UHL Emergency Performance

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

Executive Summary

Context

University Hospitals of Leicester remains under acute operational pressure caused by a combination of increased demand and sub-optimal processes internally and across the system.

We have not seen a decrease in attendances or improvement in performance over the summer. A refocus on high impact actions via the new AE Delivery Board aims to decrease attendance, reduce admissions and improve processes, thus improving 4 hour performance. UHL continues to work with ECIP and LLR to deliver these actions and rebalance capacity and demand.

Questions

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

Conclusion

Over the last month a new RAP has been developed, the delivery of this at system level will be managed by the AE Delivery Board chaired by UHL CEO and within UHL by the EQSG chaired by the COO. The RAP focuses on high impact changes which will deliver between October and the end of financial year.

UHL will focus on internal actions but will also play a key part in working with LPT, EMAS and CCGs to ensure we see reductions in attendance and improved discharge processes. The opening of ward 7 at the LRI and ward 23a at the Glenfield will play a significant part in delivery of improved performance and it is essential that these wards are staffed safely to ensure opening as planned.

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: November 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: **6 October 2016**

Four hour performance

2016/17 YTD

- 16/17 performance YTD is 79.7% and August's performance was 80.1%
- 15/16 performance YTD was 91.9% and August 2015 was 90.6%
- YTD attendance 7% up on the same period last year
- YTD total admissions 1% up on the same period last year.

September 2016

- Month to date - September 1st to 23rd is 78.5%

Attendance and admissions

Month to date in September, attendance has been eight per cent higher than the same month last year equating to 43 more patients attending per day and is a level of attendance similar to the level of attendance seen during the peak of winter 2015-16. There have been two 72 hour periods in September with the highest volume of attendance and admissions ever.

ED Occupancy

High attendance and variable outflow from the department has resulted in high ED occupancy. On the 13th September 2016, a critical incident was called in advance of the ED occupancy peaking at over 140 patients, which is the highest ever level of occupancy within ED.

Discharges

Admissions have been at a similar level to September 2015 but discharges have increased by 3% over the first 23 days of the month compared to September 2015. Despite the increased level of discharges, medical outlying (as forecast in our demand and capacity plan), increased from an average of eight beds per day in August to 21 beds per day in September and peaking at 31.

STF

As detailed in September's Trust Board paper, this month's STF target moved from 80% to 85% and delivery was a known risk. September's STF will not deliver and October's is a risk. As detailed in Appendix 1 the actions in the RAP are focused on improving all parts of the pathway to improve ED performance.

	STF Trajectory 4hr Performance	**Actual 4hr Performance**	STF Achieved?
Apr-16	78%	**81.2%**	Achieved
May-16	78%	**79.9%**	Achieved
Jun-16	79%	**80.6%**	Achieved
Jul-16	79%	**76.9%**	Not Achieved
Aug-16	80%	**80.1%**	Achieved
Sep-16*	85%	**77.2%**	Not Achieved
Oct-16	85%		
Nov-16	85%		
Dec-16	85%		
Jan-17	89%		
Feb-17	89%		
Mar-17	91.2%		

Sep-16* - 1st Sep to 18th Sep

AE Delivery Board (LLR)

The new AE Delivery Board first met on 21 September 2016 chaired by UHL CEO and will (as per national guidance:

1. Bring together local statutory organisations to oversee the development, agreement and implementation of a local A&E Improvement Plan which will deliver improved and sustained A&E performance in line with local and national targets (i.e. STF trajectories and 4 hour A&E target).
2. Provide a multi-agency forum for planning, discussion and oversight of the delivery of integrated urgent care services resulting in improved A&E performance delivery.
3. Will act as the senior executive group for the delivery of improvement across the LLR Urgent Care system, and members will represent their organisations in holding others to account for delivery of agreed actions.
4. Be responsible for the approval and oversight of Emergency Planning for LLR.

The focus is on five mandated interventions from NHSI and NHSE which are:

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

During September 2016, the new RAP was agreed by LLR which focuses on delivering the intended outcome and is prioritised to ensure we concentrate on high impact interventions. UHL has ensured that where appropriate the actions from the Trust Board thinking day have been incorporated into this process. An LLR wide AE recovery implementation group will be responsible for progressing actions and the UHL governance structure will feed into this process to ensure a streamlined united approach.

Key UHL actions in the RAP for September

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

1) To reduce time in ED and improve the use of the yellow zone

14 Aug 2016	21 Aug 2016	28 Aug 2016	4 Sep 2016	11 Sep 2016	18 Sep 2016
114	88	168	120	179	142

This action is clinically led with the consultant in charge each day responsible for identifying patients to move round to yellow zone. We had two difficult weeks (w/e 11 Sept and w/e 18 Sept) with very high inflow resulting in critical incident days and "majors yellow" being used as an escalation area both during the day and overnight, as well as short falls in nurse staffing numbers which made opening the area difficult.

In order to address the high number of nursing vacancies initiatives to increase bank pay have been introduced and eight new staff members joined our bank over a 7 day period because of the revised rates. We are optimistic the use of the yellow zone will improve in October.

2) To reduce non admitted and out of hours ED breaches

Month	ED Type 1 Attendance	All ED Type 1 Breaches	Breaches after Arriving 7pm to Midnight	% After 7pm
Jun-16	12455	3613	1125	31%
Jul-16	12624	4450	1477	33%
Aug-16	12367	3716	1095	29%
Sep-16	7726	2576	795	31%

This has continued to be challenging and has not improved primarily because of the difficult two weeks in September, when the department was cohorting up to 27 patients in the morning waiting for beds. This is a key action and focus for October.

3) To reduce the number of patients breaching by ten minutes or less

· Month	ED Type 1 Attendance	All ED Type 1 Breaches	Breaches between 241 and 250 Minutes	% of Total
Jun-16	12455	3613	145	4%
Jul-16	12624	4450	160	4%
Aug-16	12367	3716	153	4%
Sep-16	7726	2576	71	3%

We have delivered a marginal (1%) improvement in this month to date. This is a focus for both the front door and majors work streams in October.

Work streams

At EQSG in September progress on CDU and AMU work streams were discussed. Key updates are highlighted below:

AMU Key actions to improve performance in ED

- Trial Clinical Tracker for two weeks taking referrals in GPAU to decrease admissions by diverting to other ambulatory pathways, or UCC in LLR (if clinically appropriate
- Implement an E-referral system for ED to AMU to decrease delays in referring and improving out-flow
- Change reallocation of consultants responsibilities in the evening to ensure a focus on discharge
- Trial an additional consultant in AMU to expedite senior reviews in the morning
- Second trial of a consultant in ED to understand the impact on medical admissions

CDU Key actions to improve performance in ED

- Maximise current use of the Ambulatory Care pathways
- Open an additional 28 beds 1st December
- Confirm if GP ambulatory support will continue at the front door of CDU
- Review CDU criteria to ensure appropriate patients are taken by EMAS to Glenfield first
- Deliver a space review for CDU

Overall in September

A steady state against the key metrics identified above has been seen in September, at a time when there has been high inflow, high acuity and exit block. The W/e 11 September and w/e 18 September were particularly challenging with critical incidents being called due to high ED occupancy. Towards the end of September, the discharge lounge at LRI was reopened and changes to nursing pay were implemented the impact of these will be reflected in October's position.

Key UHL actions in the RAP for October

1) **Continue to work on improvements to the ambulatory pathways and use of the yellow zone**
   - An on the day review will be completed by 28.9.16 to establish a baseline of ambulatory utilisation
   - Following the above an action plan will be developed to address any gaps
   - Work has started to educate and up skilling ED staff in available ambulatory pathways and how to access them, this will be complete by the 7.12.16
   - The yellow zone is open but has been inconsistent due to staffing shortfalls (medical and nursing). From 19.9.16 nursing and medical rotas are being reviewed weekly to ensure appropriate staff skill mix in area and an intensive push and refresh of the benefits of the area will be completed by the end of September.

2) **Focus on non-admitted / out of hours breaches**
   - A late shift rota (senior management 2pm -10pm) will be started from October 3rd
   - Increased clinical matron presence 7 days per week including evening has been put in place from October 3rd
   - Safety huddles have been implemented overnight from the 5th of September with the nurse in charge, Doctor in charge and SMOC
   - Additional ward capacity for medicine will be opened on the 1st November 2016 which will decrease overnight breaches

3) **Focus on streaming/ treating and redirection of patients from ED front door.**
   - Develop an integrated Front Door model with Lakeside primary care team & UHL. The proposal has been completed and will be implemented by 1.12.16
   - Ensure a robust staffing model to allow timely access to streaming at peak times by 1.12.16
   - Ensure the clinical model increases the number of patients being treated and redirected, benefits will be seen from 1.12.16

4) **Roll out SAFER placement & reopening of the discharge lounge**
   - The roll-out across Medicine go live is the 10th October
   - Full roll-out across UHL will start in January and be complete by March 2017
   - In order for the above to be successful the discharge lounge was reopened for ambulatory patients in September and a full opening (building work to allow trollies) is planned for 14th November 2016

Ambulance handovers (data up to the19.9.16)

Handover data (CAD+) is detailed below:

	Under 15 Mins Delays	% Delay Over 15 mins (CAD+)	% Delay Over 20 mins (CAD+)	% Delay Over 30 mins (CAD+)	% Delay Over 45 mins (CAD+)	% Delay Over 60 mins (CAD+)	% Delay Over 120 mins (CAD+)
Dec-15	35.1%	64.9%	53.5%	37.2%	23.7%	15.6%	3.3%
Jan-16	57.4%	42.6%	35.4%	24.9%	16.3%	12.0%	3.3%
Feb-16	60.3%	39.7%	31.5%	22.4%	14.8%	9.8%	2.2%
Mar-16	56.0%	44.0%	35.3%	23.7%	15.6%	10.7%	2.7%
Apr-16	58.9%	41.1%	29.5%	17.1%	9.6%	6.0%	0.9%
May-16	57.3%	42.7%	30.4%	17.6%	9.1%	5.6%	0.8%
Jun-16	59.9%	40.1%	28.7%	16.1%	9.2%	5.7%	0.5%
Jul-16	51.8%	48.2%	36.9%	23.5%	14.1%	8.7%	1.5%
Aug-16	53.8%	46.2%	34.7%	20.8%	11.2%	6.6%	0.8%
Sept-16	46.8%	53.2%	42.9%	29.3%	19.1%	12.4%	2.1%

A deteriorating position up to the 19th September (reasons as outlined above). At times of escalation EMAS have provided an additional crew to cohort up to 4 patients in the corridor to enable crews to be released. This is managed by a UHL and EMAS agreed SOP. Updated actions for decreased attendances and improved ambulance handover have been developed as part of the new RAP and will be managed through the new recovery board.

Front Door/ Urgent Care Centre Process

The three CCGs and UHL have reached an agreement to extend the Lakeside streaming provision at the front door until the end of this financial year and the GP numbers will increase from two to three to ensure that as many patients as possible are streamed away from ED (where clinically appropriate). The funding mechanism for this agreement is being finalised. We are also working together on the procurement of a new front door streaming service from April. The service will be run by UHL with primary care expertise as part of the model. Due to timescales for procurement there is a risk that this is not completed prior to the start of the NFY. This concern has been shared with CCGs and we are jointly working on mitigations.

Demand and capacity update

The opening of ward 7 has been delayed due to difficulties staffing the additional space and maintenance work required on wards 42 and 43 at the LRI. Ward 7 at the LRI will open on 1 November 2016 and ward 23A at the GGH will open on 1 December 2016.

The opening of the additional beds (28 on each site) and the pre-existing actions that are being delivered to reduce length of stay, reduce readmissions or send work to the Alliance and Independent Sector are factored into the modelling in table 1 below. The table uses the planned level of activity for this year rather than a further increase. Modelling suggests that:

- Elective, cancer and emergency activity at GGH should be delivered because of the increase in capacity.
- LGH will be problematic, and in particular access to ICU beds for the elective and ca work will be challenging, based on the level of emergency demand in previous years.

- The LRI will continue to give us our biggest challenge. Escalation areas in ED are being used proactively to mitigate the risk of patients being held on the back of ambulances, and plans are being put in place to staff these consistently over winter.

Table 1

GGH

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March
Open Capacity (Jan '16 Census)	412	412	412	412	412	412	412	412	412	412	412	412
Beds required for predicted 16/17 activity	423	435	409	383	364	406	430	423	400	413	409	397
Bed Gap	-11	-23	3	29	48	6	-18	-11	12	-1	3	15

LGH

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March
Open Capacity (Jan '16 Census)	390	390	390	390	390	390	390	390	390	390	390	390
Beds required for predicted 16/17 activity	402	394	389	389	372	361	387	415	397	410	412	387
Bed Gap	-12	-4	1	1	18	29	3	-25	-7	-20	-22	3

LRI

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March
Open Capacity (Jan '16 Census)	976	976	976	976	976	976	976	976	976	976	976	976
Beds required for predicted 16/17 activity	979	976	995	965	961	994	1007	980	1014	980	991	1005
Bed Gap	-3	0	-19	11	15	-18	-31	-4	-38	-4	-15	-29

Prioritisation

We have agreed that we will protect elective and cancer capacity at UHL. Given we are going into winter with a known gap; we will have to ensure that delays in the emergency pathway are reduced to a minimum as detailed in the RAP. A dashboard is being produced to demonstrate RAP progress against performance (see appendix 2). The LRI had medical outliers in July and the first half of August (note the plan above shows that July and August are the only two months at the LRI where the plan should balance) and the cancer and elective backlog reduced. More recently 37 patients were cancelled on the day of surgery at the LRI, including ten cancer patients (wc 12 September), due to the very high levels of medical admissions. In September there were two consecutive days with a take of 111 and 99 and there are enough medical beds at the LRI to admit 70 medical patients per day. This has put RTT in September under pressure and resulted in non-delivery of the 62 day standard in September.

As we move into winter with a growing imbalance we need to hold firm on no medical outliers beyond the agreed medical bed base. To ensure this, a weekly meeting will begin wc 26 September with the COO, Director of Performance and Information, Director of Emergency Care and senior members of CMGs to determine the level of elective capacity that can be managed across the next seven days. The first meeting will also agree the organisational response to times of high pressure when we are experiencing long delays in ambulance handovers and high ED or CDU occupancy.

Delayed discharges

As detailed at the last Trust Board, we often have patients in UHL waiting beds waiting for transfer out of UHL. An update was requested to understand:

- The reasons for the delayed discharge and outcome, and
- An assessment of what factors are within/out with the Trust's control

It was not possible to look retrospectively at the 90 patients highlighted at the last Trust Board; however we have looked at the patients awaiting discharge on 20 September 2016. There were a total of 66 patients with 35 patients delayed due to external factors and 31 patients due to internal delays. The patients delayed due to internal processes are predominantly due to delays with discharge documentation and investigation outcomes. The majority of these patients are discharged within 24-48 hrs. The patients delayed due to

external factors are waiting for external funding agreements, health packages of care, and placements. The longest wait is currently 24 days and there are four patients awaiting social service intervention. Actions related to delayed discharge have been detailed in the new RAP and the AE Delivery Board on 5.10.16 is focusing on Discharge.

Risks

1. The current imbalance between demand and capacity
2. Continued attendance and admission growth above YTD
3. Lack of space in ED resulting in process breaches
4. The pace of change required in cultural change to enable the benefits of actions from the RAP to be realised.

The relevant Board Assurance Framework sections are attached for reference.

Conclusion

Over the last month the RAP has been developed by the team who have focused on high impact changes which will deliver between October and the end of financial year. UHL will focus on internal actions but will also play a key part in working with LPT, EMAS and CCGs to ensure we see reductions in attendance and improved discharge processes. The opening of ward 7 at the LRI and ward 23a at the Glenfield will play a significant part in delivery of improved performance and it is essential that these wards are staffed safely to ensure opening as planned.

It is acknowledged that there is a great deal of work to be done and a process of prioritisation of workload is taking place to ensure clinical staff are freed up where possible to deliver clinical duties and SROs are provided with the support they require to facilitate delivery of their actions

Recommendations

- Note the contents of the report
- Note the prioritised high impact RAP with a change in leadership (SROs) linked to the actions to enable ownership and leadership within the team to facilitate delivery
- Note the continuing concerns about 4 hour delays and ambulance handovers in particular and the actions in the RAP to reflect the improvements that can be made within UHL to improve performance.
- Note the continued pressure on clinical staff with increasing demand and overcrowding

Leicester, Leicestershire and Rutland Urgent Care Network
System Recovery Plan
Version 9
Last updated: 21st September 2016

Programme Structure

Workstream	Sub-workstream	SRO	Medical Lead	Link to National Actions	Link to SAFER bundle
Minimise presentations at LRI campus		Rachana Vyas	Dick Hurwood	2 (111)	
Improve ambulance response and interface		Mark Gregory		3 (Ambulance)	
Improve the LRI front door	Streaming and Assessment	Lisa Gowan	Ursula Montgomery, Ffion Davies	1 (Streaming)	
	Ambulatory care	Lisa Gowan	Vivek Pillai, Lee Walker	1 (Ambulatory care)	
Improve ED flow	Adults	Julie Taylor	Vivek Pillai	4 (Flow)	
	Children	Julie Taylor	Sam Jones	4 (Flow)	
Improve Ward Flow	Assessment units	Julie Taylor	Lee Walker	4 (Flow)	**S F E**
	Base wards	Gill Staton	Rachel Marsh	4 (Flow)	**S A F E**
Improve CDU Flow		Sue Mason	Caroline Baxter	4 (Flow)	
Improve discharge processes		Tamsin Hooton		5 (Discharge)	**R**
Overall lead for UHL-led workstreams		Sam Leak	Ian Lawrence		

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

Key Intervention No:	National Guidance ref/detail:	Action Detail	Lead Organisation	Accountable Officer	Action no.	Planned activity	Expected outcome/Impact	Key milestones	Delivery date	Contribution to ED recovery	Update (All perf. Figures are dated)	Metric			RAG rating
												Baseline (month 5)	Target	Current position	
Key Intervention Area 1: Streaming in A&E ***(Remodel the front door to better manage patient flow - to ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service).***															
1	1.2	Increase the streaming/ treating and redirection of patients from ED front door.	UHL	Lisa Gowan	**8**	1. Model streaming service integrating Lakeside with primary care team & UHL. 2. Develop staffing model to allow increased streaming. 3. Develop clinical model to enable increased treat and redirect.	1. Reduction in late referrals to ED 2. Increase in the number of patients streamed. 3. Increase in the volume of patients treated/redirected.	1. Paper to JA confirming the service integration plans 23/9/16. 2. Continuation of the streaming service 1/11/16 3. Remodelling of the streaming service 1/12/16 4. Monthly review of the service - ongoing 5. Opening of new service 1/4/17	Continuation of service 1/11/16	1. Decrease attendance in ED 2. Ensuring referrals from UCC to ED occur in a timely fashion 3. Reduction in non-admitted breaches in UCC & ED	1. Modelling commenced subject to testing with clinical teams and Lakeside+ 2. Contract with Lakeside extended from November 2016 to 1st April 2017 3. Meeting arranged with Lakeside to agree integrated model of care 4. Paper will be sent to JA on 23/9/16 confirming how the UCC and front door streaming will integrate	44% (% pts treated and redirected)	55%	Pending	**4**
1	1.4	Maximise use of ambulatory pathways to avoid ED attendance	UHL	Lisa Gowan	**11**	1. ED on the day review of utilisation of ambulatory pathways planned. 2. Develop action plan to address any gaps 3. Implement change 4. Reaudit 5. Embed a process for continual education and up skilling of all ED staff in available ambulatory pathways and how to access them.	1. Increase number of patients accessing ambulatory pathways	1. ED on the day review of utilisation of ambulatory pathways planned 28/9/16 2. Develop action plan to address any gaps 14/10/16 3. Implement change 4/11/16 4. Reaudit 25/11/16 5. Embed a process for continual education and up skilling of all ED staff in available ambulatory pathways and how to access them 7/12/16	Complete by 07/12/2016	1. Decreased ED attendances 2. Decreased non-admitted breaches	1. Audit planned for 28/9/16	Baseline to be established in the 'on the day' review	TBC	TBC	**4**
1	NA	Review short stay capacity & demand and determine if we are going to increase the short stay capacity and reduce base ward capacity	UHL	Lisa Gowan	**13**	1. Review literature on how many AMU beds are required to match demand and capacity 2. Visit other Trusts to compare the size of their AMU capacity to ours 3. Determine if we are going to increase our short stay capacity or not	1. Improvement in flow from ED 2. Improvement in patient experience 3. More efficient way of working, leading we hope to a reduction in LOS	1. Review literature on how many AMU beds are required to match demand and capacity - 9/9/16 2. Visit HEFT to compare the size of their AMU capacity to ours - 2/9/16 3. Determine if we are going to increase our short stay capacity or not - 28/9/16	Agree on whether we will increase AMU capacity or not 28/9/16	1. Improvement in flow from ED resulting in a reduction in non admitted breaches	1. ECIP recommendations state that a Trust should have sufficient AMU beds to accommodate 150% of their mean daily emergency medical admissions 2. We admit 89 medical admissions, on average, per day 3. This requires us to have 134 medical short stay beds. We actually have 80 AMU beds and a further 26 short stay beds meaning we are 28 to 50 beds short.	Improvement in volume of short stay to medical admissions ratio	TBC	TBC	**3**

1	NA	Develop ED internal professional standards	UHL	Lisa Gowan	**18**	Implement Rapid assessement: 1. On the day observation to identify areas of improvement 2. Develop improvement plan 3. Implement improvement plan Patients to be seen by senior decision maker in 90mins & have decision made within 180 mins: 1. Two hourly huddles implemented with senior nurse, doctor and manager; from 1 September there will be a focus on time to be seen by doctor. 2. Implement process to ensure appropriate use of escalation areas 3. Revise SOP for Majors 4. Rapid cycle test new medical model	1. Reduction in non-admitted breaches. 2. Reduced number of patients on ambulances	Implement rapid assessment: 1.Observation and plan - complete 31 Oct 2016 2. Implementation - complete 30 Nov 2016 Patients seen within 90mins/decision within 180mins: 1. Huddles began 1/9/16. 2. Implement process to ensure appropriate use of escalation areas - in place 3. Revise SOP for Majors - 30 October 4. Rapid cycle test new medical model - 30 October	All actions to be complete by 30 October 2016	1. Reduction in non-admitted breaches. 2. Reduced number of patients on ambulances	Huddles and process improvement are in place	48% (% patients with decision made within 180mins)	95%	Pending	**3**
1		NHS Improvement recommended presentation from South Warwick on how they improved system performance.	UHL	Lisa Gowan	**25**	-Make contact with South Warwickshire Trust - Invite to present to senior leadership team to identify any further actions for UHL to implement	Unable to comment on expected outcome until contact has been made	Unable to comment on expected outcome until contact has been made	Exchange visit to be complete by 1 November 2016	Unable to comment on expected outcome until contact has been made	- CD has contactedSouth Warks Deputy Medical Director to arrange for visit to UHL	Unable to comment on expected outcome until contact has been made	TBC	TBC	**4**
Key Intervention Area 2: No. of 111 calls transferred to Clinicians ***(Minimise presentations from primary and community care to LRI ED assessment services)***																
2	2.2 2.5 2.6 2.7 3.3	All phone based access points only direct patients to ED when clinically necessary	West CCG	Rachna Vyas	**1**	1. Implement Navigation hub 2.Implement new pathways for a specific clinical cohort of low risk 111 patients deemed appropriate for ED 3. Implement new pathways for a specific clinical cohort of low risk G1-4 patients deemed appropriate for ED	Decrease in ED dispositions of 5% Increased deflection to CRT/AVS or community based hubs from both EMAS CAT desk & 111 by > 5 per day Increase in pathway 0 patients being diverted to base visit rather than ED by 5 per day	1. Navigation hub go-live 2. Test 2: revised pathways for 'ED dispositions' 3. Test 1: Revised HAT pathways for G1-4 calls	1. Oct 31st 2. Pathway live (PDSA) 3. 28th September 2016	Reduction in Non-admitted breaches in minors/UCC Reduction in admitted breaches	Implementation of Navigation hub on track 111 > hub pathway live Sept 2016. Numbers monitored weekly. Test 2 will include revised booking process for ANP calls 111/G3-4 > Digital GP due to go live in Oct	Decrease in ED dispositions of 5% Baseline requested	Increased deflection to CRT/AVS or community based hubs from both EMAS CAT desk & 111 by > 5 per day Baseline: 13 calls/month from EMAS 0 calls/month from 111 (August 2016) Decrease ED attends by 11%	Increase in pathway 0 patients being diverted to base visit rather than ED by 5 per day Baseline requested	**4**
2	1.1	Ensure GP's have direct access to a Consultant for clinical discussions prior to acute referral	UHL	Rachna Vyas	**2**	1. Secure funding for pilot extension 2. Implement roll out plan to Paeds and geriatrics 3. Re-launch service to all GP's	Increase in avoided EAs in specific specialities (from 66% to c.70%) Increase in utilisation rates in Primary care from 74% to 95%	1. Agree to continue CC 2. Roll out to Paeds & Geriatrics 3. Re-launch at PLT using clinical case studies (City)	1. Complete 2. Complete 3. 21st Sept 2016	Reduction in admitted breaches	Funding secured for pilot until March 31st 2016 Comms for CC outstanding Case studies for PLT outstanding	Increase in avoided Emergency Admissions in specific specialities (from 66% to c.70%)	Increase in utilisation rates in Primary care from 74% to 95% Decrease ED attends by 11%	**TBC**	**4**

2	2.1	Instigate direct feedback loop re patients who were referred to acute care via BB but could have accessed other services	ELR CCG	Rachna Vyas	**3**	1. Audit sample of case notes 2. Implement direct and indirect feedback 3. Audit other patient pathways listed in national guidance, starting with EMAS & then 111	As per results of audit	1. Audit GP urgent calls to assess appropriateness 2. Feedback to Primary care at PLT's in Oct/Nov 3. Plan EMAS GP urgents line audit for LLR	1. September 15th 2. November 2016 3. October 2016	Reduction in non-admitted breaches	1. Audit underway 2. Slots booked at both Sept and Nov PLT 3. Audit planning started	**NA**	**NA**	**NA**	**3**
2	4.6 1.8	CCG led schemes to manage acute demand	City CCG	Rachna Vyas	**4**	1. Maximise utilisation of Hubs 2. Ensure all acute access services have embedded pathways to use most appropriate/lowest acuity care setting available including GP urgent referrals	Reduction in the number of City patients referred to UCC/ED by 111 by 5% Increase in utilisation rate at each City hub from c75% to 85% by September Reduction in avoidable admissions from LLR care homes by 10% of 15/16 outturn Reduction in conveyed module 0 patients to ED by EMAS by 5% Reduction in deep emergency admissions to commissioned plan	1. Increase use of City Primary care Hubs - Re-launch hubs with focus on reception staff in practices 2. Implement new 111 ED disposition trial to safely treat pts in the hub rather than at ED minors or UCC 3. Open up ANP slots for 111 booked pts, diverting from UCC Re-launch service with practices to ensure appropriate flow from GP to hubs, rather than GP to UCC. Will include increased presence on social media and revised answerphone messages 4. Commission additional resource to Clinical Response Team, specifically for care homes.	1. Complete by Sept 1st but part of rolling engagement plan with all practice staff 2. Pathway in place as of Sept 15th for GP and ANP 3. Complete 4. Complete	Reduction in Non-admitted breaches in minors/UCC Reduction in admitted breaches	1. Outstanding - awaiting NHSE sign off for hub services Q3-4 2. 1st test cycle being finalised - aim for end of Sept start 3. Complete - live from mid- Aug 4. Complete - car live on Aug 16th	ED attendances to commissioned plan M4 Baseline: +10% vs plan Emergency admissions to commissioned plan M4 Baseline: +2% vs plan	**Decrease ED attends by 11%**	**TBC**	**3**
2		CCG led schemes to manage acute demand	ELR CCG	Rachna Vyas	**5**	1. Maximise utilisation of UCC's 2. Ensure patients are aware of service provision via NHS NOW app	Reduction in the number of ELR patients referred to UCC/ED by 111 by 5%	. 1. Maximise the use of the ELR Urgent Care Centres in the four sites providing a seven day evening and weekend service. Oadby profile re-checked on DOS to ensure maximum diversion from 111 2. Focus use of NHS NOW App and continued promotion of service	1. Complete 2. Ongoing rollout programme	Reduction in attendances at ED and Non-admitted breaches in minors/UCC	1. Complete 2. App launched	Reduction in the number of ELR patients referred to UCC/ED by 111 by 5% Baseline requested	ED attendances to commissioned plan M4 Baseline: +10% vs plan Emergency admissions to commissioned plan M4 Baseline: +11% vs plan	**TBC**	**4**
2	4.6	CCG led schemes to manage acute demand	ELR CCG	Rachna Vyas	**6**	1. Launch Weekend AVS scheme	Reduction in avoidable admissions from LLR care homes by 10% of 15/16 outturn	1. New Weekend AVS scheme to commence in August/ September specifically for complex, elderly, EOL and Care home patients covering 3-4% of the ELR population at greatest risk of admission	Complete - service live	Reduction in attendances at ED and admitted breaches	1. Service launched. Activity and impact will be monitored	Reduction in avoidable admissions from LLR care homes by 10% of 15/16 outturn Baseline requested	**Decrease ED attends by 11%**	**TBC**	**4**
2	4.6	CCG led schemes to manage acute demand	West CCG	Rachna Vyas	**7**	1. Ensure adequate capacity in practices for non-urgent clinical presentations 2. Launch extended AVS service	Pharmacists in place as per trajectory Reduction in avoidable admissions from LLR care homes by 10% of 15/16 outturn	1. Commissioning of Pharmacists in every practice / group of practices to provide workforce capacity to focus on cost effectiveness and medicines related admissions 2. Increase AVS timings from 9-5 to 8pm	1. Rolling programme 2. Planned go-live Oct 16	Reduction in attendances at ED and admitted breaches		Reduction in avoidable admissions from LLR care homes by 10% of 15/16 outturn Baseline requested	ED attendances to commissioned plan M4 Baseline: +7% vs plan Emergency admissions to commissioned plan M4 Baseline: +5% vs plan	**TBC**	**4**

2		Identify multi-agency solution in high user postcodes across LLR - these are predominantly in East and City	EMAS	Rachna Vyas	**29**	1. Review and Share activity by post code to support a reduction in activity reaching 999 services 2. Review and share HAT/SAT activity by postcode	Reduction of 999 activations by 5% per day.	- Baseline activity captured - 14/09/2016 - CCG produced postcode analysis report shared - 30/09/2016 - Alternative care pathway planning &implementation including comms package for patients and practcies - Through November/December 2016	As previous column	Reduction in attendances at ED and Non-admitted breaches in minors/UCC	Postcode data received - difficult to attribute to practice level so a generic Comms and engagement programme is being planned at community level between CCG and EMAS	Reduction of 999 activations by 5% per day. Baseline requested	**Decrease ED attends by 11%**	**TBC**	**3**
2		To ensure that patients discharged from the Acute Trust with a PARR+ score of +5 are provided with adequate community support to prevent readmission within 30 days	UHL	Rachna Vyas	**66 (new)**	1. Roll out use of PARR+ tool 2. Update nerve centre with PARR score for at risk patients 3. Identify and implement community/primary care support within 48 hours of discharge	Reduction in readmissions for patients leaving the Trust with a PARR score of +5 by 10%	1. Nerve centre updated 2. Primary/community care support secured and implemented	1. November 2016 2. November 2016	Reduction in attendances at ED and admitted breaches	Initial pilot complete. Readmissions reduced in target cohort by X%	Reduction in readmissions for patients leaving the Trust with a PARR score of +5 by 10%	**Decrease ED attends by 11%**	**TBC**	**2**
2	1.8	Increase utilisation of step up ICS capacity to prevent acute activity	LPT	Rachna Vyas	**67 (new)**	1. Develop additional guidance with GP's and circulate. This should include medical management template with pre-populated prescribing guidance and parameters 2. Improve engagement and understanding of service across General Practice through use of case studies	Increase utilisation of step up capacity by > 2 patients per day by CCG	1. Guidance, template and Comms complete 2. Rolling programme of case studies and direct feedback to GP's to be implemented using Board GP's	To be completed by October 31st 2016	Reduction in attendances at ED and admitted breaches	Team identified at City CCG to lead development of template and guidance in partnership with LPT. Includes LPT team, nursing & quality, Medicines optimisation, IT leads and lead clinician.	Increase utilisation of step up capacity by > 2 patients per day by CCG City CCG currently averages 1 patient per day Baseline requested	**Decrease ED attends by 11%**	**TBC**	**4**
2		All patients referred to UHL by GP should arrive < 4 hours from time of referral	EMAS	Rachna Vyas	**69 (new)**	1. Assess viability of limiting the number of LLR practices using the direct EOC booking function 2. Reiterate to General Practice that all appropriate referrals to UHL must go via Bed Bureau for capacity planning purposes 3. Re-launch criteria for ambulance conveyance to General Practice *Linked to actions 4-6 above - if EMAS refer more CAT-triaged patients to CRT/AVS this should release EMAS capacity to convey patients into UHL earlier*	Reduction in number of GP urgents conveyed to hospital in total All patients conveyed within 4 hours of referral	1. Ability to divert all LLR requests to EOC to BB 2. Re-launch booking criteria and pathway to practices	1. 30th September 2016 2. PLT, Locality/HNN meetings in September	Reduction in attendances at ED and admitted breaches	1. In progress - turning EOC line off completely is not viable as the line services the whole region 2. Practice-specific Comms package being put together	All patients conveyed within 4 hours of referral	Reduction in number of GP urgents conveyed to hospital in total		**3**
Key Intervention Area 3: Ambulance Response Programme ***(Improve ambulance response and interface)***															
3		Monitor and increase the use of CAD+ at the Leicester Royal Infirmary	EMAS	Mark Gregory	**30**	1.Set Current baseline 2. Working with UHL arrange for notify screen move 3. Working with EMAS PMIT, generate individual compliance report 4. Ensure consistent use by Amvale resources	90% of crews using CAD+	1. Baseline generated from UHL handover report 2. link UHL & EMAS IM&T teams re the move of the notify screen 3. PIN number report to be generated and shared with divisional managers 4. Liaise with Amvale and feedback non-compliance	1. 1st October 16 2 31st October 16 3. 31st October 16 4. 30th September 16	Accurately monitor handover times and track trends		Oct 16 - 75% Nov 16 - 77.5% Dec 16 - 82% Jan 16 - 85% Feb 16 - 87.5% Mar 16 - 90%	90% of crews using CAD plus	*TBC*	**4**

3		Implement A&E Front door Clinical Navigator	EMAS	Mark Gregory	**32**	1. Identify individuals to undertake navigator role 2. Provide Supportive development with navigatrors to ensure appropriate challenge etc 3. Monitor and report against findings 4. Look towards extension to hours via Vanguard Funding	Linked across all Non conveyance metric (Reduction of 4% by 31st March 2017)	1. Clinical team Mentors identified as navigators 2. Jay Banerjee to deliver training 3. Monthly reports to be fed into the appropriate meeting structure 4. Business Case to be submitted for extension to coverage	1. 1st Sept 2016 2. 1st Nov 2016 (Complete) 3. 10th of Each Month 4. 10th Oct 2016	Reduction in A&E attendances	1. Team identified and Briefed 1. Soft launch of confirm and challenge commenced 2. Dr Jay Banerjee contacted and dates for traiing being developed	Oct 16 Clinical Navigator role on site 3 x per week for >4 hours per day	Percentage of EMAS attendances where an alternative should have been used not to exceed 15% per month (Nov 16 Onwards)	TBC	**3**
3		Implement and enhance the use of Mobile Directory of Service	EMAS	Mark Gregory	**33**	1. Ensure registration of all eligible staff to MDoS (50% by March 16) 2. Train Staff in the use of MDoS (50% by March 16) 3. Increase the number of MDoS referrals 4. gain access to mobile SystmOne enabling care plan viewing	Linked across all Non conveyance metric (Reduction of 4% by 31st March 2017)	1. Project lead to be identified 1.1 Project lead to generate project plan to increase points 1 & 2 2. Train the Trainer sessions to be held ensuring MDoS super users can support training schedule 3. Project lead to monitor use and support non compliant staff 4. Work with Commissioners to secure SystmOne access	1. 30 Sept 16 1.1 15 Oct 16 2. 31 Oct 16 3. March 17 4. Feb 17	Reduction in A&E attendances	1. Project Lead identified and in post	50% of staff registered to use MDoS (March 16)	50% staff trained to access and use MDoS (March 16)	TBC	**3**
3		Implementation of Dispatch on Disposition	EMAS	Mark Gregory	**34**	1. Trust identified as adopter site 2. Timescales for implementation Negotiated with NHSE 3. NHSE assurance review and sign off 4. Mobilisation 5. Secure exec lead for ARP/DoD at the delivery board 6. Map Nature of Call list against current keyword flows	Reduction of Resources to scene by 0.2 from 1.4 baseline Linked to above non conveyance trajectory	1. Work with NHSE to register as implementer site 2. negotiate and agree timescales for mobilisation 3. Assurance review to be arranged and undertaken 4. Mobilise scheme	1. September 16 2. September 16 3. 10th Oct 16 4. 31st October 16	Reduction in A&E attendances	1. Trust approved as implementer site 2. Timescales agreed	1.4	Oct 16 - 1.4 Nov 16 - 1.36 Dec 16 - 1.32 Jan 16 - 1.28 Feb 16 - 1.24 Mar 16 - 1.2	TBC	**4**
3		Left shift transportation of Urgent activity into UHL sites	EMAS	Mark Gregory	**34a**	1. Review current baseline 2. Scope resource availability 3. draft project and resourcing plan 4. Mobilise additional resources	Earlier attendance of HCP urgent calls	1. Working with PMiT gain average call to arrival time 2. Review current resources within LLR EMAS Pool 3. Liaise with Commissioners to plan additional commissioned resources 4. communicate launch and mobilise additional resources	1. 15 Oct 16 2. 20 Oct 16 3. 1 Nov 16 4. 30 Nov 16	Improved Flow		Percentage of patients arriving within their alloted timescale	TBC	TBC	**4**
3		Sustain Current High levels of Hear and Treat rates for LLR 999 calls	EMAS	Mark Gregory	**35**	1. Assess workforce capabilities to ensure robust 24/7 cover 2. Assess access for Clinical Advice Teams to the DoS 3. Communicate new access routes to Clinical Advice Hub once mobilised	Maintainence of the current baseline of 20% hear & Treat Rates for LLR generated calls	1. Workforce review undertaken and WFP generated 2. DoS access reviewed and available to CAT 3. Communication to be shared when CAH PID received	1. September 16 2. September 16 3. Nov 16			20%	20%	TBC	**4**
Key Intervention Area 4: Improved Patient Flow ***(Improve CDU, ED and Ward Flow at UHL)***															

4	NA	UHL to open additional emergency beds at the LRI to decrease bed capacity/demand mismatch	UHL	Gill Staton	**9**	1. Open and staff 28 beds on ward 7	1. Decrease outlying on non-medical wards (dependent on attendances and admissions remaining constant) 2. Decrease congestion in ED by improving flow 3. Contribute to an improved 4 hour performance 4. Improve staff experience by staffing a consistent ward therefore preventing staff moving from ward to ward	1. 10th October 2016 identified staffing to be confirmed 2. Equipment to be ordered and delivered by 22nd October 3. Planned opening 1st November 2016 4. Fortnightly progress update meeting in place with COO	Ward open 1 November 2016	1. Reduction in breaches linked to poor flow and ED occupancy	1. Childrens moved off ward 9 on 13/9/16 2. Estates work on ward 7 started on 14/9/16 3. Communications have gone out to all staff in September 4. Equipment ordered on 25/8/16 5. Nurse staffing rosters were set up and shifts sent out agency on 08/08/16 6. We currently do not have enough staff to open this ward. 7. There is a fortnightly meeting in	N/A	28 beds open on the ward	N/A - ward not yet open	**3**
4	NA	Trial senior acute physician in ED to challenge admissions	UHL	Julie Taylor	**10**	1. Three day trial in September 2. Two further trials to take place to confirm results 3. Collate results and review outcome of trials 4. If results positive review medical job plans to check if it can be staffed within existing resource. 5. Implement (if outcome positive)	1. Reduced conversion rate to admission 2. Increase bed capacity 3. Decrease congestion in ED 4. Improve patient experience with 'home-first' mentality	1. 15th August complete 1st trial 2. 29th August completed 2nd trail 3. 26th September complete 3rd trial 4. 3rd October review outcomes and confirm benefits and decision to progress	Decide by 14/10/2016 if this will be fully implemented	1. Decrease congestion in ED 2. Decrease breaches 3. Improve patient experience 4. Reduction in volume and % of patients admitted	1. First two trials complete- provisional data showing decreased conversion to admission 2. Third trial planned for 26 September	21.2% (ED conversion rate)	TBC	21.30%	**4**
4	NA	Reduce time from bed allocation to departure from ED	UHL	Julie Taylor	**14**	1. Establish baseline 2. Identify themes for delay 3. Allocate Rapid Flow team to ED 4. Communicate and promote change in process 5. Rapid cycle test the new process 6. Implement	1. When beds are available, patient will leave within 15mins	1. Establish baseline - complete 18th July 2. All other actions were completed in August	All actions complete 1 September 2016	1. Improve flow from ED 2. Decrease congestion in ED	1. Work with the rapid flow team has shown an reduction in the average time from 30 mins to 19 mins. 2. Delay themes identified: * Photocopying issues - resolved * Patient status issues -resolved 3. Currently looking at issues around bulking of bed availability and transport issues.	26% (% patients leaving the department within 15mins of bed allocation)	50%	31%	**5**
4	NA	Reduce handover times for medical and nursing team	UHL	Julie Taylor	**15**	1. OD facilitated workshop with medical and nursing teams on handovers 2. Trial of suggested new format of handover 3. Embedding of newly agreed process in the department	1. Reduce handover times to maximum of 20 mins	1. Baseline current handover process & times - complete 27th July 2016 2. Implement bedside handover - will be complete 7 November 2016 3. Reduce number of doctors handovers - review 7 November 2016	All actions to be complete 7 November 2016	1. Reduction in wait to be seen in ED	1. Baseline observations complete 2. As a result the key roles & responsibilities have been redefined 3. Head of Service has discussed this with the consultant body 4. Further OD support been confirmed 5. Nursing restructure is complete	Handover time: Nursing 20mins Medical TBC	TBC	TBC	**4**
4	NA	Implement ambulatory majors patient stream	UHL	Julie Taylor	**16**	1. Area identified 2. Rapid cycle testing 3. Development of SOP 4. Nursing and medical rotas reviewed weekly to ensure appropriate staff skill mix in area 5. Feedback outputs in nursing and medical handover 6. Implement 7. Monitor effectiveness of area	1. Reduce non-admitted breaches 2. Improve patient experience	1. Area identified - complete 31st March 2016 2. Rapid cycle testing - complete 7th April 2016 3. Development of SOP - complete 7th April 2016 4. Nursing and medical rotas reviewed weekly to ensure appropriate staff skill mix in area 5. Feedback outputs in nursing and medical handover - complete 11th July 2016	All actions complete 11 July 2016	1. Reduction in breaches	1. Implemented on 11th July 2016. 2. W/c 19/9 - intensive week of push and refresh of usage of area, led by senior medical and nursing staff, followed on key themes 3. Area is currently being used in escalation to care for other patients limiting the number of ambulatory patients being seen there	68% (Majors yellow area 4hr performance)	95%	55%	**3**

4	NA	Reduce delays in diagnostics for patients in ED	UHL	Julie Taylor	**20**	1. Baseline audit to be completed 2. Identify reasons for delay from audit 3. Complete trial of dedicated porter for 3 days in ED	1. Decrease congestion in ED 2. Improved efficiency of diagnostics	1. Baseline audit - complete 18th July 2. Reasons for delays identified 25th July 3. Trial of dedicated porter - delayed due to availability of porters	All actions to be complete 17 October 2016	1. Reduction in patient wait times 2. Reduction in breaches	1. Baseline audit - complete 18th July 2. Reasons for delays identified 25th July 3. Trial of dedicated porter - delayed due to availability of porters	Transfer time from ED to imaging metric is being reviewed	TBC	TBC	**3**
4	NA	Deliver interventions to improve leadership and behaviours in ED	UHL	Julie Taylor	**21**	1. Appoint OD consultant 2. Sept - Nov: delivering leadership interventions; delivering sessions with leaders and teams on behavioural competencies; integrating OD, comms, SOPS and IT. 3. Delivering coaching for key leaders within ED	Improved staff morale	1. OD consultant in post May 2016 2. Sept - Nov: delivering leadership interventions; delivering sessions with leaders and teams on behavioural competencies; integrating OD, comms, SOPS and IT. - ongoing 3. Delivering coaching for key leaders (Heads of Service & Key managers) within ED - complete August 2016	This is ongoing work until 31 March 2017	Non specific	1. Pulse check basline complete July 2016 2. Follow up taking place September 2016 3. New leadership team in place	Measured via HR metrics	TBC	TBC	**4**
4	NA	Reduce overnight breaches	UHL	Julie Taylor	**22**	1. Senior leadership shift change (2pm - 10pm) over winter 2. Pro-active use of escalation areas to allow space in ED for decisions to continue to be made 3. Ensure consistent huddles over the night period 4. Open additional beds (as per previous action re ward 7)	1. Reduction in breaches 2. Improved patient experience	1. Implementation of the late shift rota (senior management 2pm -10pm) 3rd October 2. Increased clinical matron presence 7 days per week including evening 3rd October 3. Ensure safety huddles are completed during the night (SMOC or duty manager to lead) 5th September 4. Open additional ward capacity 1st November 2016	All actions to be complete 1 November 2016	1. Reduction in breaches o	1. Shift change goes live 3rd October 2. Matron restructure complete 3. The opening of the ward has been pushed back to 1 November 2016	Currently 29% of patients arriving between 7pm and midnight are treated within 4hrs	TBC	TBC	**3**
4	NA	Implement low risk ambulatory service on CDU	UHL	Sue Mason	**26**	1. Business case to be written for EQSG 2. Meeting with CCGs to discuss commissioning 3. Implement if commissioned	1. Maintain LOS on CDU achieved during pilot (July/August) 2. Average LOS in low risk ambulatory service 2 hours 3. Improve quality for patients by decreasing time in CDU	1. Business case went to EQSG on 31st August 2. Met with CCGs to discuss commissioning 6th September 3. Implement if commissioned 1st December	If commissioned, 01/12/2016	1. Decrease in frequency of CDU going on a 'stop' therefore decreasing congestion in ED and number of breaches	1. Business case complete 2. Meeting with commissioners 6.9.16 3. Total BCF funding identified £105k - awaiting confirmation from commissioners	13 (Length of stay in CDU)	13	13.3	**3**
4	NA	Decrease conveyance of Cardiorespiratory patients between LRI and Glenfield to increase EMAS capacity	UHL	Lisa Gowan	**27**	1. Establish baseline activity 2. Review the criteria 3. Case note review to determine if the patient was conveyed to the right location 4. Develop action plan 5. Implement any required changes	1. Decrease conveyance of cardiorespiratory patients from LRI to Glenfield 2. Improve quality to ensure that patient gets to the right specialty first time	1. Establish baseline activity - complete 20th August 2. Review the criteria - complete 20th August 3. Case note review to determine if the patient was conveyed to the right location 30 September 4. Develop action plan 31st October 5. Implement high impact and short term rapid interventions 30th November	Full implementation 30 November 2016	1. Reduce attendances at ED 2. Reduce overall breach rate	1. Meeting held on the 19/08 with EMAS 2. Audit to be completed for all those patients sent direct the LRI to ascertain reasons by end of September.	107 in August (Number of pts transferred from ED LRI to Glenfield)	96 (10% reduction)	50 to date in Sept (ED LRI to GGH)	**4**

4	NA	Implement Safer Patient Placement across UHL	UHL	Julie Taylor	**36**	1. Launch communication throughout UHL 2. Project plan to be developed on how UHL roll-out on wards 3. Roll-out across Medicine 4. Full roll-out across UHL 5. Re-opening of discharge lounge	1. Increase discharges from wards before 1pm 2. Reduce breaches in ED 3. Reduce congestion in ED 4. Improve patient experience 5. Decrease use of escalation areas	1. Launch communication throughout UHL - complete 7th September 2016 2. Project plan to be developed on how UHL roll-out across wards - complete 14th July 2016 3. Roll-out across Medicine - go live 10th October 4. Full roll-out across UHL - phased roll out January to March 2017 5. Re-opening of discharge lounge - 14th November 2016	Go live of Safer across medicine on 10 October 2016	1. Reduce breaches in ED 2. Reduce time from bed request to allocation	1. Temporary discharge lounge opened 13th September 2. Project plan complete 3. Initiative communicated to all staff 7th September 2016 4. Rapid cycle test completed 15th September 2016 5. Communication with ESM ward managers and matrons started	55% of patients allocated a bed within 60 mins	75%	51%	**4**
4	4.1 4.3 4.4	Implement SAFER patient flow bundle Trustwide	UHL	Gill Staton	**37**	1. Baseline audit of wards to be completed on utilisation of the SAFER flow bundle 2. Develop actions to address gaps identified in audit 3. Re-audit once actions put in place 4. Phased roll-out across UHL	1. Increase in the number of patients discharged before 1100 2. Increase in the number of patients with EDD 3. Consistent board rounds on all wards 4. Decrease number of 'stranded' patients 5. Improve ward ownership 6. Increase patient experience by ensuring patient is part of the decision making process 7. (Percentages to be confirmed once baseline audit complete)	1. 29th August 2016 audit of 5 wards completed 2. 19th September 2016 baseline audit of 2 further wards to identify areas for improvement 3. Collation of results and feedback w/c 1st October 4. Action plan developed by 10th October 5. Implementation of plan to start 17th October on key wards 6. Start of baseline audit of remaining wards on 14th November 7. Action plan and full roll-out by mid-December	SAFER patient flow will be rolled out on two key wards by 01/11/2016	1. Improve base ward capacity for admissions from ED.	-29th August 2016 audit of 5 wards completed	5.82 (average length of stay for Medicine)	4.67	6.63	**3**
4	NA	Glenfield to open additional beds to decrease bed capacity/demand mismatch	UHL	Sue Mason	**39**	Open 28 beds on ward 23a	1. Decrease outlying on non-medical wards (dependent on attendances and admissions remaining constant) 2. Decrease congestion in CDU 3. Contribute to an improved LOS on CDU 4. Improve staff experience by staffing a consistent ward therefore preventing staff moving from ward to ward 5. Reduced frequency of CDU going on a 'stop'	1. 18th November 2016 staffing to be confirmed 2. Equipment to be ordered and delivered by 31st October 3. Planned opening 1st December 2016	Ward is due to open on 1 December 2016	1. Decrease breaches linked to better flow to GGH	1. Agreement from ESB that RRCV will utilise ward 23a at GH until March 2017. 2. Communication to staff started 15th August 2016 3. Compiled list of equipment requirements 4. Out to recruit for staff 5. Discussed with medical staff to provide cover 6. Business case has gone through RIC	N/A	28 beds open on the ward	N/A - ward not yet open	**4**
4	NA	Implement specialty in-reach of referred patients to ED	UHL	Julie Taylor	**40**	1. Review Trust Watershed policy 2. Benchmark against specialty in reach services in other Trusts 3. Work with HOS and CD to communicate policy to all other specialty CDs 4. Re-implement Trust watershed policy	1. Reduced wait times for ED patients by releasing ED medical staff 2. Improve patient experience	1. Review Trust Watershed policy - complete by 17/10/16 2. Benchmark against specialty in reach services in other Trusts - complete by 17/10/16 3. Work with HOS and CD to communicate policy to all other specialty CDs - complete by 17/10/16 4. Reimplement Trust watershed policy - complete by 17/10/16	ons to be complete by 1	1. Reduction in breaches 2. Improvement in time to be seen by a doctor and time for a plan 3. Reduction in conversion rate	Current policy under review - awaiting update from CD	21.2% (ED conversion rate)	TBC	21.30%	**4**

4	NA	Develop hospital internal professional standards (incl speciality in-reach to ED)	UHL	Sue Mason	**43**	1. Implement UHL Better Change project to decrease Cardiology inpatient LOS pre Cath Lab 2. Implement daily review of patients on monitored beds 3. Review capacity and demand of monitors available	1. Improved LOS in Cardiology 2. Decreased delay of transfer of patients from ED to CDU	1. Baseline data collection of cath lab waits - complete 2. Implement electronic referrals for Cath lab - end of September 3. Implement Hot lab Cath lab sessions - end of September 4. Reaudit Cath lab waits 11th November	All actions to be complete by 11 November 2016	1) Reduce delay of transfer of patients from ED to CDU	1. Baseline data collection of cath lab waits complete 2. Implement electronic referrals for Cath lab complete 3. Implement Hot lab Cath lab sessions complete	3.1 (Cardiology LOS)	TBC	3.7	**4**
4	NA	Improve discharge from UHL by decreasing transport delays	UHL	Gill Staton	**45**	1. Meet Arriva and CCGs to establish reasons for delays 2. Implement actions to address delays 3. Implement a weekly meeting to review patients that were re-bedded and identify themes and develop actions to resolve 4. Establish process of prospectively booking discharges 5. CCG to complete procurement of NEPTS	1. Increase early discharge 2. Decrease failed discharge	1. Set up meeting with Arriva & CCGs by 1st October 2016 2. Set up weekly review to start w/c 26th September	All actions complete by end of October	1) Reduction in breaches 2) Improved flow out of ED	-Arriva/CCG/UHL meeting arranged for end of September	4.5% (discharges pre 11am) 13% (discharges pre 1pm)	TBC	4.2% (discharges pre 11am) 12.9% (discharges pre 1pm)	**4**
4	4.2 4.5	Implement Red Day / Green Day as part of SAFER	UHL	Gill Staton	**47**	1. Investigate feasibility of method of capture of Red and Green Days (white boards or electronic) 2. Develop Red and Green Day Criteria for implementation 3. Develop launch pack 4. Communicate to and educate staff 5. Roll out across ESM -audit following roll-out	1. Decrease LOS for ESM	1. Agree Nerve Centre feasibility of recording of R&G days by 1st October 2. Agree R&G Day Criteria by 29th September 3. Roll-out of launch packs on 10th October 4. Audit 14th November 2016	All actions complete by 14 November	1) Improve base ward capacity for admissions from ED.	1) Project team met 15/9/16 to plan implementation	5.82 (average length of stay for Medicine)	4.67	6.63	**3**
4	NA	Implement direct admissions from ED to specialities	UHL	Julie Taylor	**68 (new)**	1. Develop a CMG wide clinical task and finish group to establish the type of patients that can be direct referred 2. Data analysis to determine impact change will have 3. Agree Patient criteria 4. Write SOP 5. Communicate process to teams 6. Implement 7. Feedback session to ensure the team capture any changes and improvements required	1. Decrease admitted breaches 2. Decrease overcrowding in ED 3. Improved patient experience	1. Develop a CMG wide clinical task and finish group to establish the type of patients that can be direct referred 10th Oct 2. Data analysis 31st Oct 3. Agree Patient criteria 31st Oct 4. Write SOP 11th Nov 5. Communicate process to teams 18th Nov 6. Implement 28th Nov 7. Feedback session to ensure the team capture any changes and improvements required 19th Dec	28.11.16	Decrease breaches	Not commenced	80%	77%	TBC following data analysis	**1**
Key Intervention Area 5: Improved Discharge															
5	5.6, 5.1	Additional packages of care/DRT input will need to be purchased to reduce delayed discharges from the acute trust	UHL	Tamsin Hooton	**48**	Commission extended capacity in DRT to support discharge. £155k = up to 5 beds until the end of March 2016	Increased flow, Reduced delays in discharges	Funding source to be identified. Business Case to EQSG, Discussion at AEDB 5/10	01/11/2016	Reduction in admitted breaches, reduction in LOS,	TBC	Admitted breaches	UHL LOS	Additional capacity on stream (No. of beds)	**3**
5	5.6, 5.1	Increase OPAT provision (up to 2 beds) to provide a service that delivers IV antibiotics in the patient's own home, in order to reduce LOS	UHL	Tamsin Hooton	**49**	Expansion of the current process that will allow patients who require IV antibiotics to be treated at home rather than in a hospital bed.	Increased flow, reduced LOS	MRET funding to be utilised to March (£100K) Advertise for 3 nurses (Sept 16) Identify consultant Pas (complete)	Expansion scheduled for 1/12	Reduction in admitted breaches, reduction in LOS,	TBC	Admitted breaches	UHL LOS	2 bed expansion up and running (can be phased if recruitment requires)	**4**

5	5.5	ICS to provide a programme of education to hospital ward teams in order to increase the usage of ICS.	UHL/LPT	Tamsin Hooton	**50**	Share referral criteria for ICS - 10/09 Clinical ward rounds to identify suitable people (joint with LPT)	More appropriate referrals, increased utilisation of ICS	Circulate ICS criteria Communication exercise internally and on wards Ward rounds weekly - senior LPT and UHL staff - agree frequency and put in place	30/09/2016	Increased flow, reduced admitted breaches, reduction in LOS	Significant progress in ward coding on ward 16. Lessons from this ward to be rolled out across other wards	ICS capacity utilisation (baseline 80%, increase to 90%)	Number of referrals to ICS from UHL wards. Baseline TBC	TBC	**4**
5	5.1, 5.5	Review model of ICS for opportunities to increase usage, focus on County pathways	LPT	Tamsin Hooton	**51**	Integration of ICS with county POC provision/HTLAH model	More appropriate referrals, increased utilisation of ICS	LPT /County Council workshop on 23/9 to review ICS/ social care pathway and integration Decision on further integration to go to Integration Executive Pilot in Loughborough of inreach/joint working with ICS Business Case to be developed for further integration	5/10 for agreement on future direction with County Social Care	Reduced LOS/Reduced discharge delays,also supports 'step -up' and reduced ED admissions	Business case being written by East CCG and County Social Care, to go to next Integration Exec Board (October). Business case to focus on integrated health and social care offer for pathway 2, plus an integrated discharge team inreaching into hospital (as per Rutland model)	ICS capacity utilisation (baseline 80%) increase to 90%	Increase in referrals to ICS from UHL wards. Baseline TBC	Business case for social care input to work alongside ICS agreed	**3**
5	5.1, 5.5	Review future model of ICS to support discharge to assess and 'Home First' model	UHL/LPT	Tamsin Hooton		Discharge Steering Group to agree strategic direction for Discharge to assess, reviewing ICS staffing/model and link to other pathways including reablement and domiciliary care support	Better integrated discharge to assess approach across LLR, increased use of ICS	Agree future integrated discharge to assess model Agree any changes needed to ICS model Agree Business Case with commissioners/BCT	31/03/2016	Reduced admissions, reduced admitted breacheds, reduced LOS, improved flow	As above	ICS Utilisation - baseline 80% increase to 95% post April 2017	Reduction in numbers of patients assessed for CHC in acute setting (baseline TBC) but target only 10%	Business case for social care input to work alongside ICS agreed	**3**
5	5.1, 5.4, 5.6	Commission and implement a 'home first' discharge to assess model from hospital	CCGs	Tamsin Hooton	**52**	38. Procure Pathway 2 (Home with reablement package). Implement Pathway 2 for County patients. Initial discussion with City to describe their pathway 2 offer (using existing services)	Improve flow at transfer of care stage as no waits for care packages. Improved pathway of care for non weight bearing patients, those requiring further assessment to identify true care needs, reduction in number and complexity of long term care packages. Reduction in number and complexity of CHC packages (including reduction in number of patients eligible for CHC). Reduced LOS in hospital as no eligibility assessments completed during hospital stay (possibly up to 5 days)	Procurement completed. Implement pathway on November 7th 2016. Conversation with City by 30/09/16	07/11/2016	Increased flow, reduced admitted breaches, reduction in LOS	On track to go live November 7th 2016	Number of patients using pathway 2. Baseline: 0 cases. November 7th: 5 cases. December 7th: TBA	Number of CHC assessments completed post-transfer of care. Baseline: 0. November 7th: 5 cases. December 7th: TBA.	LOS on the pathway. Baseline: 0. January: <6 weeks	**4**
5	5.1, 5.4	Commission and implement a bed based discharge to assess model from hospital	CCGs	Tamsin Hooton	**53**	39 + 40. Procure Pathway 3 (Bed based reablement and therapy package, 60 beds across LLR). Implement Pathway 3 for City and County patients.	Improve flow at transfer of care. Improved pathway of care for non weight bearing patients, those requiring further assessment to identify true care needs, reduction in number and complexity of long term care packages. Reduction in number and complexity of CHC packages (including reduction in number of patients eligible for CHC). Reduced LOS in hospital as no eligibility assessments completed during hospital stay (possibly up to 5 days)	Procurement go live on Bravo 16th August 2016, CCB for preferred provider sign off 24th November 2016 Contracts signed 14/12 Mobilisation 30/01/17 - 14/03/17	Sign contracts December 14th 2016 if procurement successful. 3 month phased mobilisation period (until 14/03/17) with initial patients reaching the service 30/01/17.	Increased flow, reduced admitted breaches, reduction in LOS	Procurement closed 16th September 2016 for the second time. Bids received for Therapy provision, no bids received for bed based services. Urgent meeting to agree future options/mitigations planned for 21/09	Number of patients using pathway 3. Baseline: 0 cases. January 31st: 5 cases. March 31st: 30	Number of CHC assessments completed post-transfer of care. Baseline: 0. January: 5 cases. March: 30	LOS on the pathway for assessment patients. Baseline: 0. March: <6 weeks	**2**
5	5.2	Design and implement an electronic solution to support a trusted assessment upon transfer of care	CCGs	Tamsin Hooton	**55**	41. Trial of trusted assessment at UHL (using Nervecentre platform) prior to go live of pathway 2.	Reduced number of assessments by multiple people (potential LOS saving), no process delays between assessment and acceptance at onwards community service	Trial go live at UHL during August 2016	November 7th 2016	Increased flow, reduced admitted breaches, reduction in LOS	Trial to be discussed 19th September with UHL - meeting cancelled. To be re-arranged.	Number of trusted assessments completed. Baseline: 0. November: 5. December: TBA	Number of accepted trusted assessments. Baseline: 0. November: 5. December: TBA	Reduced DTOC rate. Baseline UHL: 2.43% LPT: 2.85% Target 1.35% and 6.5%	**3**
5	5.2	Provide electronic means of sharing the trusted assessment with partner organisations at point of transfer of care	UHL	Tamsin Hooton	**56**	42 + 43. Commence a task and finish group to review and agree interoperability across LLR health, social care, and partner agencies. Hospital social care teams to use VPN connection in short term.	Provides initial access to trusted assessment for new pathways (enabler for success of pathways) Agree preferred option via BCT IMT group Progress Options analysis for information sharing, including Everis solution	Initial task and finish group 3rd October 2016 Options analysis to IMT group Novemberl ROI	March 31st 2017	Increased flow, reduced admitted breaches, reduction in LOS	To be discussed with UHL 19th September - meeting cancelled, to be re-arranged	Number of MDS assessments completed by UHL , number TBC at task and finsish group	Number of MDS assessments accessed by other agencies. Baseline 0, December TBC	NA	**3**
5	5.2	Create trusted assessor roles across health and social care to support transfer of care process	CCGs	Tamsin Hooton	**58**	44. Create trusted assessor roles across health and social care as part of pathway 2 and pathway 3	Appropriate patient flow into the new discharge pathways, and clear management of the journey through the pathways to get the best & timely outcomes for patients	Agree job descriptions for health and social care TA role. Recruit to posts	November for pathway 2 and January for pathway 3	Increased flow, reduced admitted breaches, reduction in LOS	Part of pathway 2 and pathway 3 mobilisation planning	Number of trusted assessors in post. Baseline: 0. November: 2. March: 6	Reduced DTOC rate. Baseline UHL: 2.43% LPT: 2.85% Target 1.35% and 6.5%	NA	**4**
5	5.1, 5.4	Provide an efficient system wide 'D2A' pathway	UHL	Tamsin Hooton	**59**	45. Switch off existing D2A pathway to coincide with commencement of Pathway 3	Pathway 3 becomes the discharge to assess route out of hospital.	Initial discussion required with UHL to start closing the pathway down ready for January	30-Jan-17	Increased flow, reduced admitted breaches, reduction in LOS	To be part of Pathway 3 mobilisation planning group commencing 26th September 2016	Number of open cases. Baseline: 50.	November: 45. January: 30. March: 0	50 open cases	**3**

5	5.1, 5.2	Engage with partner organisations to clearly describe the D2A and TA offer	CCGs	Tamsin Hooton	**60**	46. Communications messages being agreed for implementation of new pathways	Clear criteria for which patients are suitable for each pathway, including principles of home first, trusted assessors and single assessment	Messages agreed during October discharge steering group	November 2016-January 2017	Increased flow, reduced admitted breaches, reduction in LOS	Part of pathway 2 and pathway 3 mobilisation planning	Communication materials agreed 31/10	NA	NA	**4**
5	5.1	Design and deliver a pathway to support effective transfer of care for patients with severe dementia	CCGs	Tamsin Hooton	**61**	47. Scope requirements of Severe Dementia Pathway using commissioning intentions. Describe pathway to include specialised care homes for this group of patients.	Patients with severe dementia placed appropriately into the right care setting in a timely manner, follow same principles of 'home first' and 'discharge to assess'	Initial scoping session to commence 20th September 2016	31/03/2017	Increased flow, reduced admitted breaches, reduction in LOS	Task and Finish group set up	TBA during task and finish group	TBA during task and finish group	NA	**4**
5	5.1, 5.3?	Design and deliver short term improvements to capacity for end of life services in order to reduce people dying outside of their place of choice	CCGs	Tamsin Hooton	**62**	48. Scope capacity requirements for 'last few days of life' pathway	Patients in the last few days of life have choice about where to die and access the most appropriate care setting in a timely manner	Initial scoping session to commence September 2016	TBA	Increased flow, reduced admitted breaches, reduction in LOS	Arlene Neville to set up a task and finish group to review short term issues	TBA during task and finish group	Numbers of patients dying in place of choice. Increase by 10%	NA	**4**
5	5.1	Monitor Hospital Housing Team offer and review model to support new D2A and TA models where indicated	CCGs	Tamsin Hooton	**63**	49. Continue to review successes and challenges of the expanded Housing team based at UHL and Bradgate Unit	Housing team reduce LOS and delays associated with housing. Currently building team skills and expertise.	Monthly Housing steering group	Ongoing	Reductions in DTOC, reductions in LOS	Continued attendance at Steering Group. Reviewing potential need for business case to outreach to pathway 2 and 3 once operational. Mental health rep now on steering group to support DTOC at Bradgate Unit. Review of metrics to deomnstrate successes. Housing associations on board to review use of 'difficult to let' properties and enhance quicker processes from hospital	Number of patients supported by team. Baseline: 10. December: 20. March: 30	Number of patients requiring housing support on pathway 2 and 3. Baseline: 0	Reduced DTOC rate. Baseline UHL: 2.43% LPT: 2.85% Target 1.35% and 6.5%	**4**
5	5.1, 5.5, 5.6	Agree and produce a recognised DTOC measure across LLR to support operational and improvement work	CCGs and Local Authorities	Tamsin Hooton	**New**	Create a task and finish group to amalgamate reporting requirements, and agree what will be produced	Improved information on delays and process issues relating to discharge, to support better targetting of actions including improved escalation and surge processes. Supports section 4	Presentation to DSG October 2017 Dummy report produced 1/11	March 31st 2017	Improved flow, reduced admitted breaches	Task and finish group initial meeting 3rd October	Measures agreed. November 2016	First draft report December 2016	NA	**4**
5	5.3	Agree Policy on supporting patient's choice	CCGs and Local Authorities	Tamsin Hooton	**New**	Discharge Steering Group to lead process to agree policy, with appropriate entgagement with stakeholders	1/11 10/01/17 28/02/17	Discharge Steering Group to agree action plan DSG to agree policy for approval Approval by CCGs, Las/Integration Execs? Agree implentation	1/11 10/01/17 28/02/17 March 2017	Reduction in DTOCs, improved flow, reduced admitted breaches	Not yet commenced	Reduced DTOC rate. Baseline UHL: 2.43% LPT: 2.85% Target 1.35% and 6.5%	Agreed policy by March 2017	Materials supporting Policy distributed to patients March 2017	**1**
5	4.1, 5.6, 5.5	Adapt acute SAFER flow bundle to ddress the community hospital service requirements	LPT	Tamsin Hooton?	**link to 37**	Benchmark community inpuatient wards and identify additional action required Share benchmarking with DSG and confirm required actions	Identify gaps and actions for delivery of SAFER bundle in community hospitals	Completed benchmarking exercise discussed at DSG Agreed action plan	5th October Novermber DSG	Improved flow in CH, improved ability to discharge from acute, improved acute flow,	Not yet commenced	Benchmarking against 5 SAFER metrics	Agreed actions to address benchmarking gaps Nov 2016	NA	**1**

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

Leicester, Leicestershire & Rutland Local A&E Board

6th September 2016 submission

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

Initiative		Statement of good practice	B-RAG	Commentary
1. Streaming at A&E	**1.1**	All major specialties have a consultant immediately available on the telephone to provide advice & streaming for ED & primary care	**Amber**	24/7 on call cover across all major admitting specialities with 24 hr ED access. Consultant Connect available to GPs for acute medicine, Paediatrics and Geriatric medicine.
	1.2	There is a primary care stream available (if activity levels justify it) with the capacity to meet the true patient demand	**Amber**	Streaming service (Lakeside) supported by urgent care in place. Challenges around workforce and ability to recruit. Reduction in treated/redirected patients since November as service scale reduced. Winter approach to be finalised by 30/9/16
	1.3	Patients presenting with mental health illness are assessed, managed, discharged or admitted within the ED standard	**Green**	Access to 24/7 liaison mental health services is available, and this is part of our overall improvement plan. Standard not always met for pts requiring admission
	1.4	There is an ambulatory emergency care service available for 12 hours per day, 7 days per week which manages at least 25% of the emergency take	**Green**	Medical specialities. Access to ambulatory services exist but currently not taking 25% of patients. Surgical specialities via SAU with General Surgery offering a triage service Monday to Friday 0730 to 2000hrs at both LGH & LRI site.
	1.6	There is an acute frailty service available 12 hours per day, 7 days per week which treats all eligible patients	**Blue**	Access to frailty pathways are appropriate for the criteria described within 24 hours of admission.
	1.8	Community and intermediate care services respond to requests for patient support within 2 hours	**Amber**	ICRS (City) in place and responsive. CRS (County) in place but challenged with response time due to capacity constraints.
2. NHS 111 calls transferred to clinicians	**2.0**	Given there is a requirement to increase from 22% to an national interim threshold of 30% (or higher) of calls transferred to a clinical advisor by 31st March 2017, the A&E Delivery Board has plans in place to meet this requirement	**Amber**	Modelling for the Clinical Navigation Hub suggests that this will be delivered by 31/3/2017.
	2.1	Clinical expertise availability is planned according to demand	**Amber**	As above
		The A&E Delivery Board has a lead starting to integrate the NHS 111 service and local Out of Hospital Provision, particularly OOH	**Green**	Led by Director of Urgent Care. Will be in place as pilot from Oct 2016 and procured in 2017/18 as part of integrated urgent care model within the Vanguard.
	2.6	The A&E DoS service type is ranked as low as possible, apart from other A&E-type services and services not commissioned within the CCG	**Blue**	
	2.7	There are alternative services which can accept NHS Pathways outcomes for conditions that can be managed oustide A&E E.g. limb injuries, bites, stings, plaster cast problems, suspected DVT, falls	**Blue**	
	2.8	The A&E Delivery Board knows demographics of the area, including if there is a greater demand for OOH services are generated from the elderly	**Amber**	Trialled urgent care system metrics and Board will receive regular dashboard.
3. Ambulance Response Programme (DoD and coding pilots)	**3.1 & 3.2**	There is an ambulance trust executive lead on the A&E Delivery Board able to deliver the required service changes	**Blue**	Acting CE of EMAS is a member of A&EDB **BLUE**
	3.2	There are working definitions of 'Hear and Treat' and 'See and Treat' agreed across the local health economy and a baseline workforce profile to deliver an increase in these dispositions	**Green**	
	3.2 & 3.4	There are alternative services which can accept ambulance dispositions or referrals and these mapped across localities	**Amber**	Services mapped through Mobile Directory of Service. However, some local pathway confirm and challenge required to confirm
	3.4	The A&E Delivery Board has established local mechanisms for increasing clinical input into green ambulance dispositions particularly at times of peak demand	**Amber**	Clinical Hubs being developed to support patients with a green disposition
	3.4 & 3.5	The A&E Delivery Board has agreed workforce and service plans in place to deliver an increase in 'Hear and Treat' and 'See and Treat'	**Amber**	In development across health and care economy
4. Improved Patient Flow	**4.1**	SAFER patient flow bundle implemented on assessment and medical wards as a bare minimum , to improve patient flow	**Amber**	Safer bundle' concept initiated two years ago across the Acute medical wards at the LRI site. Needs re-launching and more dedicated focus- ECIP are providing support to UHL to implement SAFER bundle, work will begin with 2 pilot wards 7th Sept 2016
	4.1	What percentage of the base wards on each acute site has SAFER in place?	**Amber**	100% of Acute medical wards at the LRI has the safer bundle inplace but needs relaunching & refocus with support of ECIP
	4.2	The use of the red and green day approach has been considered	**Amber**	To be implemented- with assistance from ECIP- attending 2 medical wards on 7th Sept
	4.3	A baseline assessment of the effective use of EDDs and Clinical Criteria for Discharge has been carried out	**Green**	Audits are currently being undertaken on the medical wards at the LRI site
	4.4	Ward round checklists are in use in all wards in the acute hospital/s	**Amber**	Initiated about two years ago but not used consistently in practice - need to be relaunched.

5. Improved Discharge	**5.1**	A 'home first: discharge to assess' pathway is in operation across all appropriate hospital wards	**Amber**	Plans to deliver -pathways being implemented over next four months.Delays to discharge to assess need addressing. Significant work re comms and implementation across all wards. ICS has potential to enhance Home First approach.
	5.2	Trusted assessor arrangements are in place with social care and independent care sector providers	**Amber**	Amber in terms of pathway 2 and 3, with MDS as tool to shape the discharge work. Trusted assessor framework in place but risks to rollout.
	5.4	At least 90% of continuing healthcare screenings and assessments are conducted outside of acute settings	**Red**	Not currently in place. Existing plans for D2A will improve % assessed outside acute settings, but we have not established whether they will deliver 90% of assessments outside hospital.
	5.3	A standard operating procedure for supporting patients' choice at discharge is in use, which reflects the new national guidance	**Red**	Plans still to be developed - Discharge Steering Group to lead
	5.6	Systems are in place to review the reasons for any inpatient stay that exceeds six days	**Amber**	Baseline to be established in September, trialled on couple of wards. Roll out plan in development.
	5.6	There is a responsible director in the trust who will monitor the DToC situation daily and report regularly to the board on this specific issue	**Blue**	Chief Operating Officer
	5.6	Related to the above, there is a named senior individual in every CCG and SSD who will be the single point of contact for the nominated trust exec.	**Green**	Senior discharge leads in place, confirmation and communication across system required. DSG to lead

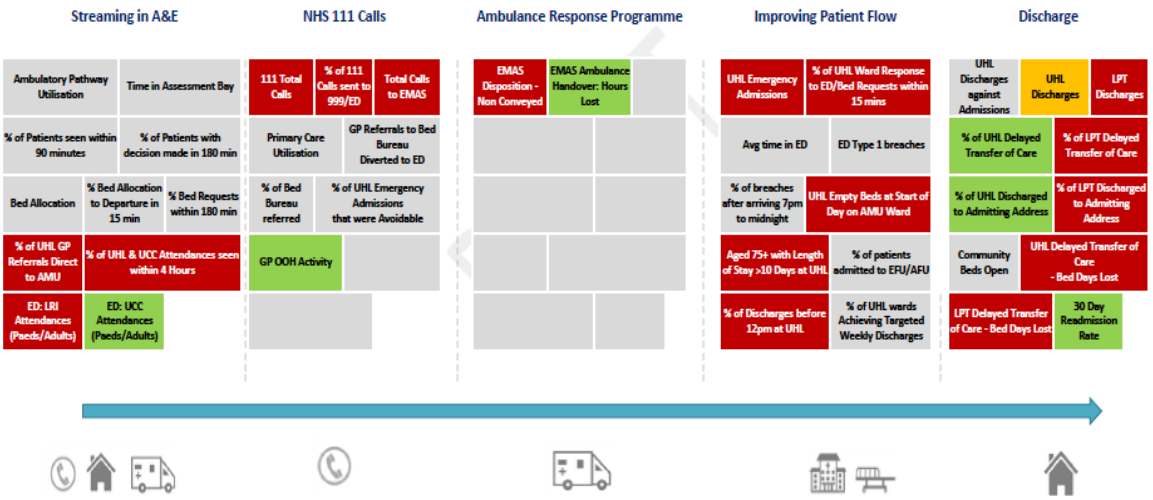
EMERGENCY DEPARTMENT METRICS DASHBOARD

Monthly updates

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

A&E Delivery Board - Dashboard

Updated to 25/8/16



Information

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

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

Key Intervention No:	National Guidance ref/detail:	Action Detail	Lead Organisation	Accountable Officer	Action no.	Planned activity	Expected outcome/impact	Key milestones	Delivery date	Contribution to ED recovery	Update (All perf. Figures are dated)	Metric: Baseline (month ...	Metric: Target	Metric: Current position	RAG rating	Priority (1 or 2)
1		Decreasing time in assessment bay will facilitate early decision making and treatment, and therefore reduce non-admitted and admitted breaches. Observed processes in assessment bay vary in length and form (ECIP feedback)	UHL	Lisa Gowan; Ursula Montgomery; Ffion Davies	17				~~01/09/2016~~ 31/10/2016		- Meeting with senior clinical team and HOS and HON to review process w/c 26/9				2	
1		Patients need to be seen by doctor in 90 mins and decision made in 180 mins.	UHL	Lisa Gowan; Ursula Montgomery; Ffion Davies	19	Super week to be held w/c 12 Sept - escalation and focus on time to be seen (and other key metrics); use of escalation areas pre-emptively. Further themes			########		- Super week started as planned 12/9				4	
1		We continue to hold patients in the back of ambulances as insufficient space inside ED to offload at time of exit block. At escalation, cohorting space needs to be identified.	UHL	Lisa Gowan; Ursula Montgomery; Ffion Davies	23	- Identified cohorting space - Rewritten SOP - Identified staff to look after patients in space - Confirmed escalation process			########						5	
1		It is widely recognised that the current ED space is not big enough and a significant number of breaches are due to space constraints; new Emergency Floor modelled on increasing demand.	UHL	Lisa Gowan; Ursula Montgomery; Ffion Davies	24	- Develop new ways of working within new space - Ensure pathways as efficient as possible with new SOPS - Provide appropriate level			########		- Workforce will be finalised by end of September - IT plan & solution being implemented in current department to allow staff training prior to opening - Recruitment drive to current vacancies (24/09) - Review completed on new staff groups/skill mix				4	
1	Remodel the front door to better manage patient flow – to ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	Currently have approx 50% GP vacancies in urgent care; opportunity to work with primary care to fill the slots and increase co-working between primary and secondary care.	CCGs	Lisa Gowan; Ursula Montgomery; Ffion Davies		Discussions with UHL and City Federations to see if they can fill vacancies	-Filling gaps in rota - Increase partnership working - Decrease numbers flowing from urgent care to ED		########		Conversations with eFederation; emailed contractual offer; no uptake to date from GPs.	**See expected impact column**			5	
1	Remodel the front door to better manage patient flow – to ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	Lakeside have provided the streaming service since Nov 2015; service was reduced by 50% in May 2016; due to finish Nov 2016. CCGs and UHL have agreed benefits of streaming and decrease in referrals to ED, therefore, been agreed that this model is the right model moving forward.	CCGs	Lisa Gowan; Ursula Montgomery; Ffion Davies		Secure streaming service from Nov to March 2017	Reduce waits and improve flow through ED:				Lakeside have agreed to continue a 3 2 model (GP/Nurses) until end of financial year.	**See expected impact column**			5	
1	Remodel the front door to better manage patient flow – to ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	We continue to hold patients in the back of ambulances as insufficient space inside ED to offload at time of exit block. At escalation, cohorting space needs to be identified.	UHL	Lisa Gowan; Ursula Montgomery; Ffion Davies		- Identified cohorting space - Rewritten SOP - Identified staff to look after patients in space - Confirmed escalation process			########						5	
2			CCGs	Rachna Vyas	28	Increasing the use of GP slots and hub direct bookings plus working on safely stopping these patients coming	Number of patients being streamed Use of GP slots and		30/09/2016	To support delivery of our four hour trajectory	Quick wins have been determined following successful x2 trials and will be implemented immediately, for example 2 Majors Yellow cubicles for FAST positive stroke patients. An extended trial was started 9.5.16					
3			EMAS	Mark Gregory	31	Review of CDU criteria to ensure that patients are taken to the right location;	Increased non conveyance of 4% by LLR EMAS	Meeting with GGH Clinical Lead - 19/8/2016 - Data	########	Reduction in A&E attendances	First Meeting Held with GGH 19/08/16, Clinical Criteria reviewed, number of transfers reviewed. Further meeting to be scheduled to review data.	See EMAS metrics on separate tab				
4		An increased number of frail elderly patients are being admitted into UHL; the pathway currently has EFU and AFU to ensure these patients are managed are effectively as possible.	UHL	Julie Taylor/Gill Staton	12	- Set up a task and finish group to review paper written by M Wightman and			########			To be agreed as project is defined.			1	
4		Reduce process delays by implementing IBWs using UHL change methodology	UHL	Gill Staton; Rachel Marsh	38	- IBW's methodology to be applied in the roll-out of safer bundle			########		- Audit of delay from 10 sets of notes is complete -On hold to align with SAFER bundle roll-out				On hold	
4		Complete a demand and capacity review in Respiratory Medicine with recommendations for closing the gap	UHL	Sue Mason; Caroline Baxter; Elved Roberts	41	- Baseline activity and demand data complete, - Job plan analysis to be completed			~~12/08/2016~~ 14/10/16		Baseline data complete; review with clinical teams planned for 2nd September to agree efficiencies and gap business case to then be developed				2	
4		Complete a demand and capacity review in cardiology with recommendations for closing the gap	UHL	Sue Mason; Caroline Baxter; Elved Roberts	42	Baseline activity and demand data, job plan analysis has been completed locally. Plan in development for deficit in			~~12/08/2016~~ 14/10/16		- Baseline data complete - Review with clinical teams being planned for mid September to agree efficiencies and gap business case to then be developed. - 2 additional consultant posts now approved and out to advert				2	
4		CDU has limited capacity which is resulting in long waits for triage and stops to admission, resulting in increased attendance in ED.	UHL	Sue Mason; Caroline Baxter; Elved Roberts	44	- Deliver a space review for CDU			########		Option of modular pod between Ward 20 and CDU is being explored to locate low risk ambulatory clinic, costs awaited from Estates.	Improve flow for ED; decreasing ED non-admitted and admitted breaches.			4	
4		Transport issues are causing delays in discharge from UHL.	CCGs	Julie Taylor/Gill Staton; Lee Walker; Rachel Marsh	46	- UHL to share with the CCG data on all discharges/transfers completed including by their third party provider, with information on time of day and complexity (stretcher/bariatr			########		'- Meeting with Arriva arranged for next week				4	
4	Improve Ward Flow	Planned outlying: Cancel elective cases to allow medicine to outlie onto surgery	UHL	Julie Taylor/Gill Staton		Medicine continues to have 15+ outliers every day in July. Choosing to implement			########		We are unable to do this because of the impact on RTT and Ca A plan to manage at times of escalation (no beds and ambulance handover delays) is being developed.				5	
4	Improve CDU Flow	Review of CDU criteria to ensure that patients are taken to the right location; decreasing inter-hospital transfers and congestion in ED.	UHL	Sue Mason; Caroline Baxter; Elved Roberts							ACTION REMOVED AS DUPLICATE ON EXISTING ACTION					
4	Improve CDU Flow	Explore alternative pilot on CDU for emergency chest pain presentations being seen in an emergency clinic	UHL	Sue Mason; Caroline Baxter; Elved Roberts		This option has now been discounted and addressed through revised low risk ambulatory project - which is			########		Business case being developed to embed GP pilot and ambulatory services - will be complete by end of August 2016 and discussed with commissioners on September 2016				5	
4	Improve Ward Flow	Transport issues are causing delays in discharge from UHL: there are a number of barriers to earlier discharge to be explored, and to ensure that transport crew capacity is planned to meet expected profile of discharge	CCGs	Julie Taylor/Gill Staton; Lee Walker; Rachel Marsh					01-Nov-16		ACTION REMOVED AS DUPLICATE ON EXISTING ACTION					
4	Improve Ward Flow	Transport issues are causing delays in discharge from UHL: Communication between UHL and Arriva of planned discharges 24 hours in advance to be improved.	CCGs	Julie Taylor/Gill Staton; Lee Walker; Rachel Marsh		- Regular communication to all teams on importance of early discharge planning -					ACTION REMOVED AS DUPLICATE ON EXISTING ACTION					
4	Improve Ward Flow	Transport issues are causing delays in discharge from UHL.	CCGs	Julie Taylor/Gill Staton; Lee Walker; Rachel Marsh							ACTION REMOVED AS DUPLICATE ON EXISTING ACTION					
4	Improve Ward Flow	Transport issues are causing delays in discharge from UHL.	CCGs	Julie Taylor/Gill Staton; Lee Walker; Rachel Marsh		UHL agreed to improve discharges earlier in the day – through Ward workstream and IBW work					ACTION REMOVED AS DUPLICATE ON EXISTING ACTION					
5	Improve discharge processe	Identify how Oxford FT have reduced their DTOC rate and confirm which learnings can be implemented within UHL. http://shelfordgroup.org/article/delayed-transfers-of-care-reduced-at-oxford-university-hos	UHL	Tamsin Hooton	49				########		Contact made: "Health system hired 60 care support workers who provide social care in people's homes after discharge from hospital. These recruits came from outside the health and care sector, and were employed on more attractive terms and with better prospects for career development They also commissioned extra intermediate beds in care homes, and staff to work closer with other clinicians, such as GPs and care home				6	
2	2.4	Providers should consider the use of Interactive Voice Response to transfer dental and/or pharmacy calls more speedily to an appropriate clinician	DHU	Rachna Vyas	64 (new)	TO UPDATE - response awaited from DHU							**Decrease ED attends by 11%**	**TBC**	1	2
2	2.8	Commissioners to consider baselining of investment in clinical services	CCG's	Rachna Vyas	65 (new)	TO UPDATE - response awaited from contracting							**Decrease ED attends by 11%**	**TBC**	1	2

A&E Delivery Board - Dashboard

Updated to 25/8/16

Arden&GEM

Streaming in A&E

- Ambulatory Pathway Utilisation
- Time in Assessment Bay
- % of Patients seen within 90 minutes
- % of Patients with decision made in 180 min
- Bed Allocation
- % Bed Allocation to Departure in 15 min
- % Bed Requests within 180 min
- % of UHL GP Referrals Direct to AMU
- % of UHL & UCC Attendances seen within 4 Hours
- ED: LRI Attendances (Paeds/Adults)
- ED: UCC Attendances (Paeds/Adults)

NHS 111 Calls

- 111 Total Calls
- % of 111 Calls sent to 999/ED
- Total Calls to EMAS
- Primary Care Utilisation
- GP Referrals to Bed Bureau Diverted to ED
- % of Bed Bureau referred
- % of UHL Emergency Admissions that were Avoidable
- GP OOH Activity

Ambulance Response Programme

- EMAS Disposition - Non Conveyed
- EMAS Ambulance Handover: Hours Lost

Improving Patient Flow

- UHL Emergency Admissions
- % of UHL Ward Response to ED/Bed Requests within 15 mins
- Avg time in ED
- ED Type 1 breaches
- % of breaches after arriving 7pm to midnight
- UHL Empty Beds at Start of Day on AMU Ward
- Aged 75+ with Length of Stay >10 Days at UHL
- % of patients admitted to EFU/AFU
- % of Discharges before 12pm at UHL
- % of UHL wards Achieving Targeted Weekly Discharges

Discharge

- UHL Discharges against Admissions
- UHL Discharges
- LPT Discharges
- % of UHL Delayed Transfer of Care
- % of LPT Delayed Transfer of Care
- % of UHL Discharged to Admitting Address
- % of LPT Discharged to Admitting Address
- Community Beds Open
- UHL Delayed Transfer of Care - Bed Days Lost
- LPT Delayed Transfer of Care - Bed Days Lost
- 30 Day Readmission Rate

Latest Week meets the Target

Latest Week is within 5% of the Target

Latest Week is > 5% from the Target

Information

Delayed discharges data are based on a snapshot of midnight census of every Thursday.

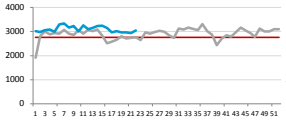
All Metrics are shown Weekly with the Year Running from 1st April

A&E Delivery Board - Dashboard

Updated to Sunday 25/08/2016

Streaming in A&E

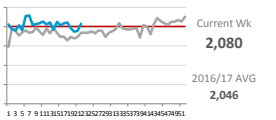
ED: LRI Attendances



Current Wk **3,046**

2016/17 AVG **3,100**

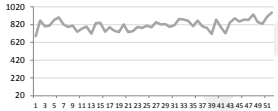
ED: UCC Attendances



Current Wk **2,080**

2016/17 AVG **2,046**

Loughborough UCC Attendances

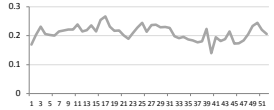


Current Wk **955**

2016/17 AVG **#REF!**

*Adjusted due to only having a few days of the week for week 1

% Loughborough UCC Outcome

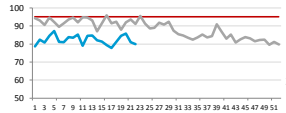


Referred

Current Wk **20.6%**

*Adjusted due to only having a few days of the week for week 1

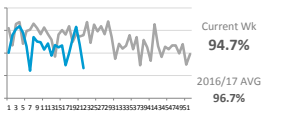
% of UHL and UCC Attendances seen within 4 Hours



Current Wk **79.9%**

2016/17 AVG **82.2%**

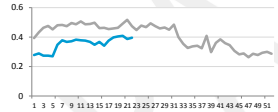
% of LRI UCC Triaged within 20 minutes



Current Wk **94.7%**

2016/17 AVG **96.7%**

% of Outcome at LRI UCC

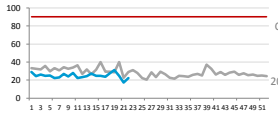


Referred

Current Wk **60.3%**

2016/17 AVG **64.6%**

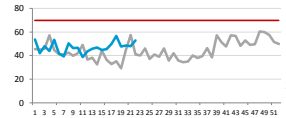
% of UHL ED with Decision about Onward Care within 120 mins



Current Wk **22.2%**

2016/17 AVG **24.9%**

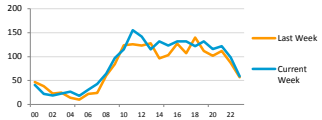
% of UHL GP Referrals Direct to AMU



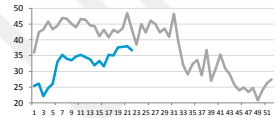
Current Wk **52.8%**

2016/17 AVG **47.1%**

Time Profile of LRI UCC Attendances



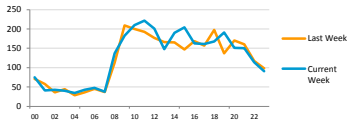
% of Patient Transfers from LRI UCC to LRI ED



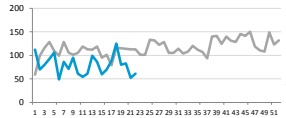
Current Wk **36.7%**

2016/17 AVG **32.5%**

Time Profile of UHL AE Attendances



UHL Admissions (Ambulatory Care Sensitive Conditions)

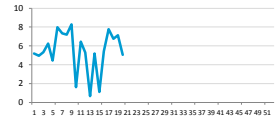


Current Wk **61**

2016/17 AVG **79**

Time Profile of Loughborough UCC Attendances

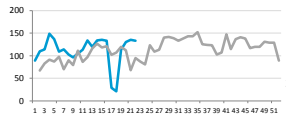
% of AE VB11Z: No investigation with no significant treatment



Current Wk **5.1%**

2016/17 AVG **5.5%**

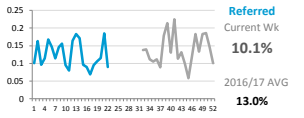
Patients Referred to Leicester City CCG Crisis Resolution Team Utilisation



Current Wk **133**

2016/17 AVG **112**

% of Outcome at Leicester City CCG Crisis Resolution Team

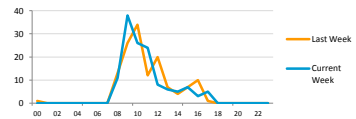


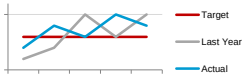
Referred

Current Wk **10.1%**

2016/17 AVG **13.0%**

Time Profile of Leicester City CCG Crisis Resolution Team



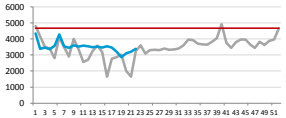


A&E Delivery Board - Dashboard

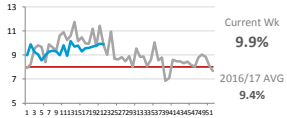
Updated to Sunday 25/08/2016

NHS 111 Calls

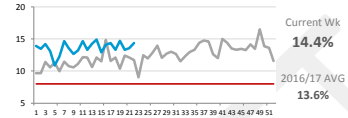
111 Total Calls



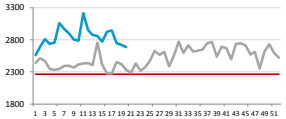
% of 111 Calls sent to Emergency Department



% of 111 Calls sent to 999



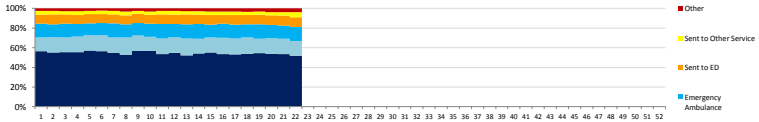
Total Calls to EMAS



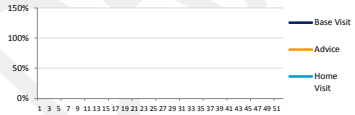
GP Total OOH Activity

*GP OOH is up to week 1 in 1617 but hard to see on chart

% of Dispositon of 111 Calls



% of Disposition from Out of Hours

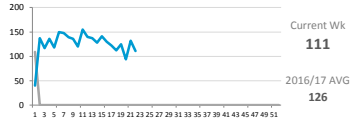


*We have no data yet for this new financial year 2016/17

Time Profile of Out of Hours Patients

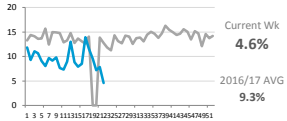
*We only have the first weeks data in for April 16/16 thereforeonly showing current week of the year

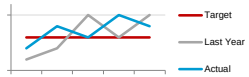
GP Referrals to Bed Bureau that are Diverted to ED



*New streaming services are put in place from 1st Apr 2016 which will decrease figures

% of UHL Emergency Admissions that were Avoidable





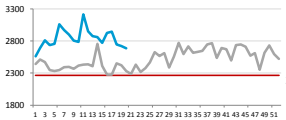
All Metrics are shown Weekly with the Year Running from 1st April

A&E Delivery Board - Dashboard

Updated to Sunday 25/08/2016

Ambulance Response Programme

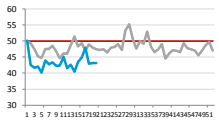
Total Calls to EMAS



Current Wk
2,685

2016/17 AVG
2,839

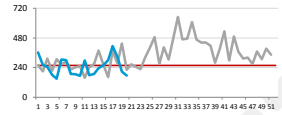
EMAS Disposition



Non Conveyed
Current Wk
43.1%

2016/17 AVG
43.3%

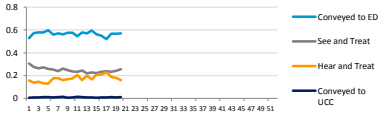
EMAS Ambulance Handover: Hours Lost

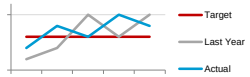


Current Wk
4176

2016/17 AVG
5904

% of Disposition of EMAS Calls





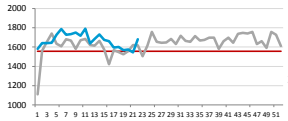
All Metrics are shown Weekly with the Year Running from 1st April

A&E Delivery Board - Dashboard

Updated to Sunday 25/08/2016

Improving Patient Flow

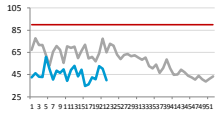
UHL Emergency Admissions



Current Wk
1,680

2016/17 AVG
1,668

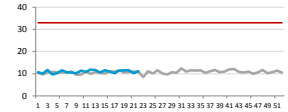
% of UHL Ward Response to ED/Bed Requests within 30 mins



Current Wk
40.1%

2016/17 AVG
45.6%

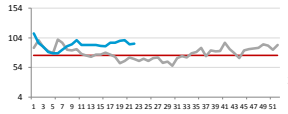
% Discharges before 12pm at UHL



Current Wk
11.1%

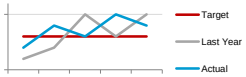
2016/17 AVG
10.9%

Patients aged 75+ with Length of Stay >10 days at UHL



Current Wk
94

2016/17 AVG
92



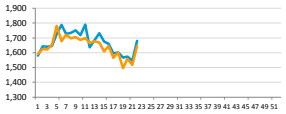
All Metrics are shown Weekly with the Year Running from 1st April

A&E Delivery Board - Dashboard

Updated to Sunday 25/08/2016

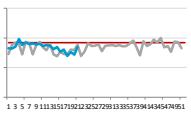
Discharge

Patients Admitted to & Discharged from UHL



	ADM	DIS
Current Wk	1,680	1,645
2016/17 AVG	1,668	1,641

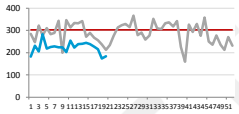
Patients Discharged from UHL



Current Wk: 1,645

2016/17 AVG: 1,641

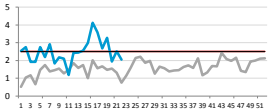
Patients Discharged from LPT



Current Wk: 184

2016/17 AVG: 223

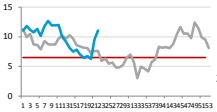
% UHL Delayed Transfers of Care



Current Wk: 2.0%

2016/17 AVG: 2.5%

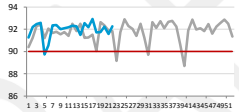
% LPT Delayed Transfers of Care



Current Wk: 11.0%

2016/17 AVG: 9.8%

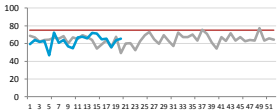
% of UHL Patients Discharged To Admitting Address



Current Wk: 92.3%

2016/17 AVG: 92.0%

% of LPT Patients Discharged to Admitting Address



Current Wk: 65.4%

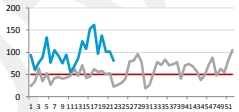
2016/17 AVG: 63.0%

Average Patients Community Beds Available at Start of Day

Current Wk: 2

2016/17 AVG: 7

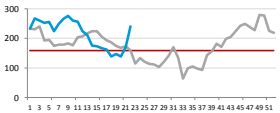
UHL Delayed Transfers of Care - Bed Days Lost



Current Wk: 81

2016/17 AVG: 99

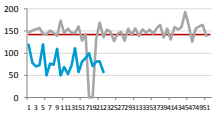
LPT Delayed Transfers of Care - Bed Days Lost



Current Wk: 240

2016/17 AVG: 214

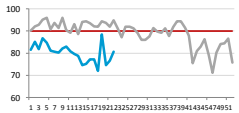
30 Day Readmission Rate



Current Wk: 57

2016/17 AVG: 79

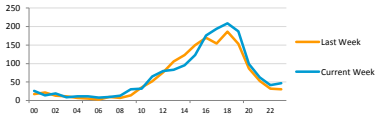
% of LPT ICS Beds Used by Patients



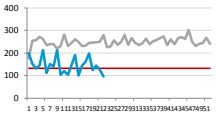
Latest Wk: 75.8%

2016/17 AVG: 80.1%

Time Profile of UHL EM Discharges



90 Day Readmission Rate



Current Wk: 96

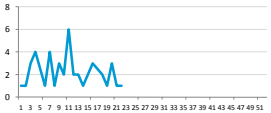
2016/17 AVG: 146

Number of Re-Beds (Arriva Aborts)

Current Wk: 17

2016/17 AVG: 11

UHL Discharge to Assess Number of Patients - Pathway 1 & 2



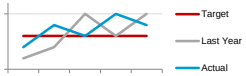
Current Wk: 1

2016/17 AVG: 2

UHL Discharge to Assess Number of Patients - Pathway 3

Current Wk: 5

2016/17 AVG: 7



All Metrics are shown Weekly with the Year Running from 1st April

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

Board Assurance Framework:	Updated version as at:	Sep-16									
Principal risk 3:	Emergency attendance/ admissions increase without a corresponding improvement in process and / or capacity							**Risk owner:**	Sam Leak, Director of Emergency Care and ESM		
Strategic objective:	An effective and integrated emergency care system							**Objective owner:**	COO		
Annual Priorities	Reduce ambulance handover delays in order to improve patient experience, care and safety. Fully utilise ambulatory care to reduce emergency admissions and reduce length of stay (including ICS). Develop a clear understanding of demand and capacity to support sustainable service delivery and to inform plans for addressing any gaps. Diagnose and reduce delays in the in-patient process to increase effective capacity Ensure whole system response to decreasing attendance and admissions							**Risk Assurance Rating**	Exec Board RAG Rating = EPB: 27/09/16		
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	5x5=25	5x5=25	5x5=25	5x5=25	5x5=25	5x5=25						
Target risk rating (I x L):	3x2=6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive / Preventative Controls NHS '111' helpline GP referrals Local/ National communication campaigns Winter surge plan Triage by Lakeside Health (from 3/11/15) for all walk-in patients to ED. (reduced resource by 50% May 2016 and ceases November 16) Urgent Care Centre (UCC) now managed by UHL from 31/10/15 Admissions avoidance directory Reworking of LLR urgent care RAP- as detailed in COO report **Detective Controls** Q&P report monitoring ED 4-hour waits, ambulance handover >30 mins and >60 mins, total attendances / admissions. UCB RAP being revised to ensure priority on decreasing attendance and admissions Comparative ED performance summaries showing total attendances and admissions.	ED 4 hour wait performance (threshold 95%) YTD 79.56% (reported on 14.9.16) Poor performance continues to be primarily driven by record ED attendances and emergency admissions but has also been contributed to by staffing issues. (staff sickness and vacancies) Total attendances and admissions (compared to previous year) 1.% increase in emergency admissions 7% increase in total A&E attendances. Ambulance handover (threshold 0 delays over 30 mins) 29.0% over 30mins 12% over 60mins, 2.1% over 120 mins Difficulties continue in accessing beds from ED leading to congestion in the assessment area and delayed ambulance handover.	National benchmarking of emergency care data RAP review and progression in the new AE implementation group Start of new format AE Delivery group Chaired by UHL CEO in September ECIP 3 day gap analysis in July and 2 days in August to review ward processes. intensive support predicted in October	(c) Lack of effectiveness of admissions avoidance plan (3.1) (c)Lack of effectiveness of attendance avoidance plan Lack of winter surge capacity (3.1)

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

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

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

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

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

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

Reasonable assurance rating:

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

Risk rating criteria:

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

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

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

Action tracker status:

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