at point of transfer of care	UHL	Tamsin Hooton	**56**	42 + 43. Commence a task and finish group to review and agree interoperability across LLR health, social care, and partner agencies. Hospital social care teams to use VPN connection in short term.	Provides initial access to trusted assessment for new pathways (enabler for success of pathways) Agree preferred option via BCT IMT group Progress Options analysis for information sharing, including Everis solution	Initial task and finish group 3rd October 2016 Options analysis to IMT group November ROI	March 31st 2017	Increased flow, reduced admitted breaches, reduction in LOS	Patients aged 75+ with LOS >10 days at UHL	To be discussed with UHL 19th September - meeting cancelled, to be re-arranged	Number of MDS assessments completed by UHL , number TBC at task and finish group	Number of MDS assessments accessed by other agencies. Baseline 0, December TBC	NA	**3**
5	5.2	Create trusted assessor roles across health and social care to support transfer of care process	CCGs	Tamsin Hooton	**58**	44. Create trusted assessor roles across health and social care as part of pathway 2 and pathway 3	Appropriate patient flow into the new discharge pathways, and clear management of the journey through the pathways to get the best & timely outcomes for patients	Agree use of existing case manager posts at UHL (October 2016) Agree job role (October 2016)	November for pathway 2 and pathway 3	Increased flow, reduced admitted breaches, reduction in LOS	Patients aged 75+ with LOS >10 days at UHL	Part of pathway 2 and pathway 3 mobilisation planning	Number of trusted assessors in post. Baseline: 0. November: 2. March: 6	Number of trusted assessors in post. Baseline: 0. November: 2. March: 6	NA	**4**
5	5.1, 5.4	Provide an efficient system wide 'D2A' pathway	UHL	Tamsin Hooton	**59**	45. Switch off existing D2A pathway to coincide with commencement of Pathway 3	Pathway 3 becomes the discharge to assess route out of hospital.	Initial discussion required with UHL to start closing the pathway down ready for January	30-Jan-17	Increased flow, reduced admitted breaches, reduction in LOS		To be part of Pathway 3 mobilisation planning group commencing 26th September 2016	Number of open cases. Baseline: 80.	November: 45. January: 30. March: 0	80 open cases	**3**
5	5.1, 5.2	Engage with partner organisations to clearly describe the D2A and Trusted Assessor offer	CCGs	Tamsin Hooton	**60**	46. Communications messages being agreed for implementation of new pathways	Clear criteria for which patients are suitable for each pathway, including principles of home first, trusted assessors and single assessment	Messages agreed during October discharge steering group	November 2016-January 2017	Increased flow, reduced admitted breaches, reduction in LOS	LPT and UHL Patients discharged to admitting address	Part of pathway 2 and pathway 3 mobilisation planning	Communication materials agreed 31/10	NA	NA	**4**
5	5.1	Design and deliver a pathway to support effective transfer of care for patients with severe dementia	CCGs	Tamsin Hooton	**61**	47. Scope requirements of Severe Dementia Pathway using commissioning intentions. Describe pathway to include specialised care homes for this group of patients. Understand capacity requirements	Patients with severe dementia placed appropriately into the right care setting in a timely manner, follow same principles of 'home first' and 'discharge to assess'	Agree scope (October 2016). Define patient cohort (October 2016). Agree current capacity available (November 2016).	31/03/2017	Increased flow, reduced admitted breaches, reduction in LOS	Patients aged 75+ with LOS >10 days at UHL, % UHL DTOC	On agenda for next LLR Dementia group (October 2016)	TBA	TBA	TBA	
5	5.1, 5.3?	Design and deliver short term improvements to capacity for end of life services in order to reduce people dying outside of their place of choice	CCGs	Tamsin Hooton	**62**	48. Scope short term capacity requirements for 'last few days of life' pathway	Patients in the last few days of life have choice about where to die and access the most appropriate care setting in a timely manner	New service specification for discharge at end of life. Workshop to test new ways of working (8th November)	TBA	Increased flow, reduced admitted breaches, reduction in LOS	Patients discharged from UHL	Working towards a new service specification with UHL and LPT with regards to discharge for End of Life Care patients. Testing out the new ways of working at workshop on 8 November	TBA	TBA	TBA	**4**
5	5.1	Monitor Hospital Housing Team offer and review model to support new D2A and TA models where indicated	CCGs	Tamsin Hooton	**63**	49. Continue to review successes and challenges of the expanded Housing team based at UHL and Bradgate Unit	Housing team reduce LOS and delays associated with housing. Currently building team skills and expertise.	New team members receiving training and upskilling (November 2016)	Ongoing	Reductions in DTOC, reductions in LOS	Patients discharged from UHL, % UHL DTOC	Continued attendance at Steering Group. Reviewing potential need for business case to outreach to pathway 2 and 3 once operational. Mental health rep now on steering group to support DTOC at Bradgate Unit. Review of metrics to demonstrate successes. Housing associations on board to review use of 'difficult to let' properties and enhance quicker processes from hospital	Number of patients supported by team: TBA.	Number of patients supported by team: TBA	Number of patients supported by team: TBA	**4**
5	5.1, 5.5, 5.6	Agree and produce a recognised delayed discharge measure across LLR to support operational and improvement work (in addition to DTOC reporting)	CCGs and Local Authorities	Tamsin Hooton	**New**	Create a task and finish group to amalgamate reporting requirements, and agree what will be produced	Improved information on delays and process issues relating to discharge, to support better targeting of actions including improved escalation and surge processes. Supports section 4	Group to meet (October 2016). Presentation to DSG (November 2016). Dummy report produced (January 2017)	March 31st 2017	Improved flow, reduced admitted breaches	% UHL DTOC, % LPT DTOC	Task and finish group initial meeting 3rd October	Group to meet 3rd October	First draft report January 2017	0	**4**
5	5.3	Agree Policy and procedure to support patient and family choice	CCGs and Local Authorities	Tamsin Hooton	**New**	Discharge Steering Group to lead process to agree policy, with appropriate engagement with stakeholders	Reduced DTOC related to family choice, improved patient/family communication about expectations	Discharge Steering Group to agree action plan COMPLETE DSG to agree policy for approval Approval by CCGs, Las/Integration Execs? Implementation plan incl comms	05/10 1/11/16 23/12/2016 March 2017	Reduction in DTOCs, improved flow, reduced admitted breaches	% UHL DTOC, % LPT DTOC	Policy circulated to UHL for initial review. To report back to DSG (October 2016)	No policy being consistently used	Agreed policy by March 2017	0	**3**
5	4.1, 5.6, 5.5	Adapt acute SAFER flow bundle to address the community hospital service requirements	LPT	Tamsin Hooton?	**link to 37**	Benchmark community inpatient wards and identify additional action required Share benchmarking with DSG and confirm required actions	Identify gaps and actions for delivery of SAFER bundle in community hospitals	Completed benchmarking exercise discussed at DSG Agreed action plan	5th October November DSG	Improved flow in CH, improved ability to discharge from acute, improved acute flow,	% LPT DTOC	Review undertaken. Red and Green reporting key action - not yet underway. LPT propose no target for am disharge	Benchmarking against 5 SAFER metrics	Agreed actions to address benchmarking gaps Nov 2016	Benchmarking completed. Red Green Day reporting key action	**3**

RAG Key:

1	Not started
2	Significant delay or no plan
3	In progress, some risk or delay
4	On track
5	Complete

4	NA	Reduce time from bed allocation to departure from ED	UHL	Julie Taylor	**14**	1. Establish baseline 2. Identify themes for delay 3. Allocate Rapid Flow team to ED 4. Communicate and promote change in process 5. Rapid cycle test the new process 6. Implement	1. When beds are available, patient will leave within 15mins	1. Establish baseline - complete 18th July 2. All other actions were completed in August	All actions complete 1 September 2016	1. Improve flow from ED 2. Decrease congestion in ED	admitted b	1. Work with the rapid flow team has shown an reduction in the average time from 30 mins to 19 mins. 2. Delay themes identified: * Photocopying issues - resolved * Patient status issues - resolved 3. Currently looking at issues around bulking of bed availability and transport issues. 4. Data requested on % of patients with bed request outside of LRI as impacting on 15min performance. Data will then be cleansed to provide a true reflection	26% (patients leaving dept within 15mins of bed allocation)	50%	31%	**5**
4	NA	Reduce handover times for nursing team	UHL	Julie Taylor	**15**	1. OD facilitated workshop with medical and nursing teams on handovers 2. Trial of suggested new format of handover 3. Embedding of newly agreed process in the department	1. Reduce handover times to maximum of 20 mins and reduce number of handovers.	1. Baseline current handover process & times - complete 27th July 2016 2. Implement bedside handover - will be complete 7 November 2016 3. Reduce number of doctors handovers - review 7 November 2016	All actions to be complete 7 November 2016	1. Reduction in wait to be seen in ED	breaches	Handover time : 20mins	Handover time: 15 mins	Maximum 15 mins	20 mins	**5**
4	NA	Reduce delays in diagnostics for patients in ED	UHL	Julie Taylor	**20**	1. Baseline audit to be completed 2. Identify reasons for delay from audit 3. Complete trial of dedicated porter for 3 days in ED	1. Decrease congestion in ED 2. Improved efficiency of diagnostics	1. Baseline audit - complete 18th July 2. Reasons for delays identified 25th July 3. Trial of dedicated porter - delayed due to availability of porters	All actions to be complete 17 October 2016	1. Reduction in patient wait times 2. Reduction in breaches	Breaches	1. Baseline audit - complete 18th July 2. Reasons for delays identified 25th July 3. Trial of dedicated porter - delayed due to availability of porters 4. Porter trial took place on 13-15 September; further meeting planned this week to discuss and review the data gathered and look at potential service improvements. Being picked up in workstream.	Transfer time from ED to imaging metric is being reviewed	TBC	TBC	**5**
1		NHS Improvement recommended presentation from South Warwick on how they improved system performance.	UHL	Lisa Gowan	**25**	-CD to make contact with South Warwickshire Trust - Invite to present to senior leadership team to identify any further actions for UHL to implement	Unable to comment on expected outcome until contact has been made	Unable to comment on expected outcome until contact has been made	Exchange visit to be complete by 1 November 2016	Unable to comment on expected outcome until contact has been made	Breaches	1. Clinical Director made contact with South Warks Director of Ops and Medical Director to confirm next steps. 2. Contact made; South Warwickshire to provide dates for UHL visit. 3. Action to be picked up by workstream	Unable to comment on expected outcome until contact has been made	TBC	TBC	**4**

Insert System Risk Register (post review)

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

Leicester, Leicestershire & Rutland Local A&E Board

6th September 2016 submission

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

Initiative		Statement of good practice	B-RAG	Commentary
1. Streaming at A&E	**1.1**	All major specialties have a consultant immediately available on the telephone to provide advice & streaming for ED & primary care	**Amber**	24/7 on call cover across all major admitting specialities with 24 hr ED access. Consultant Connect available to GPs for acute medicine, Paediatrics and Geriatric medicine.
	1.2	There is a primary care stream available (if activity levels justify it) with the capacity to meet the true patient demand	**Amber**	Streaming service (Lakeside) supported by urgent care in place. Challenges around workforce and ability to recruit. Reduction in treated/redirected patients since November as service scale reduced. Winter approach to be finalised by 30/9/16
	1.3	Patients presenting with mental health illness are assessed, managed, discharged or admitted within the ED standard	**Green**	Access to 24/7 liaison mental health services is available, and this is part of our overall improvement plan. Standard not always met for pts requiring admission
	1.4	There is an ambulatory emergency care service available for 12 hours per day, 7 days per week which manages at least 25% of the emergency take	**Green**	Medical specialities. Access to ambulatory services exist but currently not taking 25% of patients. Surgical specialities via SAU with General Surgery offering a triage service Monday to Friday 0730 to 2000hrs at both LGH & LRI site.
	1.6	There is an acute frailty service available 12 hours per day, 7 days per week which treats all eligible patients	**Blue**	Access to frailty pathways are appropriate for the criteria described within 24 hours of admission.
	1.8	Community and intermediate care services respond to requests for patient support within 2 hours	**Amber**	ICRS (City) in place and responsive. CRS (County) in place but challenged with response time due to capacity constraints.

2. NHS 111 calls transferred to clinicians	**2.0**	Given there is a requirement to increase from 22% to an national interim threshold of 30% (or higher) of calls transferred to a clinical advisor by 31st March 2017, the A&E Delivery Board has plans in place to meet this requirement	**Amber**	Modelling for the Clinical Navigation Hub suggests that this will be delivered by 31/3/2017.
	2.1	Clinical expertise availability is planned according to demand	**Amber**	As above
		The A&E Delivery Board has a lead starting to integrate the NHS 111 service and local Out of Hospital Provision, particularly OOH	**Green**	Led by Director of Urgent Care. Will be in place as pilot from Oct 2016 and procured in 2017/18 as part of integrated urgent care model within the Vanguard.
	2.6	The A&E DoS service type is ranked as low as possible, apart from other A&E-type services and services not commissioned within the CCG	**Blue**	
	2.7	There are alternative services which can accept NHS Pathways outcomes for conditions that can be managed outside A&E E.g. limb injuries, bites, stings, plaster cast problems, suspected DVT, falls	**Blue**	
	2.8	The A&E Delivery Board knows demographics of the area, including if there is a greater demand for OOH services are generated from the elderly	**Amber**	Trialled urgent care system metrics and Board will receive regular dashboard.
3. Ambulance Response Programme (DoD and coding pilots)	**3.1 & 3.2**	There is an ambulance trust executive lead on the A&E Delivery Board able to deliver the required service changes	**Blue**	Acting CE of EMAS is a member of A&EDB **BLUE**
	3.2	There are working definitions of 'Hear and Treat' and 'See and Treat' agreed across the local health economy and a baseline workforce profile to deliver an increase in these dispositions	**Green**	
	3.2 & 3.4	There are alternative services which can accept ambulance dispositions or referrals and these mapped across localities	**Amber**	Services mapped through Mobile Directory of Service. However, some local pathway confirm and challenge required to confirm
	3.4	The A&E Delivery Board has established local mechanisms for increasing clinical input into green ambulance dispositions particularly at times of peak demand	**Amber**	Clinical Hubs being developed to support patients with a green disposition
	3.4 & 3.5	The A&E Delivery Board has agreed workforce and service plans in place to deliver an increase in 'Hear and Treat' and 'See and Treat'	**Amber**	In development across health and care economy

4. Improved Patient Flow	4.1	SAFER patient flow bundle implemented on assessment and medical wards as a bare minimum , to improve patient flow	Amber	Safer bundle' concept initiated two years ago across the Acute medical wards at the LRI site. Needs re-launching and more dedicated focus- ECIP are providing support to UHL to implement SAFER bundle, work will begin with 2 pilot wards 7th Sept 2016
	4.1	What percentage of the base wards on each acute site has SAFER in place?	Amber	100% of Acute medical wards at the LRI has the safer bundle in place but needs relaunching & refocus with support of ECIP
	4.2	The use of the red and green day approach has been considered	Amber	To be implemented- with assistance from ECIP- attending 2 medical wards on 7th Sept
	4.3	A baseline assessment of the effective use of EDDs and Clinical Criteria for Discharge has been carried out	Green	Audits are currently being undertaken on the medical wards at the LRI site
	4.4	Ward round checklists are in use in all wards in the acute hospital/s	Amber	Initiated about two years ago but not used consistently in practice - need to be relaunched.
5. Improved Discharge	5.1	A 'home first: discharge to assess' pathway is in operation across all appropriate hospital wards	Amber	Plans to deliver -pathways being implemented over next four months. Delays to discharge to assess need addressing. Significant work re comms and implementation across all wards. ICS has potential to enhance Home First approach.
	5.2	Trusted assessor arrangements are in place with social care and independent care sector providers	Amber	Amber in terms of pathway 2 and 3, with MDS as tool to shape the discharge work. Trusted assessor framework in place but risks to rollout.
	5.4	At least 90% of continuing healthcare screenings and assessments are conducted outside of acute settings	Red	Not currently in place. Existing plans for D2A will improve % assessed outside acute settings, but we have not established whether they will deliver 90% of assessments outside hospital.
	5.3	A standard operating procedure for supporting patients' choice at discharge is in use, which reflects the new national guidance	Red	Plans still to be developed - Discharge Steering Group to lead
	5.6	Systems are in place to review the reasons for any inpatient stay that exceeds six days	Amber	Baseline to be established in September, trialled on couple of wards. Roll out plan in development.
	5.6	There is a responsible director in the trust who will monitor the DToC situation daily and report regularly to the board on this specific issue	Blue	Chief Operating Officer
	5.6	Related to the above, there is a named senior individual in every CCG and SSD who will be the single point of contact for the nominated trust exec.	Green	Senior discharge leads in place, confirmation and communication across system required. DSG to lead

Area	Action	Lead	Timeframe	Metric
Ambulance arrivals	1.Increase CRT capacity to 5 cars	Rachna (City)	CRT car: 16th Aug 2016	•Increase a appropriate CRT/AVS utilisation from 60% to 80% (via clinical audit)
	2.Increase EMAS > CRT referrals	Cathrina (West)	EMAS>CRT: Sept 15th	•Decrease avoidable care home admissions by 10% of 15/16 outturn
	3.Increase AVS timings from 9-5 to 8-8	Paula (ELR)	AVS: Oct 2016	
Patient Navigation	1. Implement navigation hub		1. Oct 31st	•Decrease in ED dispositions of 5%
	2. Test out revised pathways for 'ED dispositions'	Diane Eden	2. August 2016	•Increased deflection to CRT/AVS or community based hubs
	3. Test out revised pathways for G3 and G4's		3. September 2016	
Consultant connect	1.Agree to continue CC		1.Complete	•Increase in avoided EAs in specific specialities (from 66% to c.70%)
	2.Roll out to Paeds & Geriatrics	Sam Leak (UHL)	2.September 2016	•Increase in utilisation rates in Primary care from 74% to 95%
	3.Re-launch at PLT (City)		3.September 21st	

CDU Pilot	1.Agree funding for winter 2016 2.Assess other applicable 'AU's'	Dr Montgomery (UHL) Louise Young (CCG's)	1.22nd September 2.By Sept 30th		•Maintain Patients discharged from CDU < 2 hours (at 88%)
GP Urgent Audit	1.Audit GP urgent calls to assess appropriateness 2.2. Feedback to Primary care at PLT's in Sept	Dr Hurwood (CCG's) CCG leads	1.September 15th 2.September 21st	---	

Key Intervention No:	National Guidance ref/detail:	Action Detail	Lead Organisation	Accountable Officer	Action no.	Planned activity	Expected outcome/ Impact	Key milestones	Delivery date	Contribution to ED recovery	Update (All perf. Figures are dated)	Metric			RAG rating	Priority (1 or 2)
												Baseline (month 5)	Target	Current position		
1		Decreasing time in assessment bay will facilitate early decision making and treatment, and therefore reduce non-admitted and admitted breaches. Observed processes in assessment bay vary in length and form (ECIP feedback)	UHL	Lisa Gowan; Ursula Montgomery; Ffion Davies	17				~~01/09/2016~~ 31/10/2016		- Meeting with senior clinical team and HOS and HON to review process w/c 26/9				2	
1		Patients need to be seen by doctor in 90 mins and decision made in 180 mins.	UHL	Lisa Gowan; Ursula Montgomery; Ffion Davies	19	Super week to be held w/c 12 Sept - escalation and focus on time to be seen (and other key metrics); use of escalation areas pre-emptively. Further themes			01/10/2016		- Super week started as planned 12/9				4	
1		We continue to hold patients in the back of ambulances as insufficient space inside ED to offload at time of exit block. At escalation, cohorting space needs to be identified.	UHL	Lisa Gowan; Ursula Montgomery; Ffion Davies	23	- Identified cohorting space - Rewritten SOP - Identified staff to look after patients in space - Confirmed escalation process			01/11/2016						5	
1		It is widely recognised that the current ED space is not big enough and a significant number of breaches are due to space constraints; new Emergency Floor modelled on increasing demand.	UHL	Lisa Gowan; Ursula Montgomery; Ffion Davies	24	- Develop new ways of working within new space - Ensure pathways as efficient as possible with new SOPS - Provide appropriate level and skill mix of workforce			23/03/2016		- Workforce will be finalised by end of September - IT plan B solution being implemented in current department to allow staff training prior to opening - Recruitment drive to current vacancies (24/09) - Review completed on new staff groups/skill mix				4	
1	Remodel the front door to better manage patient flow – to ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	Currently have approx. 50% GP vacancies in urgent care; opportunity to work with primary care to fill the slots and increase co-working between primary and secondary care.	CCGs	Lisa Gowan; Ursula Montgomery; Ffion Davies		Discussions with UHL and City Federations to see if they can fill vacancies	-Filling gaps in rota - Increase partnership working - Decrease numbers flowing from urgent care to ED		01/08/2016		Conversations with eFederation; emailed contractual offer; no uptake to date from GPs.	**See expected impact column**			5	
1	Remodel the front door to better manage patient flow – to ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	Lakeside have provided the streaming service since Nov 2015; service was reduced by 50% in May 2016; due to finish Nov 2016. CCGs and UHL have agreed benefits of streaming and decrease in referrals to ED, therefore, been agreed that this model is the right model moving forward.	CCGs	Lisa Gowan; Ursula Montgomery; Ffion Davies		Secure streaming service from Nov to March 2017	Reduce waits and improve flow through ED:				Lakeside have agreed to continue a 3-2 model (GP/Nurses) until end of financial year.	**See expected impact column**			5	

1	Remodel the front door to better manage patient flow – to ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	We continue to hold patients in the back of ambulances as insufficient space inside ED to offload at time of exit block. At escalation, cohorting space needs to be identified.	UHL	Lisa Gowan; Ursula Montgomery; Ffion Davies		- Identified cohorting space - Rewritten SOP - Identified staff to look after patients in space - Confirmed escalation process			01/11/2016						5
2			CCGs	Rachna Vyas	**28**	Increasing the use of GP slots and hub direct bookings plus working on safely stopping these patients coming in.	Number of patients being streamed Use of GP slots and hub direct		30/09/2016	To support delivery of our four hour trajectory	Quick wins have been determined following successful x2 trials and will be implemented immediately, for example 2 Majors Yellow cubicles for FAST positive stroke patients. An extended trial was started 9.5.16 and ran for 3 days. This has been				
3			EMAS	Mark Gregory	**31**	Review of CDU criteria to ensure that patients are taken to the right location; decreasing inter-	Increased non conveyance of 4% by LLR EMAS crews (By	Meeting with GGH Clinical Lead - 19/8/2016 - Data Review of	31/10/2016	Reduction in A&E attendances	First Meeting Held with GGH 19/08/16, Clinical Criteria reviewed, number of transfers reviewed. Further meeting to be scheduled to review data. Challenges identified around IFTs	See EMAS metrics on separate tab			
4		An increased number of frail elderly patients are being admitted into UHL; the pathway currently has EFU and AFU to ensure these patients are managed are effectively as possible. The readmission component of this	UHL	Julie Taylor/Gill Staton	**12**	- Set up a task and finish group to review paper written by M Wightman and potential			01/11/2016			To be agreed as project is defined.			**1**
4		Reduce process delays by implementing 3Ws using UHL change methodology	UHL	Gill Staton; Rachel Marsh	**38**	- 3W's methodology to be applied in the roll-out of safer bundle			01/11/2016		- Audit of delay from 10 sets of notes is complete -On hold to align with SAFER bundle roll-out				**On hold**
4		Complete a demand and capacity review in Respiratory Medicine with recommendations for closing the gap	UHL	Sue Mason; Caroline Baxter; Elved Roberts	**41**	- Baseline activity and demand data complete, - Job plan analysis to be completed			~~12/08/2016~~ 14/10/16		Baseline data complete; review with clinical teams planned for 2nd September to agree efficiencies and gap business case to then be developed				**2**
4		Complete a demand and capacity review in cardiology with recommendations for closing the gap	UHL	Sue Mason; Caroline Baxter; Elved Roberts	**42**	Baseline activity and demand data, job plan analysis has been completed locally. Plan in development for deficit in cardiologists			~~12/08/2016~~ 14/10/16		- Baseline data complete - Review with clinical teams being planned for mid September to agree efficiencies and gap business case to then be developed. - 2 additional consultant posts now approved and out to advert				**2**
4		CDU has limited capacity which is resulting in long waits for triage and stops to admission, resulting in increased attendance in ED.	UHL	Sue Mason; Caroline Baxter; Elved Roberts	**44**	- Deliver a space review for CDU			19/09/2016		Option of modular pod between Ward 20 and CDU is being explored to locate low risk ambulatory clinic, costs awaited from Estates.	Improve flow for ED; decreasing ED non-admitted and admitted breaches.			**4**

4		Transport issues are causing delays in discharge from UHL.	CCGs	Julie Taylor/Gill Staton; Lee Walker; Rachel Marsh	**46**	- UHL to share with the CCG data on all discharges/transfers completed including by their third party provider, with information on time of day and complexity (stretcher/bariatric), for the past			30/11/2016		'- Meeting with Arriva arranged for next week				**4**	
4	Improve Ward Flow	Planned outlying: Cancel elective cases to allow medicine to outlie onto surgery	UHL	Julie Taylor/Gill Staton		Medicine continues to have 15+ outliers every day in July. Choosing to implement outliers in a			01/10/2016		We are unable to do this because of the impact on RTT and Ca A plan to manage at times of escalation (no beds and ambulance handover delays) is being developed.				5	
4	Improve CDU Flow	Review of CDU criteria to ensure that patients are taken to the right location; decreasing inter-hospital transfers and congestion in ED.	UHL	Sue Mason; Caroline Baxter; Elved Roberts							ACTION REMOVED AS DUPLICATE ON EXISTING ACTION					
4	Improve CDU Flow	Explore alternative pilot on CDU for emergency chest pain presentations being seen in an emergency clinic	UHL	Sue Mason; Caroline Baxter; Elved Roberts		This option has now been discounted and addressed through revised low risk ambulatory project - which is included in			30/09/2016		Business case being developed to embed GP pilot and ambulatory services - will be complete by end of August 2016 and discussed with commissioners on September 2016				5	
4	Improve Ward Flow	Transport issues are causing delays in discharge from UHL: there are a number of barriers to earlier discharge to be explored, and to ensure that transport crew capacity is planned to meet expected profile of discharge	CCGs	Julie Taylor/Gill Staton; Lee Walker; Rachel Marsh					01-Nov-16		ACTION REMOVED AS DUPLICATE ON EXISTING ACTION					
4	Improve Ward Flow	Transport issues are causing delays in discharge from UHL: Communication between UHL and Arriva of planned discharges 24 hours in advance to be improved.	CCGs	Julie Taylor/Gill Staton; Lee Walker; Rachel Marsh		- Regular communication to all teams on importance of early discharge planning -					ACTION REMOVED AS DUPLICATE ON EXISTING ACTION					
4	Improve Ward Flow	Transport issues are causing delays in discharge from UHL.	CCGs	Julie Taylor/Gill Staton; Lee Walker; Rachel Marsh							ACTION REMOVED AS DUPLICATE ON EXISTING ACTION					

4	Improve Ward Flow	Transport issues are causing delays in discharge from UHL.	CCGs	Julie Taylor/Gill Staton; Lee Walker; Rachel Marsh		UHL agreed to improve discharges earlier in the day – through Ward workstream and 3W work					ACTION REMOVED AS DUPLICATE ON EXISTING ACTION					
5	Improve discharge processes	Identify how Oxford FT have reduced their DTOC rate and confirm which learnings can be implemented within UHL. http://shelfordgroup.org/article/delayed-transfers-of-care-reduced-at-oxford-university-hos	UHL	Tamsin Hooton	**49**				31/08/2016		Contact made: 'Health system hired 60 care support workers who provide social care in people's homes after discharge from hospital. These recruits came from outside the health and care sector, and were employed on more attractive terms and with better prospects for career development They also commissioned extra intermediate beds in care homes, and staff to work closer with other clinicians, such as GPs and care home nurses, to increase capacity				6	
2	2.4	Providers should consider the use of Interactive Voice Response to transfer dental and/or pharmacy calls more speedily to an appropriate clinician	DHU	Rachna Vyas	**64 (new)**	TO UPDATE - response awaited from DHU							**Decrease ED attends by 11%**	**TBC**	**1**	**2**
2	2.8	Commissioners to consider baselining of investment in clinical services	CCG's	Rachna Vyas	**65 (new)**	TO UPDATE - response awaited from contracting							**Decrease ED attends by 11%**	**TBC**	**1**	**2**

University Hospitals of Leicester NHS
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Caring at its best

Front door workstream summary

EQSG
12 October 2016

What has gone well?

- Agreed integrated workforce model
- On track to roll out on 1 November with Lakeside support
- Progress with GP recruitment made
- Good progress with ECP recruitment
- Focus on UCC and minors breaches over last 2 weeks has shown some improvement

SRO update – position against RAP metrics

Action detail	Delivery date	Update	Metric target	Metric current	RAG
Increase the streaming/treating and redirection of patients from ED front door	1/11/16	1. Contract with Lakeside extended from November 2016 to 1st April 2017 2. Integrated model of care agreed 3. Meeting took place on 3.10.16 to operationalise the new workforce model; new model implemented from 10/10; 6 GP slots currently not filled for October - team working to fill all gaps.	55%	44%	4
Maximise use of ambulatory pathways to avoid ED attendance	7/12/16	1. Audit of yellow zone scheduled for 28/9/16 not completed as plan due to staffing issues (further date to be arranged). Feedback from observations of general department to be discussed at 12.10 EQSG. 2. Action plan being developed	20%		4
Review short stay capacity and demand, and determine if short stay capacity needs to be increased and reduce base ward capacity	30/11/16	'1. ECIP suggested we are 28 to 50 beds short. 2. RCT expansion of short stay being planned but requires GPAU relocation to be successful in order to free space for additional short stay bed / chairs . 3. Contact being made with HEFT to discuss their capacity and clarify numbers. 4. Task and finish meeting taking place w/c17/11 to plan rapid cycle test. 5. RCT results will then be reviewed alongside any additional resource requirements	134	106	2
Develop ED internal professional standards	30/10/16	1. Roles and responsibilities to be discussed at 12./10 EQSG 2. Focus of ECIP intervention 3. Huddles now in place (not consistently) 4. Ensuring appropriate use of escalation in place (not consistently) 5. SOP revised and being reviewed by senior team prior to circulation	95%	54%	2
Learning from South Warwickshire system on how they improved performance	1/11/16	'1. Clinical Director made contact with South Warks Director of Ops and Medical Director to confirm next steps			2
Decrease conveyance of cardiorespiratory patients between LRI and GH	30/11/16	1. Meeting held on the 19/08 with EMAS 2. Audit to be completed for all those patients sent direct the LRI to ascertain reasons by end of September 3. 2 FY2's have been identified to carry out audit on those patients transferred from LRI to gather evidence on process and define next steps.	10% reduction		4

Next Steps

Describe what actions are being taken to improve performance against RAP amber/red metrics, to get them back on track

Action/Initiative	Next step	Revised delivery date
Review short stay capacity and demand, and determine if short stay capacity needs to be increased and reduce base ward capacity	• Task and finish meeting taking place w/c 17/10 to plan rapid cycle test to move GPAU down to yellow zone. RCT results will then be reviewed alongside any additional resource requirements	30 November
Develop ED internal professional standards	• Discussed at ECIP meeting on 6.10.16. • Task and finish group to be established (including ECIP support) to review medical and nursing processes for senior decision maker to review patients in 90 mins, and decisions made within 180 mins . • Proactive monitoring around early use of escalation areas and internal escalation process.	30 October

University Hospitals of Leicester NHS
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Base Ward work stream summary

EQSG
12 October 2016

What has gone well?

- Completion of ‘SAFER’ Board round audit on the 2 exemplar wards.
- Stranded Patient audit completed – with mapping against ‘Red and Green’ day criteria

SRO update – position against RAP metrics

Action detail	Delivery date	Update	Metric target	Metric current	RAG
UHL to open additional emergency beds at the LRI to decrease bed capacity/demand mismatch	Ward open 1 November 2016	1. Estates work on ward 7 started on 14/9/16 2. Communications have gone out to all staff in September 3. Equipment ordered on 25/8/16 4. Nurse staffing rosters set up and shifts sent out agency on 08/08/16 5. There is a fortnightly meeting in place chaired by COO to progress 6. On Track to open November 1st (The main risk to opening remains staffing)	28 beds open on the ward	**0%**	
Implement SAFER patient flow bundle Trust wide	SAFER patient flow will be rolled out on two key wards by 01/11/2016	1. 29th August 2016 audit of 5 wards completed 2. Week of 19th September 2 further wards audited and data being collated for baseline 3. Resource for implementation of actions being identified	4.67	5.82 (average length of stay for Medicine)	
Implement Red Day / Green Day as part of SAFER	All actions complete by 14 November	1. Project team met 15/9/16 to plan implementation 2. Red Green criteria agreed 30.9.16 3.Launch days being planned throughout October 2. Stranded Patient Audit completed – Full review of 14 sets of notes with Red/Green day profiling	4.67	5.82 (average length of stay for Medicine)	

Next Steps

Describe what actions are being taken to improve performance against RAP amber/red metrics, to get them back on track

Action/Initiative	Next step	Revised delivery date
Awaiting Confirmation of criteria for Red and Green bed days	Criteria sent out for approval	Will not impact on delivery date
Implement – score boards to create a 'buzz'	Designing implementations tools/ working with staff	Will not impact on delivery date

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AMU work stream summary

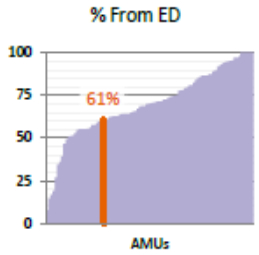
EQSG
26th October 2016

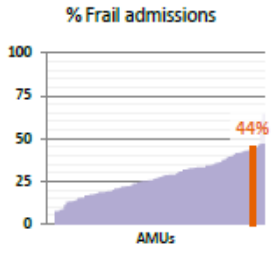
What has gone well?

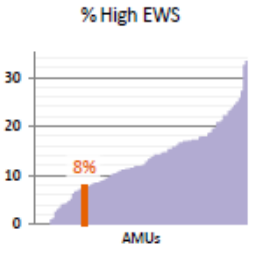
- E-referral for bed requests
- GPAU trial in “Yellow Majors”
- SAMBA
- Senior nurse taking calls to GPAU

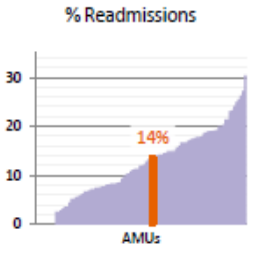
Leicester Royal Infirmary

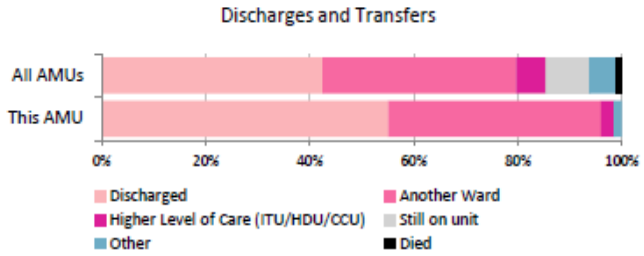
66 patients in audit (24 direct admissions)

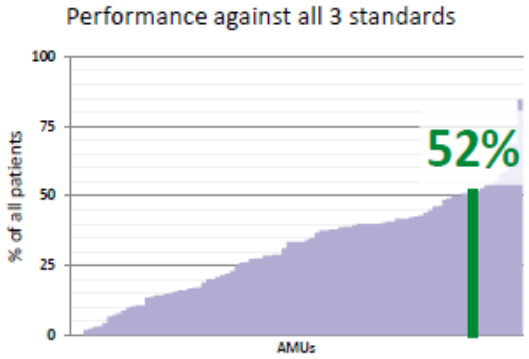


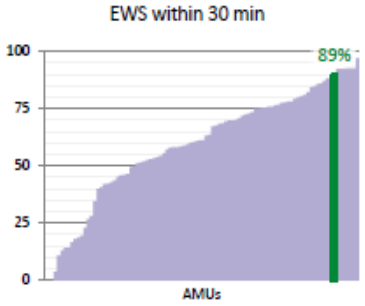


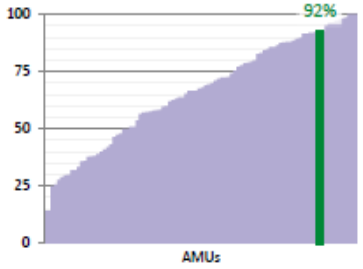


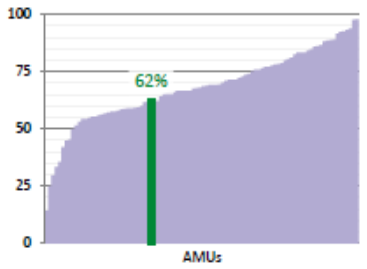




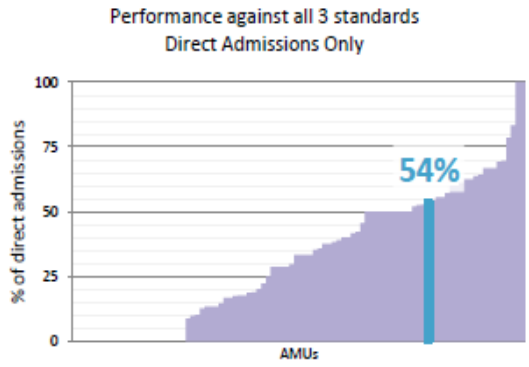


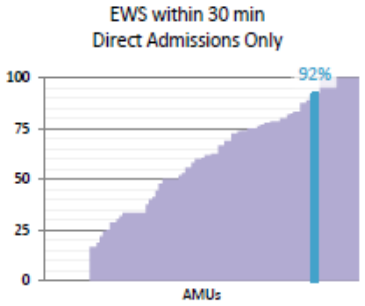


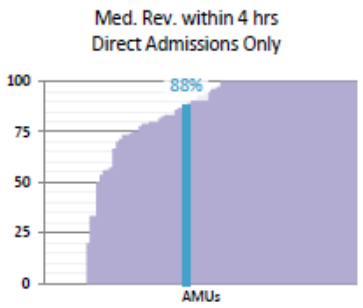


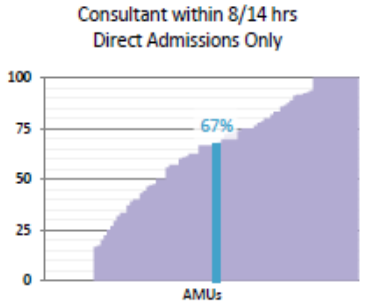


These charts show this AMU's performance compared to the other AMUs that participated in SAMBA 16.









SRO update – position against RAP metrics

Action detail	Delivery date	Update	Metric target	Metric current	RAG
% Beds Allocated within 60 minutes of the request		E-referral system embedded	90%	**67%**	
Proportion patients seen by a consultant in 14 hours		Communication to all nurses around data capture Discussion with HOS geriatrics around AFU Awaiting breakdown of performance by area	80%	64%	
Proportion of total patients admitted to AMU attending GPAU first		Recent GPAU trial in ED. Saw approx. 50% increase in admissions to that area. GPAU at saturation point. New model / venue agreed.	**33%**	**23%**	

Next Steps

Describe what actions are being taken to improve performance against RAP amber/red metrics, to get them back on track

Action/Initiative	Next step	Revised delivery date
Proportion of patients seen by consultant in 14 hours	Breakdown by clinical area to understand problem	9th November
Proportion of all patients first attending GPAU	Advertisement for Band 7 clinical navigator role (from within budget)	9th November
Proportion of all patients first attending GPAU	GPAU move to Yellow zone Use of 'old' GPAU area Pull from ED to yellow (off the clock) UCC to Yellow zone (off the clock)	7th November
Rapid flow (safer patient placement)	Work with Julie T to ensure this happens in November	30th November

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Clinical Decisions Unit

EQSG
24 October 2016

What has gone well?

- Agreement to go ahead with Low Risk Ambulatory Service from November 2016 to March 2017
- Significant reduction in cath lab waits from high of 27 (summer) to low of 0 (last week)
- Strong nursing clinical leadership for opening of Ward 23

SRO update – position against RAP metrics

Action detail	Delivery date	Update	Metric target	Metric current	RAG
Implement low risk ambulatory service on CDU	1/12/16	1. Business case complete 2. Meeting with commissioners 6.9.16 3. Total BCF funding identified £105k - awaiting confirmation from commissioners 4. Further conversations with the have CCG on 16/09/16 5. For discussion at Chief Officers meeting w/c 3rd October 6. Proposed approach and funding stream agreed; scheme being implemented as planned from 1 November.	Reduce LOS on CDU		
Decrease conveyance of Cardiorespiratory patients between LRI and Glenfield to increase EMAS capacity	30/11/16	1. Audit to be completed for all those patients sent direct the LRI to ascertain reasons by end of September 2. 2 FY2's have been identified to carry out audit on those patients transferred from LRI to gather evidence on process and define next steps.	Reduce conveyances from LRI to GH	107 in August 50 in September	
Glenfield to open additional beds to decrease bed capacity/demand mismatch	5/12/16	1. Communication to staff started 15th August 2016 2. Compiled list of equipment requirements - ordered w/c 18th Sept 3. Out to recruit for staff 4. Discussed with medical staff to provide cover 5. Funding agreed and phasing needs finalising 6. Equipment ordered 7. Weekly planning meeting in place	Open 28 beds on Ward 23	0	
1. Implement UHL Better Change project to decrease Cardiology inpatient LOS pre Cath Lab 2. Implement daily review of patients on monitored beds 3. Review capacity and demand of monitors available	11/11/16	1. Baseline data collection of cath lab waits complete 2. Implement electronic referrals for Cath lab complete 3. Implement Hot lab Cath lab sessions complete 4. Reaudit of Cath lab waits has been brought forward to October	Reduce Cardiology LOS	3.7	

Next Steps

Describe what actions are being taken to improve performance against RAP amber/red metrics, to get them back on track

None at present but we do have a potential risk that is being managed

Action/Initiative	Next step	Revised delivery date
Decrease conveyance of Cardiorespiratory patients between LRI and Glenfield to increase EMAS capacity	• Ensure timely analysis of audit results • Ensure timely development of action plan	No change at present

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

Board Assurance Framework:	Updated version as at: Oct-16		
Principal risk 3:	Emergency attendance/ admissions increase without a corresponding improvement in process and / or capacity	**Risk owner:**	Sam Leak, Director of Emergency Care and ESM
Strategic objective:	An effective and integrated emergency care system	**Objective owner:**	COO
Annual Priorities	Reduce ambulance handover delays in order to improve patient experience, care and safety. Fully utilise ambulatory care to reduce emergency admissions and reduce length of stay (including ICS). Develop a clear understanding of demand and capacity to support sustainable service delivery and to inform plans for addressing any gaps. Diagnose and reduce delays in the in-patient process to increase effective capacity Ensure whole system response to decreasing attendance and admissions	**Risk Assurance Rating**	Exec Board RAG Rating = EPB: 27/09/16

Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	5x5=25	5x5=25	5x5=25	5x5=25	5x5=25	5x5=25	5x5=25					
Target risk rating (I x L):	3x2=6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive / Preventative Controls NHS '111' helpline GP referrals Local/ National communication campaigns Winter surge plan Triage by Lakeside Health (from 3/11/15) for all walk-in patients to ED. (reduced resource by 50% May 2016 and ceases November 16) Urgent Care Centre (UCC) now managed by UHL from 31/10/15 Admissions avoidance directory Reworking of LLR urgent care RAP- as detailed in COO report **Detective Controls** Q&P report monitoring ED 4-hour waits, ambulance handover >30 mins and >60 mins, total attendances / admissions. UCB RAP being revised to ensure priority on decreasing attendance and admissions Comparative ED performance summaries showing total attendances and admissions.	ED 4 hour wait performance (threshold 95%) Poor performance continues to be primarily driven by increased ED attendances and emergency admissions but has also been contributed to by staffing issues (staff sickness and vacancies) Total attendances and admissions (compared to previous year) 1.% increase in emergency admissions 7% increase in total A&E attendances. Ambulance handover (threshold 0 delays over 30 mins) 29.0% over 30mins 12% over 60mins, 2.1% over 120 mins Difficulties continue in accessing beds from ED leading to congestion in ED and delayed ambulance handover.	National benchmarking of emergency care data New AE Delivery board chaired by CEO of UHL. RAP approved by NHSE and NHSI and being progressed by the new AE implementation group ECIP 3 day gap analysis in July and 2 days in August to review ward processes. intensive support predicted in October 1 Day ECIP review in October and new team expected to support delivery in November 2016	Lack of effectiveness of admissions avoidance plan Lack of effectiveness of attendance avoidance plan Lack of winter surge capacity

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
New LLR AE recovery plan to be progressed (as per the action dates on the plan) through the new AE recovery board.	See plan	see plan	Plan has been produced Confirm and challenge session on 14.9.16 AE Delivery Baord started 21.9.16 and will meet fortnightly New AE implementaion group started 12.10.16	4
Increased medical base ward capacity ward 7 (for medicine) and Ward 23a for Cardiology and respiratory	~~01/09/2016~~ Oct-16 Nov 1st and Dec 1st (respectively)	SL / COO	Plans being put in place to enable staffing of the wards Ward 7 delayed due to staff availability and maintance works on ward 42 which require ward 7 as a decant ward Nurse staffing ward 7 being reviewed weekly to determine if safe levels can be achieved to open part or all of the ward	3
Move to new build	Mar-17	SL / CF	Ensure pathway reconfiguration and workforce matches requirement to address this risk	4
Escalation areas in ED to be used proactivley	Nov 1st	SL	Currently escalation areas are staff dependent A change in bank rates to recruit more bank staff will allow more consistent and proactive opening of these areas.	4

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

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

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

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

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

Reasonable assurance rating:

Green	G	Effective controls in place and satisfactory outcomes of assurance received.
Amber	A	Effective controls thought to be in place but outcomes of assurances are uncertain / insufficient.
Red	R	New controls need to be introduced and monitoted and outcomes of assurances are not available to the Board.

Risk rating criteria:

Current Risk Rating: A reasonable estimate of the likely occurrence and likely consequence with the current control measures in place.

Target Risk Rating: A reasonable estimate of the likely occurrence and likely consequence with the current control measures and future actions applied.
Risk target (also referred to as residual risk) is the amount of risk that is accepted or tolerated, or the level that has been decided to manage a risk down to in an ideal world.
As the BAF is focussed on the risks to achieving its most important annual objectives the risk target score should be achieved when all actions are applied or by year end (31st March).

Impact / Consequence			Likelihood of occurrence	
5	Extreme	Catastrophic effect upon the objective, making it unachievable	5	Almost Certain (81%+)
4	Major	Significant effect upon the objective, thus making it extremely difficult/ costly to achieve	4	Likely (61% - 80%)
3	Moderate	Evident and material effect upon the objective, thus making it achievable only with some moderate difficulty/cost.	3	Possible (41% - 60%)
2	Minor	Small, but noticeable effect upon the objective, thus making it achievable with some minor difficulty/ cost.	2	Unlikely (20% - 40%)
1	Insignificant	Negligible effect upon the achievement of the objective.	1	Rare (Less than 20%)

Action tracker status:

5	Complete
4	On-track
3	Some delay. Expected to be completed as planned
2	Significant delay. Unlikely to be completed as planned.
1	Not yet commenced.
0	Objective revised.