UHL Emergency Performance

Author: Sam Leak , Director of Emergency Care and ESM Trust Board 5 May 2016 paper G

Executive Summary

Context

Despite a recent levelling out of demand, compared to this time last year, University Hospitals of Leicester's four hour emergency performance remains very poor. The report details the actions that are being taken across LLR and the further work that is required.

Questions

1. Does the Board agree with the action plan?
2. Are the Board content with progress against the three main areas of focus:
   - **Admission avoidance** – ensuring people receive care in the setting best suited to their needs rather than the Emergency Department.
   - **Preventative care** – putting more emphasis on helping people to stay well with particular support to those with known long-term conditions or complex needs.
   - **Discharge processes across whole system** - ensuring there are simple discharge pathways with swift and efficient transfers of care.

Conclusion

1. Whilst delivery of all the actions within the plan is important, the current position is caused fundamentally by an imbalance of demand and capacity. Resolving this is needs to be a relentless focus for UHL and our partners.
2. Partners from LLR are coming to a thinking day within the next couple of months and it is recommended that the three points above are a focus for the conversation.

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: 2 June 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:	**5 May 2016**

Concerns about emergency care continue. We have seen a slight increase in performance in April 2016, although performance remains much worse than this time last year.

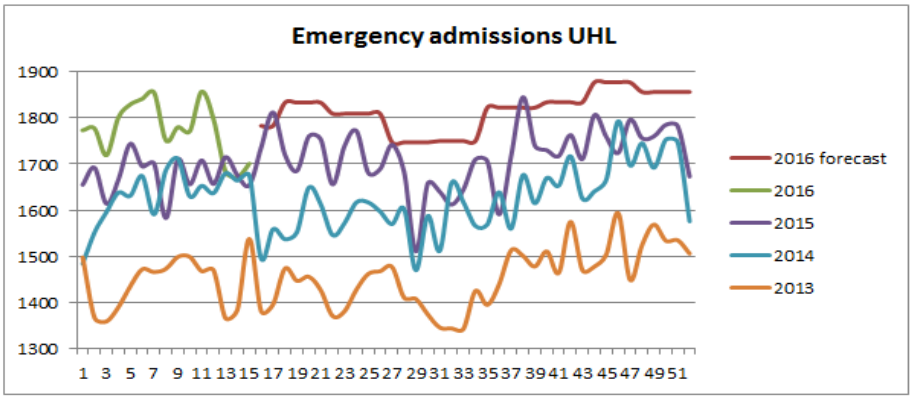
2015/16

- 15/16 performance was 86.9% and March 2016 was 77.5%.
- 14/15 performance was 89.1% and March 2015 was 91.1%.
- Attendances 6.8% up on the previous year.
- Admissions 5.9% up on the previous year.

April 2016

- Month to date is 79.8%.
- This time last year performance was 92.1%.
- YTD attendance 0.8% up on the same period last year.
- YTD total admissions 0.2% down on the same period last year.
- Due to ward reconfiguration work, medicine has access to 28 fewer beds now at the LRI than the same time last year.

Our problems continue to be driven primarily by high attendance and admissions, although admissions in the first three weeks of this financial year are similar to last year. The graph below shows weekly emergency admissions and a forecast (in red) for the rest of this year:



The impact of high demand and the mismatch with capacity is well documented and has most recently been discussed again in our Integrated Finance and Performance Committee. We have taken steps to reduce the impact on our RTT, cancer and on the day of surgery cancellation rate at the LRI and we now need to permanently embed these changes.

LLR improvement plan

The most recent update to the LLR plan will be circulated once available. Key updates include:

- EMAS and UHL continue to have weekly conference calls EMAS to manage improvements in ambulance handovers.

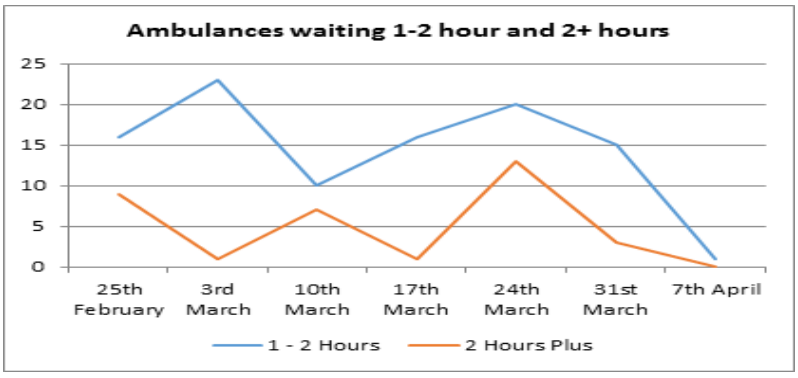
- We have now recruited to the vacant Head of Nursing and Head of Operations posts in ED. Substantive recruitment to the clinical lead post is ongoing.
- A solution for the decrease in GP input to streaming from 1 May 2016 is being implemented and work is underway to mitigate the impact of further changes which may happen in November.
- We are trialling all ward admissions being reviewed by an ED senior decision maker or Acute Physician taking place in April.
- The CMG is increasing its management presence within ED to support and push performance improvements in May.

Ambulance handovers

All Handovers using CAD data for the last five months are detailed below:

	% Delay Over 15 mins	% Delay Over 20 mins	% Delay Over 30 mins	% Delay Over 45 mins	% Delay Over 60 mins	% Delay Over 120 mins
Dec-15	62%	50%	33%	19%	10%	2%
Jan-16	63%	50%	33%	20%	11%	4%
Feb-16	57%	43%	27%	17%	9%	2%
Mar-16	61%	47%	30%	18%	9%	3%
Apr-16	59%	44%	25%	13%	6%	1%

The team has continued to improve internal processes and a CMG escalation process for patients on ambulances (POAs) has been introduced (in hours) to support early decision making and management of flow decreasing long waits for handover. The trial of a majors two (using minors as majors to increase capacity by 9 cubicles) in April (as detailed below) made a significant difference to ambulance handovers and as an expansion of the trial is being planned. Improvement is still required as UHL remains an outlier for long ambulance handovers, and as such this is a priority for the CMG to improve.



Time to Triage

Our performance is currently averaging 89% against our agreed 90% target.

Conclusion:

Although we had sustained pressure over winter, activity is now no higher than it was this time last year, however emergency performance remains very poor. The Medical Director, Chief Operating Officer, Clinical Director for ESM and Director of Emergency Care and ESM met with the ED consultants and senior nurses last week to talk about the pressure the department is under and the steps that the department, wider trust and health system can take to improve the quality of care

and operational performance. It is vital that we see a rapid improvement in performance as we are now entering a time of year that is normally easier.

The following remain the three most important areas for the health system to focus on:

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

Recommendations

The Trust Board is recommended to:

- **Note** the contents of the report.
- **Note** the concern about four hour delays at a time of year when we would expect performance to be getting better.
- **Note** the importance of reducing the mismatch between demand and capacity in 2016/17. Resolving this is one of the biggest priorities for UHL and the health system over the next 12 months.

Tab 2 - Discharge plan. March 2016

No	Objective	Actions		Description	Benefit
5	**Review discharge processes to make the discharge process more efficient**	6.1	Provide a trajectory from within UHL on the availability of Consultant led morning ward rounds taking place 7 days a week.	The target should be to support this first in medicine.	Discharge decision making improved. Supports 7 day working. Increase number of discharges before 12 noon
		6.2	Circulate and review the discharge audit data	Compare and review against benchmark and national best practice	Further improve discharge efficiency
		6.3	Refine protocols and procedures associated with patient assessments at point of discharge	Agree multiagency principles for good risk decisions - supported by each agency	Discharge process is more efficient
		6.4	Establish working group to reassess risk profiling of patient assessments at point of discharge		Clinical and patient engagement established. Protocols for risk profiling are reviewed
		6.5	TTOs and EDDs are in place the day before discharge		Improve productivity - discharge process simplified; process delays are reduced / eliminated
		6.6	Agree the use of alternative pathways of care for patients where the first choice is not available		Protocols in place to support alternative models so that the referral process is more efficient
		6.7	Undertake staff development / education process around balanced risk decisions (self assessment tools), commencing with discharge facilitators		Better staff understanding of the discharge process and sensible risk planning for each patient
		6.8	Agree protocols to maxmise the use of the ICS service		System wide engagement, improve the efficiency of referrals to ICS. Improve productivity.
		6.9	Establish a KPI for 80% of patients to have transport booked on the day before discharge.		Improve productivity - discharge process simplified; process delays are reduced / eliminated

Leicester, Leicestershire and Rutland Urgent Care Network
High Impact Recovery Plan
Mar-16

Last updated: 1-3-16 **Document Owner: Samantha Merridale - Head of Operational Resilience**

No	Objective	Related Actions	Indicator No	Indicator	2014/15 Outturn	Current performance	Target	Variance	Date of Data	Source	Accountable Officer / Organisation	RAG	Comments
1	Minimise presentations from primary and community care to LRI ED assessment services		1.1.1	UHL ED Attendances - Majors	55,555	49,091			24/02/2016	UHL local data			
			1.1.2	UHL ED Attendances - Minors	57,898	57,407			24/02/2016	UHL local data			
			1.1.3	UHL ED Attendances - RESUS	13,038	12,029			24/02/2016	UHL local data			
			1.1.4	Eye Casualty Attendances	17,673	16,985			24/02/2016	UHL local data			
			1.1.5	UHL UCC Attendances	99,619	95,182			14/02/2016	UHL local data			
			1.2	UHL ED and UCC - % 4 seen in hours	86.0%	85.1%	95%	9.9%	21/02/2016	UHL local data		R	
			1.3	Mobile DoS									
2	Reduce delays in ambulance handover times at the LRI site		2.1	EMAS Handover									
			2.2	Lost hours	484	655			14/02/2016	EMAS			
			2.3	Time bands?									
3	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		3.1	Number of Alternate Care Settings									
			3.2	Emergency Admissions	81,881	78,161			24/02/2016	UHL local data			
4	Reduction in emergency admissions		4.1	Emergency Admissions - 0-6 hours	63,586	61,623			24/02/2016	UHL local data			
			4.2	30 day readmissions	7,454	6,847			24/02/2016	UHL local data			
			4.3	Rapid Cycle Tests									
5	Review discharge processes to make the discharge process more efficient		6.1.1	Discharges before noon - Medical									
			6.1.2	Discharges before noon - Surgical									
			6.2	Transport available day before discharge			80%						
			6.3	TTO and EDD day before discharge									
			6.4.1	Weekend discharges - Medical									
			6.4.2	Weekend discharges - Surgical									
			6.5.1	DTOC - Complex									
			6.5.2	DTOC - Other									

No	ID	Actions	Accountable Officer / Organisation	Deadline	RAG	UPDATES FROM UCB 6/4/16	Actions
1	1.1	Maximise use of alternatives to admission by primary and community providers - to continuously review activity data to identify patients/groups potentially amenable to alternative care plans/services	R Vyas (LCCCG) K Tierney Reid (WLCCG) D Eden ELCCG R Haines CNCS	Weekly		Target cohort is ED attends via ambulance to be reviewed. Number of patients who died in the department (consider presence of care plan). Numbers of frequent attenders. Numbers of patients admitted where an alternative service could have been considered (UCC, OPU, AVS). Baselines per CCGs. Information is being shared with GPs and at locality meetings. OOH element to be further progressed. WLCCG: Inflow group - SOP shared with Tim and Rachna for methodology (previous week's data review). Week 48: 313 patients reviewed - 135 alt to adm identified - 34 practices to contact. All practices being contacted. ELCCG: similar process. Frequent fliers - SOP - ask patients to have MDT review. 609 patients in 1 year have attended ED > 5 times. LCCG: Similar - feedback through localities. Visits to practices. CNCS - regular and continuous dialogue with GPs - referral pathways, and repeating with relevant examples for continuous learning. Understanding the metrics - regular outcome data pulled fortnightly re dispositions. Sample audit of outcomes - has been informal; needs formalising. Regularity and size - needs confirming - can be done quickly.	2 actions confirmed: 1) Reviewing of data. 2) Follow up with practices. Need to ensure links with Out of Hours - to be included in the feedback loop. Focus on patients with >5 attends/admits - LTC, care plans, DNA in place. CNCS to review Adastra themselves and patient outcomes. Use as example: High volume service users (EMAS) project. Follow up action is to look at capacity in potential alternatives. Catherine Free looking at categories of patients - to send to Angela. Data from each CCG to be fed back weekly. CNCS to agree formalisation of feedback of data and frequency.
1	1.2	Maximise use of alternatives to admission by EMAS crews and reduce EMAS conveyance to LRI - Implement mobile device (smartphone) with MDoS access	L Brentnall (EMAS)	31/03/2016		Smartphones are now configured - need rolling out to crews. Need testing. Logistical challenge. Measuring usage and outputs. Lee Brentnall to provide a full update Mtg to be arranged to agree KPIs	Supply with trajectory of when phones with crews - when enabled. Point at which can measure other metrics. Put baseline in place. Improvements to MDOS - categorisation of services. KPI is outcome. Conveyance to alternatives to ED - trajectory to UCCs (Oadby and LUCC). CCGs to pick up with services to record data - supply to EMAS. Against conveyances to LRI. Post April - LCCCG. Continue with shadowing from UCCs with EMAS.
1	1.3	Provide system navigation facility to referring GPs bed bureau EMAS OOH Care homes to promote alternatives to admission	Dan Webster (EMAS) / R Haines (CNCS)	29/02/2016		Distribution of OOH no. to all EMAS crews. Agreement between EMAS and LUCC re. In hours period. New Paramedic pathfinder out to crews electronically and hard copy, Ban Webster arranging meeting with LUCC, Staff already working with crews on shifts Links to consultant connect. End of week 4 - acute medicine. 37 calls to date. Referrals avoided. Figures available - see Angela. Feedback - very positive from GPs in West. In hours only. Capture use of service into different specialties. (See Angela for breakdown of metric set - Sarah Smith/Julie Dixon). 2. EMAS accessing clinical advice. Cross over between EMAS clinical assessment service and how it can be accessed - need to find way of determining whether making a difference. UHL may collect through audit Catherine Free doing. Use of Bed Bureau.	EMAS - will get evidence as to how working. CNCS - smarter with definitions - paramedic calls etc. To monitor and record activity. UHL - to investigate impact. JD to put date in for meeting for use of BB - date now booked for BB meeting. **JD plans to meet with GPs to update them on consultant connect data, this meeting is planned for Wed 27th April.** **Consultant Connect report shared with ORG**
1	1.4	Review timing of GP home visits with a view to move earlier in the day / improve transportation to UHL to bring the evening peak forward reducing the likelihood of admissions.	R Vyas (LCCCG) K Tierney Reid (WLCCG) D Eden ELCCG R Haines CNCS J Dixon UHL	Weekly		Alternative transport system now operational. The AVS is fully operational in WLCCG and LCCCG and has been rolled out to an initial area in EL and Rutland CCG in Oadby/Wigston/Blaby. UHL - Bed Bureau script updated and this is happening. Complete from UHL perspective. LCCCG: Home visiting service in place. 224 visits / week. Fully utilised every day. 86% non conveyance rate. From 16/17 - another car as part of BCF - 280 / week capacity. Target into care homes. ? Record time of GP visits not done through visiting service. Aim is to spread time of visits earlier in the day - consistency across CCGs with AVS. Have GP urgent transport (non-EMAS). Impact is to get East on line. ELCCG to do weekend service. If service is now in place - avoid EMAS having urgent GP adm later in day. UHL to collect data regarding time of referral by GP, time of arrival at AMU, destination , and number of admisions compared to baseline - Deadline 11/03/16 - still awaiting data.	Look at BB admissions - look at time span. Message to the patients - highlighting importance of timing. Get data from BB. EMAS should start to see the impact - alternative provider.How do we track data to see impact. Home visiting services across three CCGs. Vol of activity and dispositions - SSAFA will pull data. **JD - Submitted report to ORG**
1	1.5	Maximise utilisation of step up ICS capacity by Primary / Community Care.	Primary Care Clinical Leads.	00/01/1900		Comms sent to all GPs and OOH services re accessing the ICS step up service as an alternative to admission. Links to action 3.2 below. GP comms across 3 CCGs - LPT attend GP practice meetings. Specific work in city. Generate data by practice and GP - Rachel has shared - issue with data quality (clinical system) - shows where practices not using ICS at all - can target. From 1/4 reconfigure clinical system - track ICS referral by source. Is room to grow and expand Step Up element. Is this clear now to practices as being available option?	Metric is no. of step up being made - get from CCGs. No of practices referring, no not using. Work to do with services - embryonic, new staff, needs development. Update weekly ICS report. Link to real time data.
2	2.1	Ensure that all EMAS crews have Pin numbers and use the CAD+ system for every handover.	R. Henderson	29/01/2016		EMAS confirmed that all EMAS crews have PIN numbers and each vehicle has an MDT. Real time escalation to EMAS ROM of crews without pin numbers started 22/02 - EMAS provided Pins for VAS and PAS crews (started 1.3.16) - EMAS confirmed CAD+ can be used when MDT not working (2.3.16) - EMAS conducting audit on 11/2 or 12/2 to look at system limitations of CAD+ outcome to be provided 8.3.16. Continue to await feedback from EMAS. - 08/03/16 - EMAS confirmed all crews now have PINS and can use CAD+. UHL to escalate any crew that don't use CAD+ to RMO. **Mark gregory and Roger Watson - CAD+ compliance is dropping. This needs to be picked up at divisional level and communicated to all crews from divisional communications.**	RW has contacted MG, who is going to action the divisional communications. Track data to see if there is an improvement with compliance. **Data has demonstrated a slight improvement to CAD+ compliance however it may be prudent to ensure that the divisional communication has been actioned.**

2	2.2	Implement recommendations of nursing skill mix review in ED.	M. McCauley	01/04/2016		Initial review by Chief nurse is complete. ED HON advert is out. Final paper and recommendations to be completed by 1/4/16 so that implementation of recommndations can commence in April.	1) Paper and recommendations to be finalised (Julie Smith)
2	2.4	Agree and implement a direct streaming SOP.	UHL (SL) and EMAS (JD/RH)	27/04/2016	6. Complete with regular review	The focus of the SOP is on exclusion criteria for the assessment bay rather than an inclusion criteria for the UCC. UCC signage updated to ED front door. SOP agreed by Medical Director, EMAS and UHL. To be implemented from 14/03/16. Update at 23/3/16 - SOP was tested during HALO trial additional criteria have been suggested. Once these small changes have been made the SOP will be embedded within EMAS and UHL. SOP to be finalised and disseminated by COP 01/04/16 **SOP disseminated and compliance needs to be ascertained.**	1) SOP to be updated with additional criteria 2) SOP to be disseminated and embedded in EMAS and UHL **Confirm dissemination of SOP with Roger Watson** **Establish KPI's for measuring compliance to SOP**
2	2.7	Agree a formal UHL task and finish group (? Include EMAS) to drive forward actions	Sam Leak	29/02/2016 30/04/2016		Meetings commencing on 4/3 The first meeting took place 04/03/16 and are planned with EMAS, UHL clinical and managerial staff to identify new solutions and implement the plan.	**RW/BG/RW reviewed data and agreed that more data regarding breach reasons are needed. BG will be reviewing this data.** **Decided that although the patient may feel that the care is poor, it was agreed that care was being prioritised to the most appropriate patient.**
2	2.8	Review protocols/guidance relating to handover and understand if align in practice	Sam Leak	29/02/2016 30/04/2016		Initial mapping of processes complete and process tested on Super Handover Day. A handover process has been drafted and agreed at the Handover Task and Finish Group on 23/3/16.	**RCT needs to be repeated to enable meanginful benefit analysis. TBC**
3	3.2	To relocate OOH service from clinic 4 to the UCC	Julie Dixon	01/04/2016 1st Step 30/04/16		~~OOH contract extended with CNCS until March 17. Attended initial meeting with CNCS~~ - Arrange meeting with CNCS to discuss move - Analyse activity through service and room utilisation especially at weekend 1 member of staff working in OOH who has flexibility in capacity. Moving down to UCC - use some of that resource. Move towards closing clinic 4 - as at LUCC - co-location of staff, for shared resources. Meeting has taken place and agreed that OOH and UCC would work in partnership but activity would be recorded in the same way so payments will be unchanged. The difference will be shared reception support, flexibility over slots ensuring pts are seen by the right person as quickly as possible **31/03/16 - First meeting with RH - Agreed plan and 1st steps**	RW/JD/RH to meet to discuss solutions and giving access to GPs and Vice Versa. **RW reached out to MK to arrange a meeting but has not had a response. JD is speaking with MK on Friday 29th so will push for a response.**
3	3.3	To increase the range of near patient testing within the UCC	Julie Dixon	08/02/2016 11/04/2016 11/05/2016		Access to diagnostics from UCC - e.g. X-ray - patients can now directly access diagnostics from UCC. Business case signed off on 15/01 for near patient testing but lagging intended implementation timeline. Equipment ordered on 4th March with 8-12 week lead time. Discussions taking place to see whether this can be expedited. A list of diagnostics currently available in the UCC has been compiled and this wil improve when the UCC has access to ICE. Update required at EQSG on 13/04/16 regarding the use of ICE in UCC - how is it working? **ICE is functional in UCC, but timelines for NPT testing installation are still being finalised. Equipment delivery set for 27th April** **LAN points to be installed this week, once complete the company can finalise instalation, and commence training. Completion date set for 11/06/16**	RM to check whether UCC can access ICE to request diagnostics. Put separate X-ray action in plan in if cannot. LT to confirm how long set up will take once equipment has arrived.

3	3.5	To ensure that patients who do not require an admission are directed to ambulatory services where possible	Sam Leak	29/02/2016 28/03/2016	6. Complete with regular review	Business case sign off for ambulatory patients to be relocated to AAU in UCC. - Install IT - Make minor infrastructure changes Update: Follow ups have moved down. Minor estates work this week and next - will increase capacity. Metric - Look at utilisation of patients going to AAU - conversion from AAU to ED. **No of BB patients through ED - should be zero.** Look at appropriateness of referrals ? How we collect that. Decrease the need for patients needing a bed. Should be less short stay admissions. Co-location with UCC will speed up process. If AAU full - patients currently go through ED - should reduce. Will increase capacity for patient obs. At 7. 3.16 all Ambulatory GP referrals now being seen in AAU in UCC. Datato be collected to measure sucess of move and caveat the opening times as a constraint on target to see all GP referrals. Data shows 50% of patients from AAU are discharged home. LT to review new data to ensure it is including the new AAU and GPAU locations.	LT to identify difference in data between PBs and SS's version as it is not as a result of the new location codes. **Data is being validated and collected for analysis, and will be available for review by 06/05/16**
3	3.6	To accelerate the admissions process.	Julie Dixon	29/02/2016		Accelerated flow protocol complete and signed off at EQSG. Interviews taken place and positions filled. Staff started on 22/2 and are undertaking training - Monitor effectiveness of accelerated flow. Delays in the system. Supernumerary group of staff - make patient flow through system more fluid. JIT delivery. Smooth movement, reduce delays. Accelerated Flow team to be managed by AMU Coordinator to ensure focus on pulling patients/preparing patients. Data collection to evidence performance to take place on 14/3/16	Keep on plan until Trust has had internal discussion about impact. **Meeting with ZB on 27/04/16 to discuss the outcomes and production of a report for EQSG** **Rapid Flow Team - Performance fedback at EQSG on 11th May**
4	4.1	Implement feedback loop to GPs regarding inappropriate admissions as a learning exercise	Lee Walker / Catherine Free	11/03/2016 13/04/16		- Review whether Adastra can be used to pull details - Undertake monthly Review of AAU notes Provide real time info to GP on inappropriate referrals - ? Alternative pathway. Review and trawl of notes - 2 audits done over last 2 months. Links to 4.4 - Catherine Free audit. Was there a different pathway the patient could have gone through. Catherine Free has started to develop an audit which will be shared to see if it could be transferable to AMU. Request made to IT to provide a field on ICE to promt to record if the referral was appropriate and if not what could have been done differently. **Results of Catherine Free's audit of inappropriate referrals to be fed back at EQSG on 13/4/16**.	Prospective peer review - getting second opinion - practices have demonstrated lowest level of admissions. Investigate whether there is someway of being able to code this - e.g. 'red flags' - missed opportunities - to enable retrospective auditing. Enable CCGs to target individual practices. Put on discharge letter. **Date for feedback to GPs needs to be confirmed for ORG. CF is on leave, upon her return a date will be confirmed.** **Drop down box has been included on ICE letters - now live.** **Absorb into Catherine Free's action to get feedback from GPs with the 8 week trial - Ursula's action**
4	4.2	Rapid Cycle Test of streaming patients into 'likely admission' and 'likely discharge' in ED to reduce occupancy and front load senior decision making in department	Ian Lawrence	18/03/2016 27/04/16		Trial taking place on 31/3/16 at the same time as the majors expansion trial. **Initial trial is complete, and 2nd RCT complete on 7th April. Results to be fed back to EQSG on 13/04/16**	**Next steps to be discussed and reported back to EQSG on 27/04/16**
4	4.3	Rapid Cycle Test of all patients being seen by Senior Decision Maker (Emergency or Acute Medical ST4 or above) prior to admission to Medicine	Ian Lawrence	18/03/2016		RCT delayed as information may be captured already. Data showing 'senior review' in consultation box being pulled to establish baseline. Reminder email has been sent to consultants asking them to make sure they record this when it takes place. Update at 23/3/16 - data shows that a low proportion of patients are seen by a seinor decision maker before admission, though this could be due to poor data quality. This will be rapid cycle tested in early April when the ED General Manager returns from leave. **Run two RCTs one from EDs perspective and one from AMUs perspective. looking at data quality for reporting. feedback at EQSG on** **This action is a follow-up of 3.1**	Action - to review data IL/RW - to identify a date for the RCT before ORG Acute medicine to place medical consultant in ED after the strike from 9-5. 28-29/04/16 - **This is going ahead as planned.** Need to agree date for EDs contribution - Suggestion for the strike days **- This is going ahead as planned.** **Outcomes to be shared by RW and IL at EQSG on 11/05/16**

4	4.4	Expand ACPs if high volume potential is identified	Catherine Free	01/05/2016		Proforma for notes audit designed. - Pull patient notes for decided date - Agree teams to do notes audit - one for AMU one for CDU - Complete audit Catherine Free audit - if patients could have used alt. amb. Care pathway. Drafted criteria. Run at same time as GP trial at Glenfield. To be done in 2 weeks time at Glenfield - ? When done in ED. Ambulatory care sensitive conditions (graph in UCB dashboard) - national definition of ACS. Audit took place on 18/3/16 at the same time as the GP trial. Numbers were small but some patterns have been identified. Notes to be reviewed and themes identified when CF back from leave. Data was presented at the last EQSG - T&F group was set up to decide the next steps and report back to EQSG on 13/04/16, with proposed plan. **Managerial support has been provided and the team is preparing for the second trial phase.** **Proposal to utilise system one in AAU.** **Currently it is costing CDU approx £500 per month to maintain the current module.** **Previously quoted around £6000 for a new unit and then set up costs with HISS (external provider) which includes setting up all aspects and training the staff of around £5000.** **However, unsure if we can just extend the license being used in UCC, as number of users is not limited?**	Action - to review data **Update at EQSG post 2nd Trialtrial.** **Trial to start on 9th May for 8 weeks.**
4	4.5	Analysis of what 0-6 hour LoS are made up of – identify opportunities to reduce LoS further/identify patients who shouldn't have been admitted	CCG	31/03/2016		Initial analysis of specialty mix complete. LCCCG leading - Niki has data - outputs of 4.3 will be useful.	SP to d/w RM.