UHL Emergency Performance

Author: Richard Mitchell, Chief Operating Officer paper F

Executive Summary

Context

University Hospitals of Leicester is under acute operational pressure because of the increasing emergency demand and capacity constraints. Ambulance handover delays are causing significant concern.

Questions

1. What are the drivers of the current issues?
2. Are the actions being taken sufficient to address these issues?
3. Does the Board agree with the new approach agreed at the Escalation meeting on 1st February?

Conclusion

1. The current position is caused fundamentally by an imbalance of demand and capacity. There are limited opportunities to increase bed capacity so the focus must be on reducing admissions. It was agreed at the Escalation meeting on 1st February that the LLR Plan should be refocused with that principal aim.
2. The report also updates on the importance of getting our demand and capacity planning right next year and being clear at the outset that there is a balance between the two.

Input Sought

The Board is invited to consider the issues and support the new 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: March 2016

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

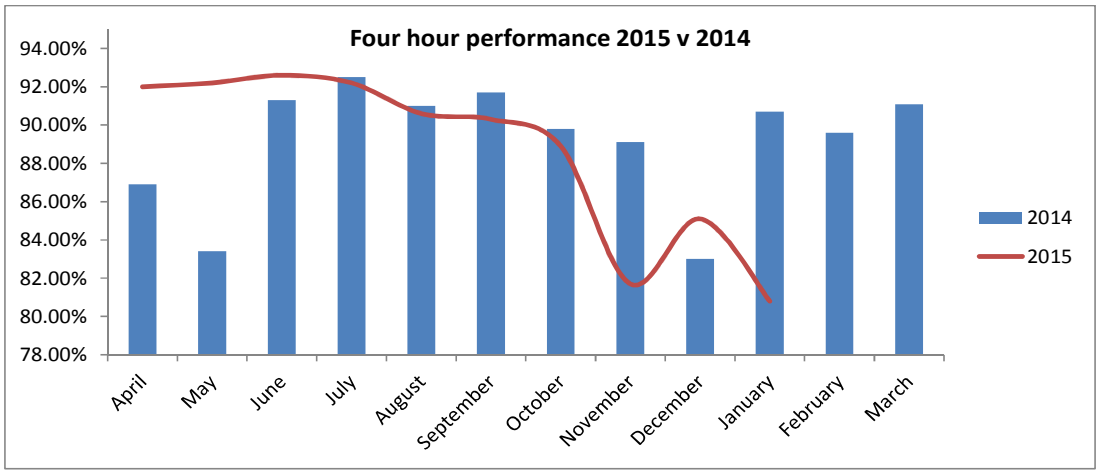
7.Papers should not exceed 7 pages. [My paper does comply]

REPORT TO:	**Trust Board**
REPORT FROM:	**Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT:	**Emergency Care Performance Report**
REPORT DATE:	**4 February 2016**

High level performance review

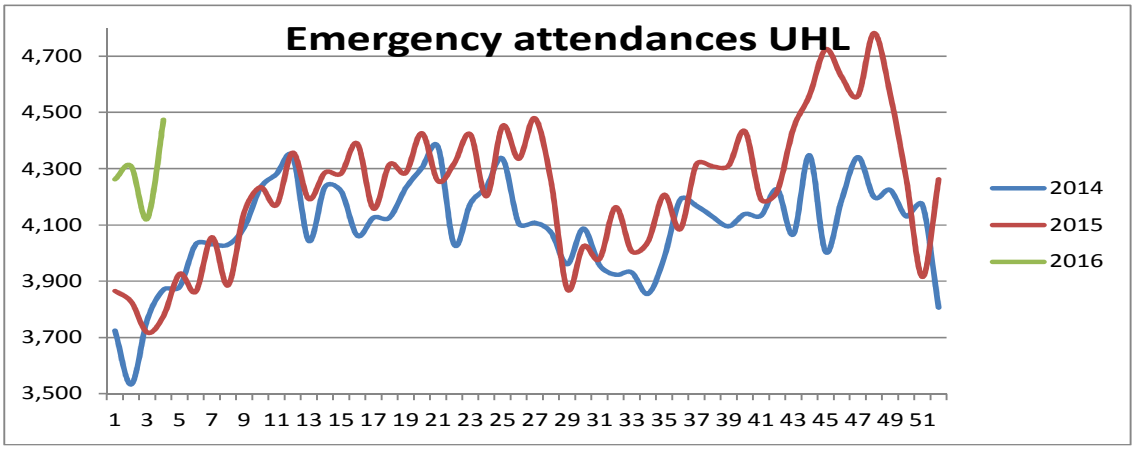
- (As of 29/1/16) 89.4% year to date (+0.7% on last year)
- Attendance +5.1%
- Admissions +6.5%
- Performance in January will be worse than the same month last year (80.7% v 90.3%)
- Performance remains consistently below 95%.

January has been a challenging month for emergency pressures across the Leicester, Leicestershire and Rutland (LLR) health system. Four hour performance for the month of January 2016 will be circa 10% worse than the same month last year and six of the last seven months have been worse than the corresponding months last year.



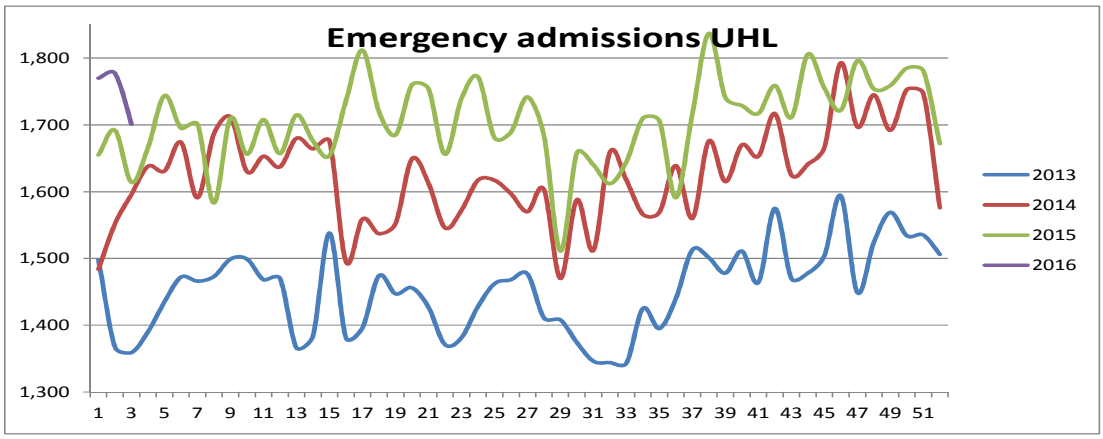
NB: 2014 is 1 April 2014 to 31 March 2015
2015 is 1 April 2015 to ytd

The deterioration in January 2016 is so poor that it is likely to be the worst month in over four years. Our problems continue to be primarily driven by two forms of demand; attendance and admissions. Attendance in January 2016 is 13% higher than the same month last year. On average 71 more patients per day are now attending LRI than the same time last year.



NB: 2014 is 1 Jan 2014 to 31 December 2014
2015 is 1 Jan 2015 to 31 December 2015
2016 is 1 Jan 2016 to ytd

Admissions are 5.8% higher than the same time last year and the general trend continues of each month having higher admissions than the corresponding month the previous year. On average we are now admitting 14 more emergency patients per day than the same time last year and 29 more patients per day than the same time two years ago.



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The high attendance and admissions inevitably have an impact on the quality of care provided to patients on the emergency and elective pathways. As has been publicised, despite the best efforts of EMAS crews and UHL staff, patients have been waiting too long for handovers at the LRI site and the occupancy in the emergency department has regularly been higher than we want. We have taken down a lot of elective (planned surgery) work in January to enable medicine to outlie their patients into a larger bed base. The challenges are not just at the LRI though, with the CDU at the Glenfield Hospital also experiencing record demand.

The challenges faced by UHL replicate the problems faced across the health system. Primary care, NHS 111, social services, EMAS and Leicester Partnership Trust all continue to experience high demand.

UHL action plan

As in previous months, the LLR action plan is attached for information. This includes the actions that UHL is taking both in the short term and longer term to improve performance.

Two key actions to update on are:

- We have been working closely with Lakeside partners and the Vanguard team on the improvements to the front door and UCC function. A detailed update is attached explaining the work that has been done, the impacts and how it compares to the original proposal.
- We have been working closely with EMAS on ambulance handover times which remain a very serious problem for the health system. A detailed report is attached and the updated actions are included in the flow section of the LLR action plan. Despite the right actions being identified and pursued there continues to be a disconnect with improvements in the handover times. This will remain a big focus of our activity for the coming months.

Demand and capacity

It is apparent that over the last couple of years demand for emergency services has increased. We predicted an increase in demand this year but for a range of reasons were unable to change our medical bed base to accommodate the demand changes. As detailed, this is now causing a lot of problems. Over the last month we have been working closely with our commissioners and Vanguard team to agree the expected demand for 2016-17. The modelling from this will be presented to members of the Trust Board in February and will come to Trust Board in March 2016 with a plan as to how the gap between demand and capacity will be closed.

The actions we will take over the next couple of months to address the current capacity imbalance include:

- Improving use of ICS beds by GPs, UHL and or LPT referring to them
- Moving the ambulatory clinic downstairs to be collocated with the UCC
- Improvements to the front door

At present, we have a gap between our predicted demand and capacity next year. Medical length of stay has reduced by 16% in the last year and we need to be cautious with beliefs about further dramatic gains next year. Nevertheless, we must have the mind-set that demand and capacity must be balanced in 2016/17, including the impact of reconfiguration changes.

Other actions for 2016

One of the options that we need to consider is increasing our bed capacity to match demand but there are other actions that must also be taken. These include:

- **Admission avoidance** – ensuring people receive care in the setting best suited to their needs rather than the Emergency Department. This includes maximising our own use of alternatives to admission (i.e. ambulatory pathways).
- **Preventative care** – putting more emphasis on helping people to stay well with particular support to those with known long-term conditions or complex needs.
- **Discharge processes across whole system** - ensuring there are simple discharge pathways with swift and efficient transfers of care.

As stated previously, to achieve sustainable improvement requires all parts of the health economy to improve. The fragile nature of the pathway means that slow adoption of improvements in one part of the health economy will hinder the overall improvement.

Update from Sub-Regional Escalation meeting

On 1st February a Sub-Regional Escalation meeting was held in the light of poor four hour and ambulance handover performance. This meeting involved the Managing Directors of the three LLR CCGs, the Chief Executive of UHL and senior representatives from the NHS TDA and NHS England. The meeting concluded that although there are many sound actions in the current LLR Plan, it has become too large and insufficiently focussed on the actions that will make the most difference. It was further acknowledged that the key problem is the level of emergency admissions to UHL (and the resulting capacity shortfall), as detailed earlier in this report. The plan is therefore to be completely refreshed with the principal aim of reducing the level of emergency admissions. This refocussing has the potential to make the plan more effective but will require concerted and rapid effort by all partners, including UHL.

Given that the main cause of ambulance handover delays is lack of flow out of ED, it follows that the better balance of demand and capacity that will be generated by lower admissions will help with these delays. There is however also a particular bottleneck in the ED assessment bay (to which ambulance crews first present with their patients). It was therefore agreed at the esclation meeting that a secondary focus of the refreshed plan would be to minimise the number of patients going through the assessment bay, for example by increasing the number of patients referred from the UCC who go direct to other areas and by suitable ambulance patients being streamed to the UCC.

The above approach is to be progressed at the Urgent Care Board on 4th February with the aim of having the new plan in place by 17th February. It should also be noted that ambulance handover delays were the principal outstanding concern at the Risk Summit, also held on 1st Febaruary (and originally convened to oversee action to comply with the CQC conditions on our registration). The actions included in the report appended to this report

were supported; it is therefore essential that we fully implement these in accordance with the timescales shown.

Recommendations

The Trust Board is recommended to:

- **Note** the contents of the report
- **Note** the continuing concerns about ambulance handover delays in particular
- **Note** and comment on the new approach to tackling these issues agreed at the Escalation meeting

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EAST MIDLANDS AMBULANCE SERVICE NHS TRUST

REPORT ON ACTIONS TO REDUCE AMBULANCE HANDOVER DELAYS

Introduction

This report describes the actions being taken by UHL and EMAS to reduce handover delays at the Leicester Royal Infirmary. These actions form part of the larger LLR UEC Recovery Plan but are described in narrative form here for ease of reference and to allow a fuller explanation of the rationale behind each action and any issues with their implementation. It is also intended that this presentation will allow the UCB, NTDA and NHSE to more readily sense-check these actions and make further suggestions as appropriate. Because of the urgency of the situation, the bulk of timescales focus on the very short term.

It must be recognised that the most significant cause of handover delays is an imbalance between demand and bed capacity. In the short term, there is limited scope to address this but it will be essential to get this balance right in 2016/17 in order to ensure sustained improvement. In the meantime, the actions in this report focus on optimising processes once patients arrive at the LRI. Wider actions to reduce attendances and improve downstream flow can be found in the relevant sections of the full LLR plan.

The success or otherwise of these actions can be readily judged by whether handover delays are significantly reduced or not. The aim is to eliminate very long delays and to reduce average time to handover towards the 15 minute standard. A bespoke report will be prepared to allow this to be assessed (using EMAS data). This will supplement the regular reports already produced by EMAS.

The actions below are listed in broadly logical groups rather than by significance of impact. Please also note that actions to continue to develop the new Front Door/UCC are the subject of a separate report to UCB. These actions will assist in further reducing flow to ED.

Data capture

Rationale: It is essential to have accurate, jointly accepted, reporting of handover times in order to be able to focus on improvement action rather than arguments about data validity. It has been agreed that the most accurate recording method is CAD + where EMAS and UHL staff jointly input the time of handover into the EMAS CAD system using PIN numbers. At present only 50 % of journeys are captured in this way.

Action: Ensure that all EMAS crews have PIN numbers and use the CAD + system for every handover.

Responsibility: EMAS (RH)

By: 29/1/16

Action: Ensure that all assessing nurses ask EMAS staff to use CAD + to record handover time.

Responsibility: UHL (MM)

By: 29/1/16

Action: Monitor completeness of CAD + data through EMAS daily handover report and take remedial action if coverage does not improve rapidly.

Responsibility: UHL and EMAS (RM and RH/JD)

By: Immediate with report to CEOs fortnightly re trends.

Assessment process

Rationale: Although the principal cause of long handover delays is ED exit block, which in turn causes assessment bay exit block, it is recognised that the current assessment process is inconsistent and has the potential to be speeded up, thus improving overall handover times.

Action; Undertake a review of the ED assessment process against the ECIST Rapid Assessment model and develop an action plan to ensure compliance with that model.

Responsibility: UHL (SM-K/SL)

By: 28/1/16

Assessment staffing

Rationale: To maximise flow, it is important to ensure that staffing is flexed to match predicted demand as far as possible. This can be done by adjusting the staffing on each shift and by staggering the timing of shift changes and breaks.

Action: Review assessment bay staffing to check matching to demand and staggering of shift changes and breaks (further actions will depend on results of review).

Responsibility: UHL (MM)

By: 28/1/16

Nurse staffing structure

Rationale: Initial review has shown that there is the potential to improve nursing skill-mix (and thus flow) by adjusting the ED nurse staffing structure.

Action: Complete the current review and make recommendations for change.

Responsibility: UHL (MM)

By: 5/2/16

Action: Implement recommendations of review

Responsibility: UHL (MM)

By: 1/4/16

HALO Role

Rationale: The EMAS HALO provides a key role at times of escalation and handover delays in improving the co-ordination between EMAS and UHL staff and in agreeing actions to free up ambulances to respond to new calls.

Action: Redefine the role of the HALO and who should undertake it and undertake a rapid cycle test of the HALO working with an ED Consultant/Acute Physician at time of escalation to expedite flow.

Responsibility: EMAS (RM/JD) and UHL (SL)

By: 17/2/16

Ambulance streaming to UCC

Rationale: At present, a limited number of ambulance patients are taken directly to the UCC, but there is no SOP or standard clinical criteria covering this. This means that this approach may be under-utilised, routing patients unnecessarily through ED assessment.

Action: Agree and implement a direct streaming SOP.

Responsibility: UHL (SL) and EMAS (JD/RH)

Pre-assessment cohorting:

Rationale: When there is exit block or other delays in the assessment bay, there are 4 patient spaces (the “red zone”) where patients can be held awaiting assessment. If additional staffing resources can be identified, the ambulance crews looking after those patients can be released.

Action: Trial the deployment of a private ambulance crew (contracted by EMAS) and an HCA (provided by UHL) to care for patients in the “red zone” (subject to satisfactory prior risk assessment signed off by EMAS and UHL).

Responsibility: EMAS (RH/JD) and UHL (SL)

By: 17/2/16

Pre-admission cohorting

Rationale: Pre-admission cohorting increases the effective capacity of the ED when there is exit block. Two pre-admission cohorting areas have been identified and a SOP is in place governing their use, including triggers. These triggers have recently been widened. Together the areas have the capacity to hold up to 8 patients. Staffing is provided through Medicine and ED.

Action: Monitor the use of the cohorting areas and provide a fortnightly report to the CEOs, covering numbers of patients cohorted in each area, the relationship to handover times and any issues (including safety issues) arising.

Responsibility: UHL (RM) and EMAS (RH/JD)

By: First report by 1/2/16 then fortnightly

Handover delay escalation

Rationale: When there are delays, it is important that all possible resources are brought to bear to improve the situation. One way to ensure that this happens is to have an escalation system in place. The current system (in force since 14/1/16) requires escalation of any threatened 2 hour plus delays to the UHL CEO, 24/7. It is intended that the 2 hour plus threshold will be reduced over time, consistent with having a workable protocol.

Action: Monitor compliance with protocol via daily handover report and review potential to reduce threshold.

Responsibility: UHL (JA)

By: Immediate

Ambulatory acute assessment;

Rationale: The Acute Assessment Unit (AAU) is currently located on the 5th floor of the Balmoral building and has limited capacity/hours. This limits the proportion of patients who can be dealt with in an ambulatory setting and thus reduces available bed capacity on the main assessment units, increasing the frequency of ED exit block.

Action: Relocate the AAU to the UCC and expand capacity (business case has been approved)

Responsibility: UHL (SL)

By: 29/2/16

Diversion of all attenders from GPs

Rationale: The limited capacity of the ED assessment bay means that it is essential to minimise the number of patients who go through it. GP admissions booked via Bed Bureau go direct to AMU whenever there is capacity (see above re increasing that capacity). However some patients come to ED from their GP (with or without a letter).

Action: Redirect all attenders from GPs to the UCC

Responsibility: UHL (JD)

By: In place; regular monitoring

Accelerated flow

Rationale: Analysis has shown that there is often a long time lag between when beds become available on the base wards and when patients actually move out of ED. Two rapid cycle tests have demonstrated the benefits that can be gained from having a dedicated team to move patients, alongside other process changes.

Action: Recruit team (already in progress) and implement Accelerated Flow process on an ongoing basis.

Responsibility: UHL (JD)

By: 15/2/16 (or earlier if staff in post)

22/1/16 – V2

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Caring at its best

ED Streaming Service and UCC Patient Outcomes – Nov and Dec 2015

Data for November and December has been analysed to review the impact of Lakeside:

- 73% (13,636) of patients were seen between the hours of 9am and 9pm (opening hours of Lakeside)
- Of the patients seen by Lakeside, 33% of patients were directed to Minors (25%) or Majors (8%). In comparison, out of hours 35% of patients were directed to Minors (21%) or Majors (13%)
- The greatest pressure for ED is patients arriving through Assessment Bay to Majors, therefore the reduction in transfers to Majors by Lakeside is beneficial, equating to approximately 12 patients per day
- The proportion of patients transferred to Resus (1%), Leicester Royal Infirmary, Leicester General and Glenfield are similar with no material difference in proportions
- Of the patients seen by Lakeside, 55% were treated in UCC or redirected back to their GP. In comparison, out of hours 53% were treated in UCC or redirected
- In hours patients spent 52 minutes on average within the service.

December 2014 v December 2015 comparison

	Dec-14		Dec-15		Vol
Activity	6068		6821		753
Discharge home	3097	51%	3411	50%	314
Left before treatment	232	4%	89	1%	-143
Admitted	370	6%	498	7%	128
Refer to other	2261	37%	2580	38%	319

- Demand increased by 12% Dec- Dec (753 patients)
- Percentage of patients on each pathway has not changed
- Vol of patients on deflection pathway has increased (314 patients)
- Fewer patients and reworked process in UCC has identified GP time that can be used for other activities.

Next Steps

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- Introduction of a GP based at reception to assess all admissions from the Urgent Care Centre. This will ensure the appropriateness of admissions and the correct pathways are followed. This has been implemented in January 2016.

- The UCC is looking to implement near patient testing to the UCC. This is expected to have a significant impact on the number of patients referred to minors and majors. Date TBC

- All pathways are currently under review for clinical appropriateness. This is expected to be completed by March 2016.

- Implementing ICE requests for testing and imaging. This will allow patients to return to the UCC once tests have been completed for treatment without a referral to minors. This will also reduce delays for patients that are referred to minors or admitted to the hospitals. Set to be completed by Feb 2016.

- Introducing injury trained practitioners to reduce referrals to minors.

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Benefits of front door change – Sep 2015

- A single front door for all walking urgent and emergency attendances at the UHL site (building on the model in place at present)
- Consistent, timely and rigorous assessment of urgency of patient needs by senior clinicians
- Clinically appropriate, timely streaming to all streams of ED (including UCC)
- Improved clinical confidence between the Urgent Care Streaming and ED, which will improve access to Acute Medicine and ED ambulatory streams meaning further patients will bypass the assessment bay and majors, reducing multiple assessment e.g. patients could be admitted directly from Urgent Care Streaming by the urgent care clinician to EDU if they met the current admission criteria – e.g. renal colic pathway
- Patients arriving in the Injuries & Majors streams will have appropriate investigations and/or treatment instigated at the point of referral, reducing waste and the amount of time patients spend in the department – this will have a significant impact on the injuries stream in particular, improving 4 hour ED performance.
- Workforce efficiencies, including for the UCC which currently requires a transfer nurse (funded through non-recurrent winter monies) and additional portering
- Reduces over-crowding of the ED department, which will help to improve ambulance turnaround times (due to less congestion in the Assessment Bay).
- Dual booking onto UCC and ED IT systems in order to remove duplication in booking processes for patients therefore enhancing patient experience and improving transparency of the whole site and allowing diagnostics to be ordered on UHL systems.
- Greater confidence from specialty teams in direct referrals such that they go directly to assessment units rather than ED
- Contribution to service development of frail-elderly attendances at the ED via admission avoidance & interaction with EFU. This will involve working closely with the community older persons unit (OPU) at Loughborough Community Hospital.
- Makes better use of 'clinical time' before breach pressures exist and consequently better clinical decision making which is likely to include reduced onward admission.

Group	Objective	Action area	Delivery description & detail	Senior accountable lead	Delivery date	Expected impact	Activity Monitoring	Delivery Status	Progress to date
Inflow	1.1 To provide consistent and useable information to enable patients to make informed choices about when and how to access the most appropriate urgent and emergency care service	1.1.1 - Targeted Patient Information campaigns	CCGs reviewing potential to increase flu vacc uptake; LC offering vaccination to patients with a BMI >40 and their care homes workforce **ELR CCG are targeting through General Practice and Urgent Care Centres Flu Vaccinations for key workers and vulnerable patients**	R Vyas (LC CCG) / I Potter (WL CCG) / D Eden (ELR CCG)	LC - Nov 2015 WL - 21/12/2015 ELR -Commenced	Reduced risk of major flu epidemic	Increase in uptake of flu vaccs in targeted groups. CCGs baselines @ 31/10/2015 for Over 65y (target 75%) / Under 65y (target to increase on 2014/15 of 49.6%); LC - 61.5% / 36.6% WL - 60.6% / 32.7% ELR - 62.3% / 33.8%	3. Some delay – expected to be completed as planned	LC care homes workers initiative completed. Patients with a BMI >40 to commence (Rach to advise date) LC scheme details being reviewed by WL and ELR with a view to implementation Review completed in WL - to trial care homes workers initiative from mid-January 2016 **Update 27/01: ELR pushing through GPs and UCCs care home staff vaccination and vulnerable patients to increase uptake**
Inflow	1.1 To provide consistent and useable information to enable patients to make informed choices about when and how to access the most appropriate urgent and emergency care service	1.1.1 - Targeted Patient Information campaigns	To deliver Stay Well (inc Flu) outreach campaign across LLR targeting hard to reach and at risk groups, carers, parents of children 0-10y, Partnership with voluntary sector and GEM outreach - ways to stay well, appropriate attendance locally per CCG Series of local public events Dec 2015 - Feb 2016	R Crabb (LLR Urgent Care)	Dec 2015 - Feb 2016	Increase public awareness of alternatives available	Target cohorts for outreach campaign per CCG to include; Parents of 0-5y, patients 65+y, LTC, carers groups, Age UK contacts, multiple deprivations Niche voluntary sector groups will in-reach to moderate/frequent flyers who are low volume high impact users	4. On track	PPG quarterly mtgs + monthly mini mtgs going forward WL network event Feb 2016 ELR PRGs event 22/01/2016 for cascading Outreach campaign commenced in WL Nov 2015 To undertake cross-referencing exercise during December for the identified lists with the hard to reach moderate/frequent flyers LC - specific info on stay well/norovirus/cold weather/hubs sent out via daily social media feed and via engagement forums across City. Specific focus on cold weather during weeks 12/01 onwards - special 'cold weather alert' edition of newsletter sent to 5000 people and uploaded onto website. Volunteers in UCC Le for pilot week from 18/01 - 63 questionnaires completed on day 1
Inflow	1.1 To provide consistent and useable information to enable patients to make informed choices about when and how to access the most appropriate urgent and emergency care service	1.1.1 - Targeted Patient Information campaigns	To develop consistent patient information for each UCC, WIC, City Hubs, ED Streaming Service, CRT, AVS, OPU To be disseminated in leaflet format; Artwork confirmed 11/12/2015 Distribution of info w/c 14/12/2015 Implement PDSA for direct public engagement @ LRI campus	R Crabb (LLR Urgent Care)	w/c 14/12/2015	All front line clinicians to hand to patients at the end of their clinical consultation Increase public awareness of alternatives available	No of leaflets handed out and patient contacts made @ LRI campus, UCC Lo, City Hubs, EMAS See & Treat calls and CRT/AVS visits Baseline - not currently monitored Aiming for 100% distribution rate Average distribution per week based on current activity circa; UCC Le - 2,000 UCC Lo - 700 UCC Oadby - Rich Crabb to advise EMAS S&T - TBA CRT - 600 AVS - 350	6. Complete and regular review	Discussion with printers complete and artwork confirmed GEM comms staff to undertake direct public engagement PILs distributed w/c 21/12/2015 Regular push at each provider site via e-mail UHL have not yet distributed any PILs Leaflet PDF distribution to GPs via electronic comms 22/01/2016
Inflow	1.1 To provide consistent and useable information to enable patients to make informed choices about when and how to access the most appropriate urgent and emergency care service	1.1.2 - Roll out Patient service navigation app 'NHS Now'	Roll out to LC and WL CCGs: Review information databases Develop marketing & comms Go live	R Vyas (LC CCG) / I Potter (WL CCG)	w/c 07/12/2015 w/c 14/12/2015 w/c 21/12/2015	Increase awareness & utilisation of alternatives	Anticipating 1000 downloads per week across LLR over next four weeks	2. Significant delay – unlikely to be completed as planned	ELR to write analytics and advise of downloads as hosts of the app. Update 05/01 - analytics available from 11/1/16 WL data further updated over Christmas 2015. Now on hold for WL & LC pending resolution to inaccuracy of data Work progressing for an API to allow the App + MDoS (+ later NHS Choices) to link + become integrated + direct access for providers to maintain their own DoS entries Temporary manual updates of the DoS snapshot data feed are required - WL now done + LC to be done by 12/01/2016 Wave 2 T+FG to link to live waiting times **(this is being investigated, but may not be possible. IT developers working on this)**
Inflow	1.1 To provide consistent and useable information to enable patients to make informed choices about when and how to access the most appropriate urgent and emergency care service	1.1.2 - Roll out Patient service navigation app 'NHS Now'	Pilot launch and refinement in EL&R	T Sacks (ELR CCG)	30/11/2015	Increase awareness & utilisation of alternatives	ELR baseline 600 downloads in first 2w	5. Complete	App fully rolled out across LLR Work progressing for an API to allow the App + MDoS (+ later NHS Choices) to link + become integrated + direct access for providers to maintain their own DoS entries Wave 2 T+FG to link to live waiting times - mtg w/c 08/02 **Update: API being tested to ensure that all data is directly linked between APP / DOS and NHS Choices. This will keep all data immediatley up to date. Aim to assess the IG implications and accuaracy by end January.**
Inflow	1.1 To provide consistent and useable information to enable patients to make informed choices about when and how to access the most appropriate urgent and emergency care service	1.1.2 - Roll out Patient service navigation app 'NHS Now'	Explore link to real time waiting information for ED/UCC services	Tim Sacks (ELR CCG)	31/03/2016	Increase awareness & utilisation of alternatives	Monitoring on a weekly basis of hits per CCG	5. Complete	To be added to Phase 2 as functionality not available for Phase 1 Discussions commenced with TPP re: availability of data feed - awaiting their confirmation Not for further pursual as the App does not require 3G/4G/WiFi but the link to waiting times does

Inflow	1.2 To improve 7 day urgent access (same/next day) to primary care services	1.2.1 - Extended GP services	Leicester City CCG: Hubs hours of operation M-F 18:30-22:00 S-S 09:00-22:00 Increasing utilisation of City Hubs; Continue application of comms strategy Implement remote booking by EDSS Implement remote booking by NHS111	S Prema (LC CCG)	Weekly Weekly Live from 23/11/2015	Decrease in ED attendance/Increased access primary care	1,700 available per week. Last four weeks utilisation: 701/1740 40.3% 623/2120 29.4% (inc capacity for Xmas) 978/2500 39.1% (inc capacity for Xmas) 792/1740 45.5% Leic City patient passports linked to Hubs and CRT from w/c 18/01/2016	3. Some delay – expected to be completed as planned	• Weekly utilisation for last four weeks was: o W/C 14.12.15 - 40.3% o W/C 21.12.15 - 29.4% o W/C 28.12.15 - 39.1% o W/C 04.01.15 - 45.5% • 111 remote/direct booking already live. • Telephone booking for EDSS already live. • Training at EDSS occurring on 20.01.16 for remote/direct booking with go live by 22.01.16. • CCG/Federation early project evaluation being developed for 28.01.16.
Inflow	1.2 To improve 7 day urgent access (same/next day) to primary care services	1.2.1 - Extended GP services	ELR CCG: Coverage of total ELR population increased from 10% to 30% (95,000 patients) in Dec 2015. This equates to 3%-5% (2,850 to 4,750) complex patients who have weekend access	T Sacks (ELR CCG)	21/12/2015	Reduction in ED attendance and EA for at risk cohort	Supporting an anticipated 50 patient contacts per weekend day	**4. On track**	**Service commenced for all 4 sites on 22/1/2016**
Inflow	1.2 To improve 7 day urgent access (same/next day) to primary care services	1.2.1 - Extended GP services	West Leics CCG: Implement West Leics GP on the day access scheme	A Bright (WL CCG)	07/12/2015	Increased availability of appointments	Expected 85% uptake by general practice which would give additional 235 appointments per day	4. On track	Spec to all WL practices 03/12/2015 Confirmation of practice uptake by 14/12/2015 Current position @ 04/01/2016 48 of the 49 practices have confirmed participation, giving 1,899 additional appts per week
Inflow	1.2 To improve 7 day urgent access (same/next day) to primary care services	1.2.1 - Extended GP services	West Leics CCG: Hours of operation 08:00-22:00 Implement West Leics primary care weekend access scheme targeting 2% at risk / end of life / moderate-frequent flyer patients	A Bright (WL CCG)	05/12/2015	Reduction in ED attendance and EA for at risk cohort	Can accommodate up to 100 extra patient contacts per weekend Will monitor the number of patient passports issued	6. Complete and regular review	Federations all signed up Implemented service 05/12/2015 in conjunction with AVS - 1000 passports issued in early January.
Inflow	1.3 To extend range and timing of alternative UCC services for immediate but non-life treatening conditions	1.3.1 - Urgent home visiting service (Clinical Response Team /Acute Visiting Service) including direct referrals from care homes	LC CCG & WL CCG: Optimise appropriateness of use of existing SSAFA CRT and AVS services by; ECPs to undertake daily audit of referrals SSAFA to inform CCGs weekly of any inappropriate use CCGs leads to contact practices directly to discuss WL to submit BCF request for funding of 1 WTE ECP for dedicated triage to allow extended daily coverage Extend AVS West Leics hours of operation at weekends	A Bright (WL CCG) / S Prema (LC CCG)	Monthly review 08/12/2015 05/12/2015	Urgent home visit requests earlier in the day, reduction in care home calls to EMAS	Monthly monitoring Current utilisation as at 31/10/2015; LC - 611 visits per month of 502 contracted capacity WL - 340 visits per month of 350 capacity Additional appoinments offered and utilised Linked to the WL Weekend Access Scheme to see 100 extra patients per weekend	4. On track	Enhanced phone system and dedicated triage within CRT & AVS Address the highest and lowest GP practice users to target both inappropriate referrals and under-utilisation ELR SSAFA service commencement 18/01/2016 WL shared data on comparative usage of AVS @ Dec 2015 locality mtgs SSAFA additional WL ECP from 18/01/2016 WL audit completed re: appropriateness of referrals - awaiting report LC: care home proactive element of CRT also has activity increasing with 650 patients identified for review. Care home admissions trend for City showing a downward trend but not causally linked to this scheme at this
Inflow	1.3 To extend range and timing of alternative UCC services for immediate but non-life treatening conditions	1.3.1 - Urgent home visiting service (Crisis Referral Team /Acute Visiting Service) including direct referrals from care homes	ELR CCG: Establish ELR in-car visiting service by; Activity review to inform pilot area Identify level of funding to requested through BCF Identify workforce Implement for trial	T Sacks (ELR CCG)	01/12/2015 08/12/2015 09/12/2015 18/01/2016	Urgent home visit requests earlier in the day, reduction in care home calls to EMAS	Anticipated 100 patient contacts per month to Service	4. On track	An initial area of Oadby/Wigston/Blaby/LFE identified BCF funding application approved ELR SSAFA service commencement 18/01/2016 WL to share comms with ELR in preparation for launch with GPs **Fully signed off and commencing 1/2/16 covering 50% ELR CCG population**
Inflow	1.3 To extend range and timing of alternative UCC services for immediate but non-life treatening conditions	1.3.2 - Implement Loughborough UCC extended care pathways	Maximise appropriate use of increased specialist medical cover 9am - 10pm Monday-Friday, 10am - 10pm at weekends to allow increased referrals from GPs, AVS and EMAS WL to go back to GPs to discuss low activity + patient needs going forward UCC Lo clinicians to ride with EMAS crews to promote referrals to UCCs during Dec-Jan Simon / Dan to agree paperwork + rota plan	C Tierney-Reed (WL CCG) S Court (CNCS) / Dan Webster (EMAS)	01/11/2015 31/01/2016	Reduction in referrals to ED for ambulatory conditions	Number of referrals to extended pathways; Phased trajectory of avoidable emergency attends Nov 2015 - anticipated 130, actual 30 Cumulative total of extended pathways capacity at 31/03/2016 anticipated to be 850, of which 450 would be avoidable emergency attends No. of EMAS shifts attended by UCC clinicians Utilisation of UCC Lo for Oct 2015 was 3,604 appts vs capacity of 3,750 appts	4. On track	Updated EMAS Pathfinder and NHS111 DoS Weekly monitoring of use of extended pathways UCC Lo staff to ride with EMAS crews throughout Feb 2016
Inflow	1.3 To extend range and timing of alternative UCC services for immediate but non-life treatening conditions	1.3.3 - Increase referrals from OOH GPs to alternative services	Communication to OOH GPs regarding UCC Lo enhanced GP pathways has been done Weekly review of ED attendances following OOH contact within preceeding 24h - Rob H. to define process inc. no. of times care plan is accessed Reinforce all LLR non-ED options available to OOH GPs Improve internal tracking of referrals by OOH GPs - Rob H. to define process	R Haines (CNCS)	14/12/2015 15/12/2015 15/12/2015 14/12/2015	Increased use of alternatives to admission by OOH GPs	Increased utilisation of alternatives to admission above current baseline position Current baseline TBC Weekly monitoring of final patient dispositions; telephone consult face to face consult referral to OOH clinic, UCC, ED, CRT, social care	2. Significant delay – unlikely to be completed as planned	Active comms channel now established with OOH GPs Updated service directory distributed to all OOH GPs Internal tracking for patient informational outcomes now established First report due for 12/02/2016

Inflow	1.3 To extend range and timing of alternative UCC services for immediate but non-life treatening conditions	1.3.4 - ELR CCGs 4 Urgent Care Centres	Deliver increased utilisation of appts Winter 2015/16 compared to Winter 2014/15	T Sacks (ELR CCG)	18/12/2015	Reduction in referrals to ED	Utilisation of 3,200 additional appointments available 18/12/2015 - 31/01/2016 than last Winter - 1,000 extra patients seen Reduction in LLR and OOA ED attendances at peripheral hospitals over the Christmas & New Year period	6. Complete and regular review	Weekly utilisation to be demonstrated within enhanced Inflow Dashboard ELR to scope potential for increased capacity @ Oadby site **Update: 27/1/16. Over the Dec/Jan period over 1600 more patients seen than the previous period in 14/15. New and additional Triage Nurse ANP in place in Oadby since 24th December. Increased capacity and 98% patients now seen treated and discharged within 2 hours**
Inflow	1.3 To extend range and timing of alternative UCC services for immediate but non-life treatening conditions	1.3.5 - Implementation of live waiting times data feeds for the public to access	Web page, with URL links available for other devices to use, showing the live waiting time at each LLR UCC/WIC	R Crabb (LLR Urgent Care)	11..01.16	Reduction in self-referrals to ED	Once service commenced, to monitor no. of hits TPP analyst w/c 11/01/2016 to assess viability + timeframe Possible private URL for clinicians only to see UCC Le waiting times	3. Some delay – expected to be completed as planned	Adastra feed available UHL feed available but still outstanding TPP to advise of timescale by 22/01 re: information feed for SystmOne sites
Inflow	1.4 To reduce EMAS conveyance to LRI	1.4.1 - Implement mobile device (smartphone) with MDoS access	Rapid roll out across LLR crews with link to live waiting times web page, 400 front line staff to have use of devices.	L Brentnall (EMAS)	Jan-Mar 2016	Awareness for crews of alternatives to admission	Increased utilisation of alternatives to admission above current baseline by front line staff	4. On track	Phones purchased SOP signed off Set up of phones and roll out over coming weeks on plan Roll out complete by March 2016
Inflow	1.4 To reduce EMAS conveyance to LRI	1.4.2 - Increase use of alternatives to admission by EMAS crews by referral to UCC Lo and OPU, ELR UCCs, LC Hubs and use of Falls Pathway	EMAS CAT to be able to directly book into City Hubs All new services to align to Pathfinder outcomes ELR UCCs to confirm that they capture direct and indirect EMAS referrals	Dan Webster (EMAS)	weekly review 14/12/2015	Increased use of alternatives to admission by EMAS crews	EMAS to develop own metric for reduction of conveyances to ED/UCCs Current baseline for use of alternatives by EMAS crews @ Oct 2015; UCC Le - 0 (not currently measured) WIC Le - 0 (not currently measured) UCC Lo - 33 (target 40) OPU - 4 (target 18) AVS - 1 (target 40) CRT - TBA LC Hubs - 0 (not currently measured) UCCs ELR - 0 (not currently measured) Falls Pathway - 55% 60%	2. Significant delay – unlikely to be completed as planned	EMAS to devlop own metric for reduction of conveyances to UHL ED. EMAS (WL) doing ground work on proposal to increase nursing capacity in CAT EMAS metrics still outstanding SLS meeting with MCK 22/01 to discuss pathway from EMAS CAT to Hubs ELR still to confirm data captures
Inflow	1.4 To reduce EMAS conveyance to LRI	1.4.3 - SSAFA to be reflected as a Pathfinder disposition	Include AVS/CRT as alternative service on version2	Dan Webster (EMAS)	14/12/2015	Referrals by EMAS to SSAFA	see above	6. Complete and regular review	Pending the new Pathfinder booklet, we have provided our crews and clinicians with a local directory of services including AVS, CRT and back-office GP numbers.
Inflow	1.4 To reduce EMAS conveyance to LRI	1.4.4 - Develop process to enable EMAS access to GP medical opinion and prescriptions; In hours Out of hours Circulate Service description to all front line staff (daily to ensure all EMAS shifts covered)	In hours via UCC Lo enhanced GP resource as a pilot (assuming CNCS CG approval) Out of hours via the CNCS HCP line	Dan Webster (EMAS) / R Haines (CNCS)	14/12/2015	Non conveyance and increased use of alternatives to admission	EMAS use of OOH HCP line TBA No of consults to UCC Lo to be advised once commenced	2. Significant delay – unlikely to be completed as planned	Distribution of OOH no. to all EMAS crews SLS to obtain update from Rob H.
Inflow	1.4 To reduce EMAS conveyance to LRI	1.4.5 - Dedicated GP patients transport as pilot extension to existing service where transport is provided for a range of clinics	Implement additional service via Bed Bureau for appropriate GP urgent transport for patients not requiring a clinical chaperone Rapid testing in Leic City with focus on LE2, LE3, LE5 to inform roll out Comms to GP practices to promote default of self-transportation where a clinical chaperone is not required	Sarah Smith (LLR Urgent Care) / Julie Dixon (UHL)	w/c 14/12/2015	Freeing up EMAS capacity/reduction in batching	No of patients transported by dedicated transport crews	2. Significant delay – unlikely to be completed as planned	EMAS and TMAS solutions implemented CNCS OOH to commence 01/02/2016 Comms distributed
Inflow	1.4 To reduce EMAS conveyance to LRI	1.4.6 - Reduce referrals to EMAS from NHS111 and OOH	Review referral activity to identify scope for alternative dispositions to LRI ED	EMAS/CCGs	TBC				New action identified through UNIPART exercise Awaiting Unipart update DoS ranking strategies reviewed to ensure appropriate community pathways return first on options list
Inflow	1.5 To minimise the need for GP initiated/related admission to acute hospital	1.5.1 - Review referral activity from GP practices who do not arrange for a face to face consultation with their patient prior to referral to acute care	Identify and feedback specific issues to CCG primary care teams at named GP practice level Comms to GP practices to specify need to direct patients to ED Streaming Service within UCC Le Confirm ED team is recording presence of referral letter to allow GEM to extract appropriate data	Julie Dixon (UHL)	14/12/2015	Reductions in inappropriate emergency attends where there are suitable alternatives available	Decrease in the number of inappropriate GP attendances from pre-identified practices	5. Complete	Information circulated 20th November confirming details from face to face audits from the 12th and 22nd october and the GP level information. ED is recording presence of referral letter.
Inflow	1.5 To minimise the need for GP initiated/related admission to acute hospital	1.5.2 - Improve process by which GPs refer to UHL for specialist opinion/admission	Implementation of 'Consultant Connect' telephone advice for respiratory and gastro patients who are at risk of admission	Julie Dixon (UHL)	14/12/2015	Reductions in inappropriate emergency attends where there are suitable alternatives available	Collate nos of contacts for advice by GPs	2. Significant delay – unlikely to be completed as planned	Consultant Connect have completed set up for Diabetes & Endocrinology, Gastroenterology and Neurology. It is not currently feasible to extend this to respiratory due to the exceptionally high levels of activity. All GP numbers are with Consultant Connect. Service commenced 25/01/2016

Inflow	1.5 To minimise the need for GP initiated/related admission to acute hospital	1.5.2 - Improve process by which GPs refer to UHL for specialist opinion/admission	Deploy LHIS support to; Access GP care plans for ED clinicians and upskill ED ward clerks in accessing primary care information via LHIS Reinstate dedicated IT support to ED - John Roberts to action within Flow Section of RAP	C Tierney-Reed (WL CCG) John Clarke (UHL)	14/12/2015 TBC	Increased utilisationof care plans to inform treatment pathway Feedback to GPs where care plans are not available for at risk patients	Tailored SystmOne view to meet ED clinician needs to assess no. of care plans accessed Key words to be identified from across the UHL Trust	4. On track	Amendments to system configuration complete O/s hardware (laptops) + quick swipe access - CTR chased John Roberts with no response, request for update from Steve Jackson sent 19/01/2016 SystmOne records have a blue star to mark them and indicate to acute care staff to view appropriately
Inflow	1.5 To minimise the need for GP initiated/related admission to acute hospital	1.5.2 - Improve process by which GPs refer to UHL for specialist opinion/admission	Understanding remit and current specification of ambulatory clinics to understand appt timeframes	Catherine Free	10/12/2015	Ensure 'rapid' clinics are in fact rapid Increase utilisation of clinics by GPs and EDSS	All rapid access pathways accessible within intended timeframes. Improved utilisation of ambulatory clinics capacity by GPs and EDSS	6. Complete and regular review	Timeframes have been checked with each service and added to front of directory to facilitate feedback if issues arise with slot availability SLS to cascade info to all UCC Ops Mgrs and OOH clinicians
Inflow	1.5 To minimise the need for GP initiated/related admission to acute hospital	1.5.2 - Improve process by which GPs refer to UHL for specialist opinion/admission	Implement rapid cycle testing by placing a GP in ED to observe the assessment and decision making process by ED clinicians, producing recommendations for community-based alternatives and the role of the care plan in supporting decision making	C Tierney-Reed (WL CCG)	10/12/2015	Increased utilisation of care plans to inform treatment pathway Feedback to GPs where care plans are not available for at risk patients	No of primary care records accessed, to include care plans and medications	6. Complete and regular review	Visit has been done Report produced Recommendations reviewed @ Demand Group mtg 08/01
Inflow	1.5 To minimise the need for GP initiated/related admission to acute hospital	1.5.2 - Improve process by which GPs refer to UHL for specialist opinion/admission	Review early experience in November of Pathway Co-ordinators in Bed Bureau	Sarah Smith (LLR Urgent Care)	10/12/2015	Review has informed a discontinuation of this service	Review has informed a discontinuation of this service	7. Closed	Changes in UHL pathways have resulted in no need for clinical navigator roles. Bed Bureau Call Assessment Frameworks being written for each patient pathway to inform a gap analysis of breakdowns in patient flow
Inflow	1.6 To continuously review activity data to identify patients/groups potentially amenable to alternative care plans/services	1.6.1 - Regular attenders picked up and management plans agreed across agencies	WL to develop SOP based on current process for weekly review of real time data to share with ELR & LC Utilise review of real time data to target moderate/frequent flyers, paeds (particularly 0-10y) CCG leads to contact individual GP practices directly to discuss alternative services ELR and LC to circulate and adopt WL SOP	C Tierney-Reed (WL CCG) / D Eden (ELR CCG) / R Vyas (LC CCG)	11/12/2015 14/12/2015 14/12/2015	Reduction in frequency of attendance/admission for target patients	Target cohort is ED attends via ambulance to be reviewed Nos of patients who died in the department (consider presence of care plan) Nos of frequent attenders Nos of patients admitted where an alternative service could have been considered (UCC, OPU, AVS) Baselines per CCG; WL - circa 250 records reviewed every week with circa 110 reviewed in more detail, circa 5 GP practices contacted per week	3. Some delay – expected to be completed as planned	WL CCG system fully operational & their SOP shared LC CCG system fully operational ELR adoped SOP - reviewing data and practices contacted when alternatives available, generating requests for clearer clinical DoS. **11/1/16 ELRCCG: weekly deep dive of data to find alternatives to admission and contact practices where obvious cases. Outcomes to be collated and shared wqith Inflow group.**
Inflow	1.6 To continuously review activity data to identify patients/groups potentially amenable to alternative care plans/services	1.6.2 - Short stay admissions	Specific review of ED attends / Em Adms for Paeds & Gynae LC CCG to organise patient info sessions in high usage areas; undertake a book bag drop in every city school 'when should I worry' booklet; To Assess viability of providing community pathway at Westcotes Health Centre. Also online eShot weekly from school nurses (Rachna to define criteria) WL to develop targeted comms campaign as part of outreach campaign (see 1.1) re: use of UCC Lo by parents / carers ELR conducting deep dive analysis of all Em Adms	R Vyas (LC CCG) / R Mitchell (UHL) S Venables (WL CCG) / R Crabb (LLR Urgent Care) D Eden (ELR CCG)	21/12/2015 11/12/2015 14/12/2015	Detailed understanding of short stay presentations	Reductions in Paeds and Gynae short stay activity Increase in Paeds presentations to UCC Lo	4. On track	City school nurse team contacted to enable regular feed of info to parents via email. Plan under development for City schools with City engagement team. EPAU/GAU T+F group set up to plan for service development. CDU pilot under way WLCCG - Plan in place to target Surestart, Mother and Toddler groups and similar with winter messages. Outeach events ongoing from Dec 2015 to Mar 2016 Comms plan completed **ELRCCG: Significant COMMs campaign for NHS NOW app and Winter campaign to every school, Leisure centre, Library, pharmacy, dentist, GP and Optometrist. This includes self care and how to access the right**
Inflow	1.6 To continuously review activity data to identify patients/groups potentially amenable to alternative care plans/services	1.6.3 - UHL admission variance YTD by CCG and condition	UHL to identify key variances YTD by CCG and condition to inform development of further targeted plans	R Mitchell (UHL)	18/12/2015	Detailed understanding of presentations	Review commenced, analysis to be shared with CCG colleagues w/c 21.12.15	2. Significant delay – unlikely to be completed as planned	Data capture commenced. First tranche was analysis of GP practices activity within UCC Le received for Nov-Dec 2015 for CCGs review

Group	Objective	Action area	Delivery description & detail	Senior accountable lead	Delivery date	Expected impact	Activity Monitoring	Current performance against metric in column I	Delivery Status	Progress to date
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.1 - Pre-handover co-horting arrangement	New protocol reviewed in light of deployment	EMAS/UHL/CCGs	16/12/2015	Reduction in handover delays	Fewer lost hours and zero 2hr+ delays Reduction in ED Occupancy Fewer lost hours and	Following implementation on the 11th January there were no delays of >2 hours for 6 days. As demand has increased since then, delays have reoccured.	Complete	This protocol is now fully deployed. Where 2 hour breaches have occurred, it was because the protocol was not followed and this has been chased up with the individuals concerned.
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.1 - Pre-handover co-horting arrangement	Mobile treatment centre	Tim Slater / Richard Mitchell	w/c 30/11/15	Provision of power to support additional temporary capacity	Zero 2hr+ delays	The mobile treatment centre was deployed during the weekend of 23/24 January due to very high demand.	Complete	UHL have confirmed that shorelining can take place.
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.2 - Learning from best practice elsewhere	Look at QMC systems and processes	Richard Mitchell	w/c 30/11/15	To support reduction in ambulance handover delays.	Overall improvement in key KPIs	N/A	Complete	UHL and NUH have met and a three way meeting is being organised between UHL, NUH and United Lincs
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.2 - Learning from best practice elsewhere	Contact Royal College of Emergency Medicine re external expert peer support	John Adler	w/c 30/11/15	Identification of further potential actions	Overall improvement in key KPIs	N/A	Complete	JA contacted RCEM w/c 23rd November re. external support. Awaiting confirmation whether this is possible.
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.3 - Pre-admission space	Transition area protocol and staffing arrangements	Richard Mitchell	w/c 30/11/15	EMAS crews freed up to respond to incoming calls in the community	Fewer lost hours and zero 2 Hr+ delays	Ambulance handover have reduced at times, but in general remain unacceptably high. Further work necessary to validate data and reduce delays further	Complete	Signed off and in use, in line with protocol . Where possible staff are pulled from other areas of the hospital to staff this area if necessary. A daily report showing the total number of patients, average time in transition area, and longest wait in transition area is in place. If we keep ward 11 (18 beds) open as well (to improve medical flow) we may have difficulty staffing the TIA clinic in the next couple of weeks because of staffing levels.
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.4 - Optimising system and process to reduce variation	Unipart initiative	EMAS	16/12/2015	Reduction in variation	Fewer lost hours and zero 2 Hr+ delays	Actions arising from the unipart initiative have been included in this plan	Complete	Actions arising from the unipart initiative have been included in this plan
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.5 - Introduce routine flow management/co-ordination for patients arriving at LRI by ambulance to increase referrals to non-ED majors dispositions. To complete SOP supporting the streaming of patients from EMAS to the streaming service and implement	Agree and implement direct streaming SOP for Ambulances to UCC	Sam Leak Richard Henderson	31/12/2015		Increase in ambulance streaming to UCC. 67 patients in November, 121 patients in December.	We are beginning to capture this information but do not have accurate retrospective information to share	Complete	Confirmed agreement with EMAS that SOP will be in place by 17/2/16. We currently do this at times of high pressure but are putting it in as routine practice. We are working this through with our clinicians at the moment.
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.6 - Introduce routine flow management/co-ordination for patients arriving at LRI by ambulance to increase referrals to non-ED majors dispositions	Redefine the role of the HALO and who should undertake it and undertake a rapid cycle test of the HALO working with an ED Consultant/Acute Physician at time of escalation to expediate flow	EMAS? Sam Leak	17/02/2016	Fewer lost hours and zero 2 hour + delays. Crews freed up earlier.	Fewer lost hours and zero 2 Hr+ delays	New action added 26th Jan - for ongoing review and monitoring.	On track	Meeting 8.1.16 (EMAS and UHL) agreed the redefinition of the purpose of the HALO who should be functioning in this role. - Undertake RCT of ED Consultant or Acute Physician to work with Halo at times of escalation to measure number of patients dispositions from Assessment area Rapid Cycle Test will begin next week
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.7 - Agree a consistent handover assessment process/approach/tool/template	Trial the deployment of a private ambulance crew (contracted by EMAS) and an HCA (provided by UHL) to carte for patients in the "red zone" (subject to satisfactory prior risk assessment signed off by EMAS and UHL(	Sam Leak Richard Henderson	17/02/2016	Increased proportion of handovers within 15 minutes. Reduction in over 2 hour handovers. Monitored by the daily handover report produced by EMAS.	Fewer lost hours and zero 2 Hr+ delays	Lost times for handovers have improved but remain unacceptably high	On track	Meeting attended between UHL and EMAS. Process agreed for arrival DPS and process for use of private crew. - Trial a private crew from EMAS plus a UHL HCA to manage patients in the red zone to allow handover in 15mins and the crew to be released. - Trial UHL HCA lookiing after red zon pts to release some crews (if risk assessed and appropriate) - The clock stop for handover to be agreed as the time of handover to the red zone
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.8 - Agree data and reporting to monitor impact of new arrangements and ensure operational process changes are embedded and sustained	Monitor compliance with protocol via daily handover report and review potential to reduce threshold	John Adler	25/01/2016		Fewer lost hours and zero 2 Hr+ delays	Lost times for handovers have improved but remain unacceptably high	Complete	This is in place and is monitored daily. We had some success early on but this has been negated by high volumes of attendance and admissions
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.8 - Agree data and reporting to monitor impact of new arrangements and ensure operational process changes are embedded and sustained	Monitor the use of the cohorting areas and provide a fortnightly report to the CEOs, covering numbers of patients cohorted in each area, the relationship to handover time and any issues (including safety issues) arising	Richard Mitchell Richard Henderson	01/02/2016	Increase effective capacity of ED when there is exit block	Fewer lost hours and zero 2 Hr+ delays	Lost times for handovers have improved but remain unacceptably high	On track	Daily monitoring report agreed to show number of patients, average wait time and longest waiting patient by transition area and corridor - Create fortnightly report for circulation to CEOs. Will commence 29/1/16.
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.8 - Agree data and reporting to monitor impact of new arrangements and ensure operational process changes are embedded and sustained	Ensure that all EMAS crews have PIN numbers and use the CAD+ system for every handover	Richard Henderson	29/01/2016	Improve data quality and reporting.	Fewer lost hours and zero 2 Hr+ delays	Lost times for handovers have improved but remain unacceptably high	Some delay - expected to be completed as planned	Circa 50% of crews have PIN numbers. The aim is to increase this to 80%. As of 28/1/16, UHL teams have been instructed to take the numbers of crews without a PIN number. This will be monitored weekly.
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.8 - Agree data and reporting to monitor impact of new arrangements and ensure operational process changes are embedded and sustained	Ensure that all assessing nurses ask EMAS staff to use CAD+ to record handover time	Maria Mcauley	29/01/2016	Improve data quality and reporting	Fewer lost hours and zero 2 Hr+ delays	Lost times for handovers have improved but remain unacceptably high	Some delay - expected to be completed as planned	Circa 50% of crews have PIN numbers. The aim is to increase this to 80%. As of 28/1/16, UHL teams have been instructed to take the numbers of crews without a PIN number. This will be monitored weekly.
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.8 - Agree data and reporting to monitor impact of new arrangements and ensure operational process changes are embedded and sustained	Monitor completeness of CAD+ data through EMAS daily handover report and take remedial action if coverage does not improve rapidly	Richard Mitchell Richard Henderson Julie Dixon	26/01/2016	Improve data quality and reporting	Daily handover and turnaround report produced by EMAS allows tracking of CAD +.	Current performance is 56% usage.	On track	Part of the ongoing implementation of CAD+ - use is improving, and will continue to be monitored.
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.10 - Perform a diagnostic on the assessment bay process to see if this can be accelerated.	Undertake a review of the ED assessment process against the ECIST Rapid Assessment Model and develop an action plan to ensure compliance with that model	Sam Leak Stuart Maitland-Knibb	28/01/2016	Faster flow through assessment bay (dependent on occupancy of Majors)	Fewer lost hours and zero 2 Hr+ delays	Lost times for handovers have improved but remain unacceptably high	On track	Diagnostic against ECIST rapid assessment model has taken place. Next step is to write up the report, and implement recommendations and resultant actions. Initial report has been circulated.

Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.1 - Understanding the impact on patient flow of the new LRI front door service model	Accurate reporting against agreed activity metrics for each step of patient pathway	Richard Mitchell	10/12/2015	Clearity about impact of new service model on patient flow	Increase in referrals from LRI campus site and reduction in patients transferred from UCC to ED	2% reduction in patients being transferred to ED (Between in hours and out of hours). This is particularly evident with transfers to Majors (reduction of 5% circa. 12 patients per day)	Complete	We have an improved understanding about patient flow from UCC to ED over the past six weeks. There are conversations happening about extending the front door service in terms of hours per day and functionality linked to UCC and minors. We had hoped the reduction in patient transfers would have been greater
Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.2 - Refining pathways for new assessment service	Review and adjust onward referral pathways from assessment service based on actual experience during Nov	Julie Dixon	04/12/2015	Continued refinement in processes to optimise performance	Increase in referrals from LRI campus site and reduction in patients transferred from UCC to ED	2% reduction in patients being transferred to ED (Between in hours and out of hours). This is particularly evident with transfers to Majors (reduction of 5% circa. 12 patients per day)	Complete	As above
Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.3 - Consider extension of current service to 12am		Richard Mitchell	Lead in time once funding has been confirmed	Reduction in number of patients attending main ED and therefore a reduction in ED occupancy	Further decrease in referral rate from UCC to ED	Target is similar reduction in transfers to majors by 5% between 9pm and midnight as seen in usual operating period for Lakeside service.	On track	We are awaiting confirmation of whether this can be funded
Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.4 - To increase the number of patients redirected by the streaming service to community alternatives/ambulatory clinics		Julie Dixon	31/01/2016	Reduction in number of patients attending main ED and therefore a reduction in ED occupancy	Increased proportion of patients diverted to alternative services	2% reduction in patients being transferred to ED (Between in hours and out of hours). This is particularly evident with transfers to Majors (reduction of 5% circa. 12 patients per day) NOTE: Due to increasing attendance overall a reduction in ED occupancy has not been achieved	Complete	We have an improved understanding about patient flow from UCC to ED over the past six weeks. There are conversations happening about extending the front door service in terms of hours per day and functionality linked to UCC and minors. We had hoped the reduction in patient transfers would have been greater
Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.5 - To relocate OOH service from clinic 4 to the UCC		Julie Dixon	31/01/2016	better flow within UCC	Reduction in ED occupancy	Not currently in place	Some delay - expected to be completed as planned	Activity levels have been scoped. - Match activity levels to number of rooms available and current utilisation of rooms. (Risk will be weekend days and bank holidays) - Potential limitation will be weekend days and bank holidays. - RIsk due to contract coming to close for service in April
Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.6 - To increase the range of near patient testing within the UCC		Julie Dixon	08/02/2016	Reduction in number of patients attending main ED and therefore a reduction in ED occupancy	Further decrease in referral rate from UCC to ED	Not currently in place	On track	Business case signed off on 15/01 for near patient testing. - Confirm timelines for procurement w/c 18/01. Target date 08/2/16.
Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.7 - To establish pathway in UCC to assess ambulatory patients from GPs		Julie Dixon	31/01/2016	Reduction in number of patients attending main ED and therefore a reduction in ED occupancy + reduction in admissions	Reduction in volume of GP referrals needing to access ED	Tracking of this has only just begun	Complete	Now completed. All patients asked to attend ED by GP (GP urgents) are redirected from minors reception to UCC and are seen in an ambulatory setting.
Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.9 - To establish observation room in UCC to both reduce admissions and if appropriate enable direct admissions by passing ED		Julie Dixon	31/01/2016	Reduction in number of patients attending main ED and therefore a reduction in ED occupancy + reduction in admissions	Reduction in ED attendances and in majors congestion	Not currently in place	Some delay - expected to be completed as planned	This has been delayed. Aim to roll out in next week.
Flow	2.3 To ensure adequate ED nurse staffing levels to maintain 5/6 assessment bays	2.3.1 - Increase ED nursing establishment to 28 plus 2/3 for transition area	Agency 'long lines' increased.	Julie Smith	Complete	ED assessment bays operating at full capacity	No. assessment bays and resus bays operational	Number of times when some assessment bays or resus bays have shut has reduced	On track	Authorisation to long line agreed w/c 23 November. Fill rate has been marginal although has increased ability to fill the baseline staff levels. Further debate around staff utilisation required.
Flow	2.3 To ensure adequate ED nurse staffing levels to maintain 5/6 assessment bays	2.3.2 - ED establishment and skill mix review	Review skill mix, numbers of staff and roles in place and refresh if indicated	Julie Smith	05/02/2016	Balance of staffing and skill mix to demand	No. assessment bays and resus bays operational	Number of times when some assessment bays or resus bays have shut has reduced	On track	Skill mix review has been completed - actions related to training and recruitment agreed and being monitored through CQC action plan.
Flow	2.3 To ensure adequate ED nurse staffing levels to maintain 5/6 assessment bays	2.3.3 - Assessment bay staffing review	Review assessment bay staffing to check matching to demand and staggering of shift changes and breaks (further actions will depend on results of review)	Maria Mcauley	28/01/2016		No. assessment bays and resus bays operational	Number of times when some assessment bays or resus bays have shut has reduced	On track	Review has been completed. Demand mapped to capacity. This report has been submitted to John Adler - actions to improve assessment bay staffing have a longer lead in time. Will be completed by 31/3/16.
Flow	2.3 To ensure adequate ED nurse staffing levels to maintain 5/6 assessment bays	2.3.4 -ED establishment and skill mix improvement	Implement recommendations of 2.3.2	Maria Mcauley	01/04/2016		As above	As above	On track	Ongoing.
Flow	2.4 To accelerate the admissions process from ED to base wards	2.4.2 - To consider Relocation of bed bureau to enable expansion of service-.	To review BB processes and how many calls are being taken - improve efficiencies and staff environment.	Julie Dixon	End of January	More efficient working	Reduction in admissions	N/A	Some delay - expected to be completed as planned	Two options shortlisted for relocation: Samuel Jordan Room and UCC. Potential third option is to reduce scope of Bed Bureau internally and to relocate the GP element in SPA. - Workshop on 19/01 to discuss BB processes with a view to streamlining bed allocation process for GP admissions. - Pick preferred option
Flow	2.5 To maximise availablilty/flexibility of safely staffed bed capacity	2.5.1 - Reschedule some elective activity from Monday's to weekends	Reduce elective work for 2-3 weeks in January 2016 in anticipation of the predicted spike in non-elective activity	Richard Mitchell	01/01/2016	Surgical ward capacity freed up to support medicine	Additional medical bed capacity during January	We have reduced elective work more than we originally expected	Complete	We have reduced elective work more than we originally expected
Flow	2.5 To maximise availablilty/flexibility of safely staffed bed capacity	2.5.2 - Identify opportunities to deliver UHL activity away from the 3 acute sites	Review potential for re-comissioning space on wards used for non-clinical purposes	Darryn Kerr	04/12/2015	Physical potential to create additional bed capacity	Number of acute hospital beds	N/A	Complete	In the last month additional gastro, oncology and paediatric beds have been opened. A further piece of work is taking place to open additional beds and we are also confiming required bed capacity for 16/17. It is worth noting that ability to open additional beds is dependent on access to increased staffing levels. All additional space clinically safe to use is being used, dependent upon ability to staff.
Flow	2.5 To maximise availablilty/flexibility of safely staffed bed capacity	2.5.3 - Improve utilisation of all available and appropriate beds	Improve process for early outlying by sending out an early outlying plan with the bed state on Friday afternoon (4:30/6pm)	Julie Dixon	11/11/2015	Improved flow out of the ED	Reduced time from decision to admit to patients leaving ED	There has not been progress on the metric	Complete	Outlying plan is circulated every Friday. Work is ongoing to improve process. Data request made to confirm effectiveness of process and to monitor impact on patient outcomes and surgical activity.

Flow	2.6 To speed up and bring forward (time of day) the discharge process	2.6.2 - Improve utilisation of the discharge lounge between 8am and 12pm.	Review current processes and approach to utilisation of the discharge lounge	Julie Dixon	18/12/2015	Increased utilisation of the discharge lounge between 8am and 12pm Freed up acute ward capacity	Increased utilisation of the discharge lounge Patients discharged by time of day	Discharge rate has improved	Complete	Driven increased discharges to the discharge lounge on oncology and day wards by visiting outlying patients, and encouraging staff to use the discharge lounge Designed a 'meet me in the discharge lounge' project for patients. Further benefits to be gained from this action - e.g. improved utillisation of the discharge lounge. However early data does not suggest any major improvements.
Flow	2.7 To ensure that the hospital responds appropriately to capacity pressures in ED	2.7.1 - Co-ordinated escalation response between ED. AMU and CDU to share risk appropriately across the areas in the safest possible way	Design and implement an escalation policy for CDU as part of the whole hospital response to improve flow through department	Sam Leak	31/01/2016	Reduced number of diverts from AMU/CDU Reduced occupancy in CDU/ED	Evidence of escalation plans being enacted in line with policy	No impact as yet	Complete	Escalation policy is complete - and has been shared with clinical leads for the clinical decisions unit on 28/1/16.
Flow	2.7 To ensure that the hospital responds appropriately to capacity pressures in ED	2.7.1 - Co-ordinated escalation response between ED. AMU and CDU to share risk appropriately across the areas in the safest possible way	Coordinated escalation process to be implemented in the ED	Richard Mitchell	19/12/2015		Evidence of escalation plans being enacted in line with policy	No impact as yet	Complete	This is tracked on a daily basis through gold command
Flow	2.7 To ensure that the hospital responds appropriately to capacity pressures in ED	2.7.1 - Co-ordinated escalation response between ED. AMU and CDU to share risk appropriately across the areas in the safest possible way	Agree and implement escalation response between AMU and ED	Richard Mitchell	19/12/2015		Evidence of escalation plans being enacted in line with policy	No impact as yet	Complete	Attendance and admissions have been so high recently, we have not, as yet, seen the expected impact
Flow	2.7 To ensure that the hospital responds appropriately to capacity pressures in ED	2.7.2 - To implement accelerated flow	Recruit team and implement Accelerated Flow process on an ongoing basis	Julie Dixon	15/02/2016		Accelerated discharge		On track	Accelerated flow protocol complete and signed off at EQSG. Interviews have taken place, for additional staff. Dedicated HR support put in place to fast track onboarding process. Next steps: Onboard staff, and monitor effectiveness of accelerated flow.
Flow	2.8 To ensure that patients who do not require an admission are directed to ambulatory services where possible	2.8.1 - Implement RCT of acute physicians reviewing ED admitting decisions	Agree process for trialling + expected benefits	Ian Lawrence	~~16/12/2015~~ 25/12/2015	Reduction in admissions	Reduced admission rate from ED	No evidence this is working	Complete	Trialled w/c 28/12 with following results: Deferred admission (discharges home) use of ambulatory pathways (particularly Acute Medical Clinic) Expedited admissions (ACB from Resus/Assessment Bay), direct admissions to SSU/speciality base wards (thus bypassing AMU/AFU) This should be continued and further actions will be added to deliver this sustainability.
Flow	2.8 To ensure that patients who do not require an admission are directed to ambulatory services where possible	2.8.2 - Increase capacity on AMU for GP access	Relocate the AAU to the UCC and expand capacity	Sam Leak	29/02/2016	Reduced occupancy in ED	Increased number of patients going through AAU	N/A	On track	Business case sign off for ambulatory patients to be relocated to AAU in UCC. - Install IT - Make minor infrastructure changes - Commence recruitment
Flow	2.8 To ensure that patients who do not require an admission are directed to ambulatory services where possible	2.8.3 - Work with CDU to develop ambulatory clinic to streamline flow through department	Stream patients at triage who are likely to be ambulatory into separate area to facilitate rapid turnaround	Sam Leak	14/12/2015	Reduced CDU Occupancy	Increased propotion of patients with LoS on CDU of > 6 hours CDU Occupancy	Positive results demonstrate increase of 7% from 14/15 to 15/16 since this commenced. Further benefits expected once staff fully in post.	Complete	Streaming service launched on 14/12 with comms to all CDU staff and patient information posters. Full implementation will be complete by March once all staff in post.

Group	Objective	Action area	Delivery description & detail	Senior accountable lead	Delivery date	Expected impact	Activity Monitoring	Delivery status	Progress to date
Outflow	3.1 To increase community 'step-down' capacity	3.1.1 - Phased increase of Intensive Community Support (ICS) capacity	Implement additional 16 ICS beds; Oct 16 Dec 16 Jan 8 Feb 40 (subject to successful staffing recruitment) Mar 50 (subject to successful staffing recruitment)	Rachel Bilsborough (LPT)	w/c 30/11/2015	Increase of alternatives to acute hospital admission	Number of ICS beds operational	On track	Additional December and January capacity opened in line with plan
Outflow	3.2 To optimise use of existing community services capacity	3.2.1 - Utilisation of available LPT community services and community hospital beds	Identification of notional 'target' number of daily discharges from LPT to support flow	Rachel (LPT)/ Richard (UHL)	10/12/2015	Optimised utilisation of ICS and community hospital bed capacity	Occupancy rate for ICS and community hospital beds	On track	LPT and UHL have confirmed that daily target for community hospital is average 10 patients per day. This is being met and on most days is exceeded. ICS target is based on 10 day LoS, 90 % occupancy and will vary as number of beds increase. Current target of 25 patients per week and is being met.
Outflow		3.2.2 - Utilisation of available LPT community services and community hospital beds	Improved signposting/utilisation of community based services with UHL clinical teams supported by in-reach	Ian Lawrence (UHL)	18/12/2015	Optimised utilisation of ICS and community hospital bed capacity		On track	The directory of services for ambulatory care is available on insite and contains information on out of hospital services. Further work ongoing on the wards re. signposting to ICS + other services. Additional work between UHL and LPT to review night time needs requirement and identify actions to support transfer.
Outflow		3.2.3 - Additional Primary Care Co-ordinators to expedite identification of patients suitable for discharge to community services	7 WTE PCCs to be recruited to existing team to work across Glenfield and LRI to support transfer of patients to community services	Nikki Beacher (LPT)	21/12/2015	More patients identified as suitable for discharge to community services earlier in LOS	Number of patients identified for earlier discharge	On track	October additional PCC in Glenfield, December 2 x additional PCC in LRI, 25 January additioanal PCC in Glenfield, 1 Febrary PCC to commence in LRI. 3 additional PCC posts out to recruitment. Staff undertaking additional hours to supplement while PCC team while recruitment takes place. Programme of inreach for community teams to support the identification and transfer of patients in community hospital wards
Outflow		3.2.4 Improve transfer of patients from Community Hospital In patients to Community Services	Improved knowledge and understanding of ICS within Community Hospital Inpatinet wards	Nikki Beacher (LPT)	31/01/2016	More patients identified as suitable for discharge to community services earlier in LOS	Community Hospital Bed capacity and availability	On track	
Outflow	3.3 To maintain DTOC rates at current low levels	3.3.1 - Maintaining daily multi-disciplinary partnership approach	Maintaining daily bed management and DTOC calls	Sarah Prema (City CCG) /Tracy Yole (LLR Urgent Care)	Ongoing	DTOC not being rate limiting factor in discharge flow	DTOC rate to be maintained <2%	On track	Current DTOC position remains low at 1.72%