UHL Emergency Performance

Author: Sam Leak , Director of Emergency Care and ESM paper N

Executive Summary

Context

University Hospitals of Leicester remains under acute operational pressure because of the increasing emergency demand. We are working with partners across LLR to rebalance capacity and demand otherwise next winter it will be even more challenging to deliver emergency, elective, cancer and specialist 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

1. The current position is caused by an imbalance of demand and capacity and process issues in ED.
2. It is essential that the health system focusses on delivering the actions detailed in the attached action plan.

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: August 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: **July 2016**

Introduction

The two key reasons for the level of performance are:

1. The imbalance between bed demand and capacity
2. Lack of space in ED resulting in process breaches

2016/17 YTD

- 16/17 performance YTD is 80.6% and last month's performance was 79.9%
- 15/16 performance YTD was 92.1% and May 2015 was 92.2%
- YTD attendance 6.1% up on the same period last year
- YTD total admissions 1.4% up on the same period last year.

June 2016

- Month to date is 80.79%

STF

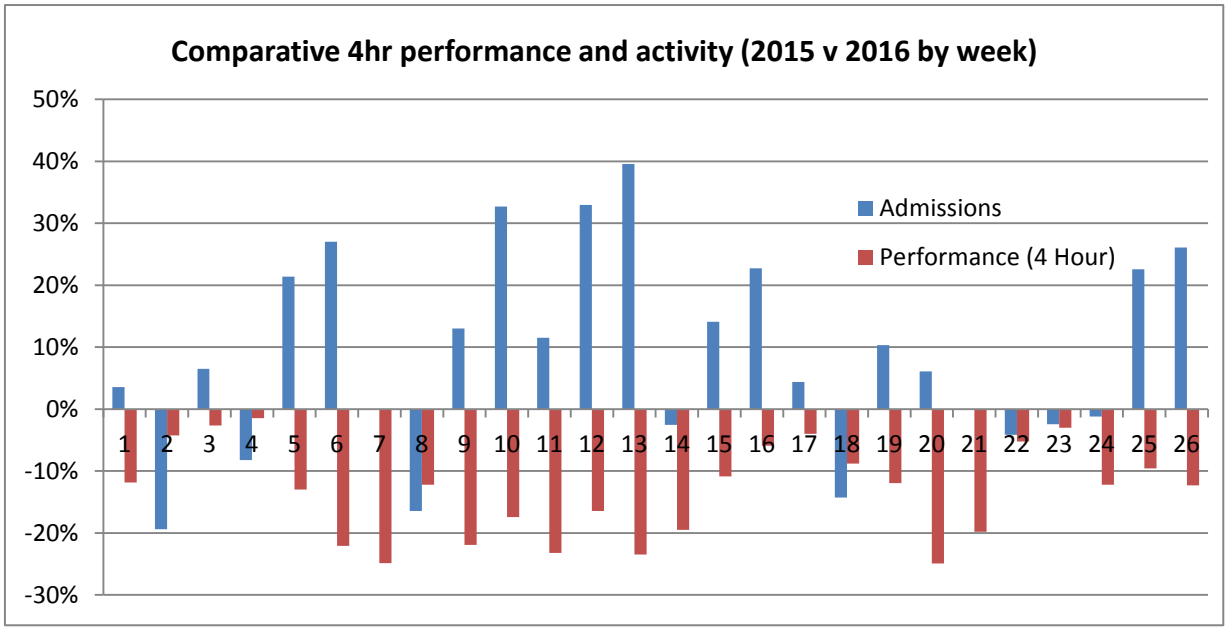
We have delivered the first three months of our STF trajectory (June unvalidated). Expected performance ramps up from September 2016.

	STF Trajectory					
	Total patients seen	Attendances <4 hour wait	Attendances >4 hour wait	Projected 4hr Performance	**Actual 4hr Performance**	STF Achieved?
April	19,072	14,876	4,196	78%	**81.2%**	Achieved
May	19,949	15,560	4,389	78%	**79.9%**	Achieved
June	19,497	15,403	4,094	79%		
July	18,869	14,907	3,962	79%		
Aug	18,949	15,159	3,790	80%		
Sept	19,057	16,198	2,859	85%		
Oct	19,912	16,925	2,987	85%		
Nov	20,715	17,608	3,107	85%		
Dec	19,821	16,848	2,973	85%		
Jan	20,290	18,058	2,232	89%		
Feb	16,593	14,768	1,825	89%		
March	19,452	17,740	1,712	91.2%		

Breaches

Breach performance remains poor as a result of increased attendance, processes in ED and outflow. The team have made improvements in UCC and minors and further analysis of breaches has identified areas for improvement eg time to senior clinical review, time to bed allocation and time to move out of the department once a bed has been provided.

As detailed below, performance remains consistently worse than last year and we experienced in June, a much higher level of activity than 12 months ago. A further key change from June 2015 to June 2016 is the reduction in the medical bed base at the LRI and GGH.



LLR improvement plan

The most recent update to the LLR plan is attached. Key UHL updates include:

- The expansion of Majors (relocating minors) by creating a fast track home stream. This will allow decongestion of majors and fast track of patients predicted to be non-admitted.
- Focus on exclusion criteria for assessment bay rather than inclusion criteria for UCC to ensure that all appropriate patients are seen in UCC.
- A Rapid Cycle Test of all patients being seen by Senior Decision Maker (Emergency or Acute Medical ST4 or above) prior to admission to Medicine has taken place and demonstrated an increase in avoided admissions. An Acute physician will be joining the team in August to ensure this benefit is continued.

Ambulance handovers

Improvement in handovers (CAD plus data) is detailed below:

	Delay Over 15 mins	Delay Over 20 mins	Delay Over 30 mins	Delay Over 45 mins	Delay Over 60 mins	Delay Over 120 mins
Dec-15	65%	54%	37%	24%	16%	3%
Jan-16	43%	35%	25%	16%	12%	3%
Feb-16	40%	32%	22%	15%	10%	2%
Mar-16	44%	35%	24%	16%	11%	3%
Apr-16	41%	30%	17%	10%	6%	1%
May-16	43%	30%	18%	9%	6%	1%
June-13th	42%	30%	18%	11%	7%	1%

Implementation of majors 2 (using minors as majors to increase capacity by 9 cubicles) is planned for July and it is anticipated that this will improve ambulance handovers further. Significant improvement is still required as UHL remains an outlier for long ambulance handovers, and as such this is a priority for the CMG to improve.

Front Door/ Urgent Care Centre Process

Lakeside reduced its capacity by 50% on the 1st of May and is due to stop in November 2016. UHL has managed the reduction by using UHL GP's to stream patients. Discussions are taking place with the CCG in order to:

- Provide a streaming service between November and April 2017
- Commission a model from April 2017

Options for b. include

- A wider UCC procurement
- CCG and UHL work jointly to procure a partner to work with UHL to provide UCC (UHL subcontract)
- CCG's ask UHL to provide an integrated front door with no formal procurement

Organisational Development

An OD plan has been developed to ensure that staff are capable of delivering exemplar emergency care that is safe, effective and timely now and in the new emergency floor, this is being supported by ECIST and will provide:

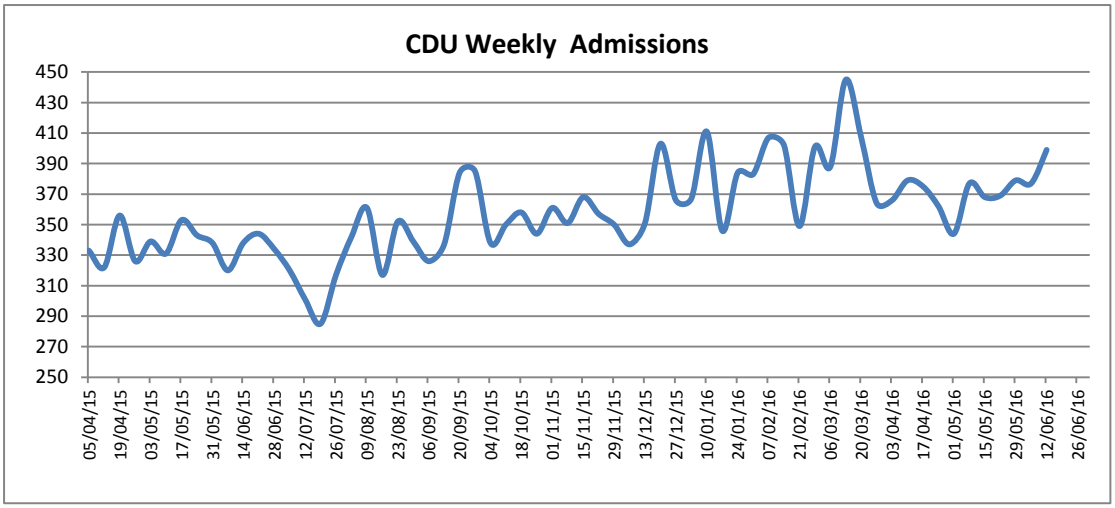
- Coaching
- Action Learning Sets
- Mediation
- Supply expert and credible clinicians to support change plans for ED

Key ESM actions for month ahead

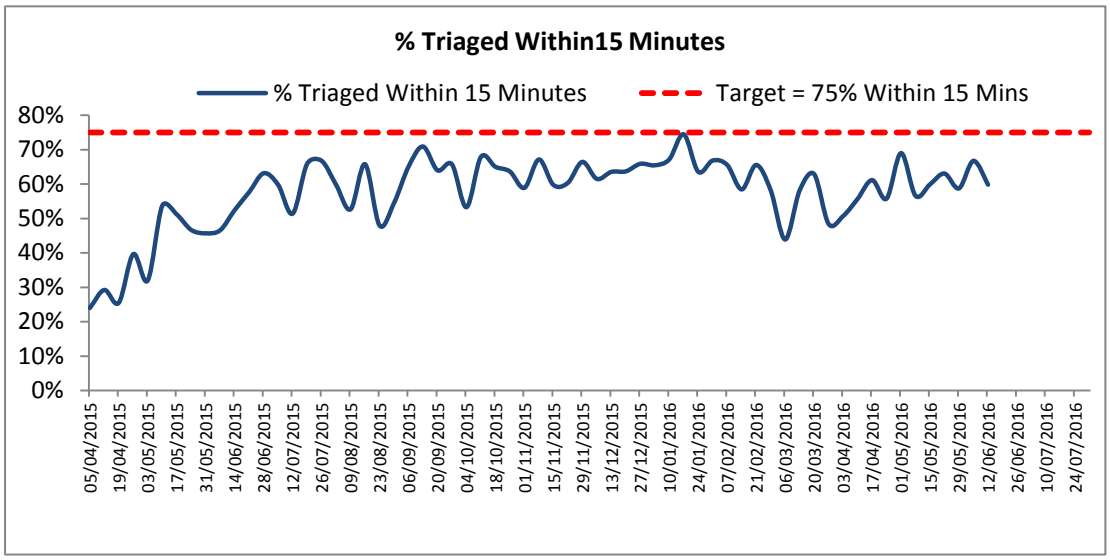
- Action feedback provided by the CQC
- Increase managerial and clinical leadership with the start of the new HON for ED and new Head of Operations
- Advertise and appoint to the triumvirate model of HOS for ED (Paeds, Front Door, Majors and Resus)
- Enable additional medical capacity in September when Ward 7 moves to ward 9 leaving a ward available for medicine.
- 3 W's (why are we waiting) investigating and tackling delays experienced by patients in their pathway on the medical wards.
- Non admitted breaches **-** Focus on decreasing no admitted breaches.
- Consultant leadership support from ECIST to provide:
    - Embedding Consultant clinical Leadership within the team
    - Challenge of current practice
    - Definition of roles and responsibilities within the Medical team
    - Tackling poor performance
    - On the shop floor review of the current workforce model
    - On the shop floor review of the current pathway model

GGH key CDU details

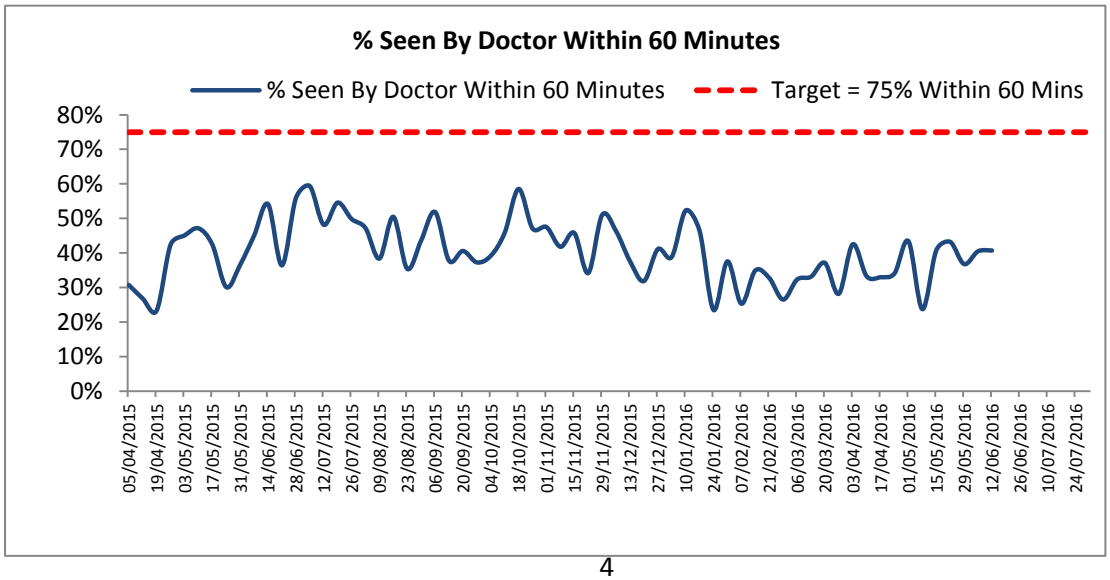
Admissions remain higher than the same time last year



The percentage of patients triaged within 15 minutes has plateaued



The percentage of patients seen by a doctor, ANP or ENP within 60 minutes has also plateaued



Key GGH actions for month ahead

- Extended GP Pilot commenced on the 9th May for 8 weeks this will be formally reviewed in July 2016.
- Demand and Capacity review in Respiratory Medicine, this will look at all elements of the service but will overlap with CDU looking at the right workforce model and the time requirements to meet service needs. The work is anticipated to be completed in July 2016.
- Demand and Capacity in Cardiology this will look at all elements of the service but will overlap with CDU looking at the right workforce model and the time requirements to meet service needs. The work is anticipated to be completed in June 2016.
- UHL Better Change project reviewing Cardiology inpatient LOS pre Catheter Lab, is underway with initial data collection complete, this shows an average pre-op LOS of 5.5 days across all procedures.
- Increase usage and improved recording of ICS through ward education
- Explore alternative pilot on CDU for emergency chest pain presentations being seen in an emergency clinic.
- Clarity of how the vision for CDU will be signed off organisationally and how the expansion costs will be funded by the Trust.

Conclusion

Despite continued efforts, performance remains poor. The Trust Board Thinking Day in July will explore the answers to the primary problem of; 'given the way we operate, we have a fundamental imbalance between demand and capacity.

Recommendations

The Trust Board is recommended to:

- **Note** the contents of the report
- **Note** the continuing concerns about 4 hour delays and ambulance handovers in particular
- **Note** the continued pressure on clinical staff with increasing demand

Leicester, Leicestershire and Rutland Urgent Care
High Impact Recovery Plan

Jun-16

Document Owner: Samantha Merridale - Head of Operational Resilience

No	Objective		Description	Link to UCPB Plan	KPI/Outcome measures				Accountable Officer / Organisation	Deadline	RAG		Constraints / interdependencies	Current actions/progress
					Measure	Baseline	Current	Target			Progress	Impact		
1	**Minimise presentations from primary and community care to LRI ED assessment services**	1.1	Maximise use of alternatives to admission by primary and community providers - to continuously review activity data to identify patients/groups potentially amenable to alternative care plans/services. Utilise review of real time data to target moderate / frequent fliers including paediatrics.	Strand 1 - Navigation hub, pathway. Strand 2 - Operationalising Strand 5 - As part of feedback loop					R Vyas (LCCCG) K Tierney-Reid (WLCCG) D Eden ELCCG R Haines CNCS	Weekly				1. Obtain data from each CCG - need breakdown by practice if possible 2. Agree mechanism for achieving consistency in feedback to primary care 3. Set target and trajectory
		1.2	Maximise use of alternatives to admission by EMAS crews and reduce EMAS conveyance to LRI - Implement mobile device (smartphone) with MDoS access. Rapid roll out across LLR crews with link to live waiting times web page, 400 front line staff to have use of devices.	Strand 1 - Navigation hub. Enhancements to clinical support. Strand 6 - Designation of services.		75% - current deployment		100%	L Brentnall (EMAS)	30/06/2016				Meeting to be arranged between Sam Merridale and Lee Brentnall to agree potential KPIs, to monitor non-conveyance outcomes. Full deployment expected by end June 2016.
		1.3	Provide system navigation facility to referring GPs bed bureau EMAS OOH Care homes to promote alternatives to admission and enables: - active consultant to GP dialogue (through expanded use of Consultant Connect) with the ability to onward refer to alternative services. - Implement process to enable EMAS access to GP medical opinion/prescriptions. In hours via UCC at Loughborough, OOH via CNCS healthcare professional line. (**Note** this is wider system navigation and should potentially include access by ED clinicians)	Strand 1 - Navigation Hub. Strand 6	Number of contacts through Consultant Connect. Number of avoided hospital admissions.				Ian Lawrence (UHL) Rob Haines (CNCS)	30/06/2016				Consultant Connect pilot ends 30/6/2016. UHL to provide full evaluation report to the ORG on its effectiveness. SM to obtain feedback from the 3 CCG primary care leads as to specific evaluation from GPs, regarding alternatives to admission. To include AMH. Promotion to GPs - how is this being taken forward?
		1.5	Maximise utilisation of step up ICS capacity by Primary / Community Care, and step down from acute UHL beds. Reduce conveyance of patients to UHL. Increase number of patients discharged from acute beds into ICS	Strand 1 - system navigation.	Spot audit of ICS step down referrals and appropriateness to provide baseline				Primary Care Clinical Leads.	31/07/2016				Step up referrals - update from LPT is that data will be available by late June, and an update will be given in July. With respect to step down from UHL, a spot audit will be carried out on those patients who were turned down as part of the assessment process, so that we understand the reasons why and what actions need to be taken to improve the asssessment and approvals process.
2	**Reduce delays in ambulance handover times at the LRI site**	2.1	Ensure that all EMAS crews have Pin numbers and use the CAD+ system for every handover.	Strand 2 - mobilisation work	Use of CAD+	70%	90%	90%	R. Henderson	30/06/2016				Need to agree and include trajectory for improvement, including list of actions. Data has demonstrated a slight improvement in CAD+ compliance - however it may be prudent to ensure that the divisional communication has been actioned.
		2.4	Agree and implement a direct streaming SOP. . Focus to be on exclusion criteria for assessment bay rather than inclusion criteria for UCC. As with 2.3, this is an important action but senior clinical streaming may be more effective.	Strand 2 - mobilisation work					UHL (SL) and EMAS (JD/RH)	28/02/2016				Follow up action: Review effectiveness of streaming service including clinical coordinator type function. Adherence to SOP to be tested. Chase Becky for a resonse JD to pull reports daily on SOP compliance.

3	**Remodel the front door to better manage patient flow - To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service**	3.2	To relocate OOH service from clinic 4 to the UCC. Designed to provide greater continuity with OOH service and potential source of surge capacity at times of pressure.	Strand 1 - navigation hub. Strand 2 - mobilisation work		ED Performance: 81.6%		78%	Julie Dixon	01/04/2016			Data review regarding utilisation. Review use of UCC - check with Sarah Smith. Need activity numbers - how many OOH bookings made to UCC. Gives additional clinical capacity for streaming as well as treatment.
		3.3	To increase the range of near patient testing within the UCC . Availability of a range of basic tests will reduce chances of requiring transfer to ED	Strand 2 - mobilisation work Strand 4 - 7 day services, diagnostics.					Julie Dixon	08/02/2016 11/04/2016 27/05/2016			Need update as to implementation. Monitor utilisation of equipment - reduction of referrals from UCCto ED (is currently 36%). Need to determine what is the trajectory - check with Ben Teasdale. LAN points to be installed this week - once complete the company can finalise installation and commence training. Completion date set for 27/6/16
		3.5	To ensure that patients who do not require an admission are directed to ambulatory services where possible. Increase capacity on AAU for GP access. This is to ensure that chances of GP admissions being routed via ED are minimised.	Strand 2 - mobilisation work					Sam Leak	~~29/02/2016~~ 28/03/2016			KPI is those patients with very short stays - should be a reduction (i.e. an increase in the number of patients being admitted directly to AAU). We need to understand what is the potential target? Is there an increase of capacity on AAU?
		4.2	Rapid Cycle Test of streaming patients into 'likely admission' and 'likely discharge' in ED to reduce occupancy and front load senior decision making in department. Involves significant redesign of patient flows within ED in order to emphasise non-admission wherever possible.	Strand 2 - mobilisation work					Ian Lawrence	18/03/2016 27/04/16			**Review of ambulatory pathways following discussion at ORG.**
4	**Reduction in emergency admissions**	4.3	Rapid Cycle Test of all patients being seen by Senior Decision Maker (Emergency or Acute Medical ST4 or above) prior to admission to Medicine. Senior decision making may increase avoided admissions through different attitude to risk and better knowledge of alternatives.	Strand 2 - mobilisation work		Em. Admission		Em. Admissions	Ian Lawrence	18/03/2016			What impact are we expecting? Success measures - how many patients turned away (had core plan altered).
		4.4	Expand ACPs if high volume potential is identified. Comprehensive range of Ambulatory Care Pathways in place but may be potential for further expansion if volumes make this viable.	Strand 2 - mobilisation work. Strand 4 -					Catherine Free	01/05/2016			Review of ambulatory care pathways. Conversation with Ursula / Catherine. How do we make it more visible to ORG? Is the scope appropriate?
		4.5	Analysis of what 0-6 hour LoS are made up of – identify opportunities to reduce LoS further/identify patients who shouldn't have been admitted. Proportion of recent increase in admissions has been short stay. Analysis of types and sources of admission will inform further actions.	Strand 2 - mobilisation work					CCG	31/03/2016			Links to action 1.1
		5.1	Improve responsiveness and timeliness across the acute discharge process. Identify problems and solutions to the internal processes within UHL connected to discharge planning	Discharge					Julie Dixon / Ian Lawrence	Oct-16			

5	**To improve the discharge planning process across the whole system and reduce delays**	5.2	Improve staff training and support connected to the discharge process. Map out the scope of the training required, and implement new training packages to support	Discharge		DTOC			Mandy / Julie	Oct-16				
		5.3	Shared risk. To identify the mechanisms for sharing risk across the system particularly when pressures are high.	Discharge					Mandy G / Nikki Beacher	Oct-16				
		5.4	Step up / Step Down Care Navigation Hub. To identify the scope for the establishment of a single point of access / care navigation hub, to faciliate discharge, ensuring that links are made to current programmes of work for step up.	Discharge					Tamsin Hooton / Sam Merridale	Oct-16				
		5.5	Single Assessment process – shared care and management plan. Patient owned record. To identify the scope for moving towards a single assessment process, and trusted assessor model	Discharge					Mandy G, Tracy Y, Jackie W	Oct-16				

Closed Actions / Actions for Regular review

No	Objective	Actions	Description	Benefit	KPI/Outcome measures	Accountable Officer / Organisation	Deadline	Milestones - for review W/C 16/05/16	RAG	UPDATES FROM UCB 6/4/16	Actions
1.4		Review timing of GP home visits with a view to move earlier in the day / improve transportation to UHL to bring the evening peak forward reducing the likelihood of admissions.	Maximise usage of Urgent Home Visiting Service (Clinical Response Team/Acute Visiting Service) including direct referrals from care homes. Dedicated GP patient transport service to convey urgent GP patients to UHL earlier in the day.	Reduction in attendance at ED. Reduction in emergency admissions		R Vyas (LCCCG) K Tierney-Reid (WLCCG) D Eden ELCCG R Haines CNCS J Dixon UHL	Weekly		CLOSED	Alternative transport system now operational. The AVS is fully operational in WLCCG and LCCCG and has been rolled out to an initial area in EL and Rutland CCG in Oadby/Wigston/Blaby. UHL - Bed Bureau script updated and this is happening. Complete from UHL perspective. LCCCG: Home visiting service in place. 224 visits / week. Fully utilised every day. 86% non conveyance rate. From 16/17 - another car as part of BCF - 280 / week capacity. Target into care homes. ? Record time of GP visits not done through visiting service. Aim is to spread time of visits earlier in the day - consistency across CCGs with AVS. Have GP urgent transport (non-EMAS). Impact is to get East on line. ELCCG to do weekend service. If service is now in place - avoid EMAS having urgent GP adm later in day. UHL to collect data regarding time of referral by GP, time of arrival at AMU, destination , and number of admisions compared to baseline - Deadline 11/03/16 - still awaiting data.	Look at BB admissions - look at time span. Message to the patients - highlighting importance of timing. Get data from BB. EMAS should start to see the impact - alternative provider.How do we track data to see impact. Home visiting services across three CCGs. Vol of activity and dispositions - SSAFA will pull data. JD - Submitted report to ORG **Contract has been terminated**
2.2		Implement recommendations of nursing skill mix review in ED.	Initial review of nursing numbers/shift patterns complete. Review numbers and skill mix to optimise flow though assessment and majors.	Reduction in handover delays		M. McCauley		Further update at ORG on 1/6/16	Complete with regular reviuew.	Initial review by Chief nurse is complete. ED HON advert is out. Final paper and recommendations to be completed by 1/4/16 so that implementation of recommndations can commence in April.	The skill mix review is complete for the current floor and vacancies have reduced in numbers, however the skills take time to develop. We have changed working practice, increased the amount of nurses in the assessment area, and focused on handover delays. The delays in the assessment bay are reduced significantly as the time to triage compliance has increased. We also have 2 EMAS staff working in the assessment bay daily to reduce the delays. There is a manager in assessment bay daily to focus on time to triage and handover delays.
2.3		Redefine the role of the HALO and who should undertake it and undertake a rapid cycle test of the HALO working with an ED Consultant/Acute Physician at time of escalation to expedite flow.	HALO role to be made more consistent so as to maximise impact. Also to be adapted into further action related to senior streaming role - may have more impact. (see 3.1)	Reduction in handover delays		EMAS (RH/JD) and UHL (SL)	17/02/2016				Role of HALO has been redefined and agreed by UHL and EMAS. UHL RCT of HALO on 8/3/16. UHL RCT of Lakeside at the front door to redirect patients as appropriate to be completed by 11/3/16. Comparison to be made against the effectiveness of HALO V Lakeside vs new acceptance exception SOP.
2.5		Trial the deployment of a private ambulance crew (contracted by EMAS) and an HCA (provided by UHL) to care for patients in the "red zone" (subject to satisfactory prior risk assessment signed off by EMAS and UHL).	Release EMAS crews by having additional private crew. Designed to maximise quick release of crews at time of ED congestion.	Reduction in handover delays		EMAS (RH/JD) and UHL (SL)	28/02/2016			SOP drafted and agreed with UHL and EMAS Medical Directors - EMAS have crew in place for 20/2/16	EMAS have crew in place from 20/2/16 to support the management of patients in the red zone. Feedback from both EMAS and UHL is positive and this releases crews when assessment bay is full.
2.6		Relocate the AAU to the UCC and expand capacity (business case has been approved)	Designed to provide clearer distinction between ambulatory and admission pathways and to increase capacity.	Reduction in handover delays		Sam Leak	29/02/2016			Follow ups have moved down - Estates work required to facilitate full move	Complete 7/3/16 - This will provide additional capacity avoiding a 'stop' to AAU and patients being diverted to ED. AAU has moved as of Mon 7/3. Some work around IT required. Seems to be working.
2.7		Agree a formal UHL task and finish group (? Include EMAS) to drive forward actions	Evidence that heavy focus is improving handover performance. Formalises approach to ensure sustainability.	Reduction in handover delays		Sam Leak	29/02/2016	Remove from RAP	CLOSED	Meetings commencing on 4/3 The first meeting took place 04/03/16 and are planned with EMAS, UHL clinical and managerial staff to identify new solutions and implement the plan.	RW/BG/RW reviewed data and agreed that more data regarding breach reasons are needed. BG will be reviewing this data. Decided that although the patient may feel that the care is poor, it was agreed that care was being prioritised to the most appropriate patient. **Action is complete on both the CQC action log and RAP**

2.8	Review protocols/guidance relating to handover and understand if align in practice	Detailed review and rationalisation of all protocols/SOPs and testing against reality through observation.	Reduction in handover delays	Sam Leak	29/02/2016	Remove from RAP	**CLOSED**	Initial mapping of processes complete and process tested on Super Handover Day. A handover process has been drafted and agreed at the Handover Task and Finish Group on 23/3/16.	**Action is complete on both the CQC action log and RAP**
3.1	Rapid Cycle Test of Urgent Care GP at front door of assessment bay (9am – 9pm) to stream patients into appropriate care setting reducing pressure on assessment bay and Majors	Relates to streaming SOP actions. Evidence indicates that senior clinical decision maker at front door may be most effective way of diverting patients. Service to be provided by Lakeside.	Reduction in emergency admissions	Martin McGrath	11/03/2016			RCT taking place 22nd and 23rd February. Links back to ambulance actions. Rely on SOP - ensure EMAS taking patients to right place. Started last week - 2 sessions last week, 1 this week. Outcomes by Fri next week. ? Inappropriate patients coming to front door. Early indications - similar to Unipart trial - redirecting 17 (out of 180) pts / day (10%). Diversion SOP now agreed with EMAS - section 2.4. EMAS take any ambulatory patient to UCC unless fall into exclusion criteria. Are we able to track no of patients arriving by EMAS who end up in UCC. Definition - referral into streaming service - not always UCC.	RCT was completed on 7/3/16. Report on RCT to be completed by 11/3/16. 1. Lakeside GP. 2. Impact of SOP. Measure impact of both tests - what is added value of GP? SOP implemented on 17/3 - time for EMAS education process - will measure from point of implementation. ? HALO - possibly more risk averse
3.4	To establish observation room in UCC to both reduce admissions and if appropriate enable direct admissions by passing ED	Availability of observation facilities will allow some patients to avoid transfer to ED for that purpose.	Reduction in number of patients attending main ED and therefore a reduction in ED occupancy + reduction in admissions	Julie Dixon	01/04/2016			Process for patients to be transferred directly to AAU from UCC identified. Propose action is closed as limited benefit of creating another observation stream , physical and resource limitations. Decided not to proceed. Closed because of physical resource and space. Exploring other options. Other pathway make better use of the space.	CLOSED

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

No	Objective	Actions	Benefit	Link to UCPB Plan	KPI/Outcome measures	Accountable Officer / Organisation	Deadline	Milestones - for review 1st June 2016	RAG	Comments
I1	Comms & Engagement Plan – targeted patient information	SM to contact Sue Venables - check progress with year round plan. Take to ORG for sign off.			-	SM/SV	15/06/2016			
I2	Roll out of NHS Now app across LLR and the link to the live DoS	SM to contact Tim Sacks/Guarav for update				SM	15/06/2016			
I3	Access to seven day services across the three LLR CCGs	LC CCG: Primary Care Hubs WLCCG: Charnwood Test Bed ELR CCG: UCC Oadby ED Liaison Desk Pilot				SS	15/06/2016			No plan for City. West - 8th June meeting - CTR has plan East - mtg to be confirmed - SS has written the plan.
I4	EMAS access to primary care support in hours and via CNCS out of hours	(a) contact with GPs via back office numbers to support admission avoidance in core hours (b) contact with OOH GPs for prescriptions / ad hoc support				SS	15/06/2016			Progress update to ORG by 15/6
I5	Consultant Connect activity and outcomes	(a) Consultant Connect to provide evaluation data to UHL (b) UHL to evaluate scheme against their own outcomes © LLR Urgent Care to compare and complete independent evaluation				SS	15/06/2016			SS to d/w JD To ORG on 15/6
I6	Patient transport in hours via CNCS/TMAS activity and outcomes	Closed as no longer continuing - to be incorporated into the new patient transport service specification				SS	15/06/2016			
I7	Ongoing review of GP referrals into acute care without a referral letter	UHL to report back on audits undertaken to identify patients and associated GP practices. CCGs to advise how follow ups have been actioned and evidence imporvements.				SS	15/06/2016			Data from JD - SS will obtain To take to ORG on 15/6
I8	UHL ED access to personalised health care plans via MIG – there are a variety of outstanding IM&T issues	Installation of dedicated PCs within ED Access for doctors and nurses working within ED Confirm RBAC is in place to enable nurses to make use of bespoke views Outcome of meetings(s) from 14/1/16 onwards to discuss care planning possibilities				SL	15/06/2016			Care plans / special patient notes - SL to pick up
I9	Review of Unipart recommendations and the impact upon ambulance handover performance	To be continued via High Impact RAP				SS	15/06/2016			
I10	CNCS OOH HCP line activity and outcomes	Establish current usage via CCG. Agre whether activity could be routed via NHS111.				SS	15/06/2016			SS to email RH
I11	UHL GP Hotline activity and outcomes	Determine capacity vs actual demand Establish whether activity could be routed via Bed Bureau.				SL	15/06/2016			SL to pick up
I12	ED Notes Audit (Oct 2015): Moderate / frequent attender reviews	Each CCG to advise of (signed off) SOP fo rthe management of moderate/frequent flyers SOP should include frequence of reviews and whether improvements in patient outcomes are evident EMAS frequent attenders to follow the same process via Deborah Scouthern				SS	15/06/2016			Link to 1.1 Evidence of each SOP etc.
I13	ED Notes Audit (Oct 2015): GPs who don't arrange a face to face consult prior to referral – link to RAP 4.3	To be continued via High Impact RAP				SS	15/06/2016			SS to check with JD To update RAP
I14	UHL Ambulatory clinics activity and outcomes – link to RAP 4.4	To be continued via High Impact RAP				SS	15/06/2016			SS to check with JD To update RAP
I15	Follow up to the 2015/16 Eight High Impact Interventions	(1) Inflow - HII 1 - urgent GP appointments (2) Inflow - HII 3 - Local DOS complete, accurate and continuously updated. (3) Inflow: HII 4 - See and Treat ambulance responses maximised (4) Inflow: HII 5 - care homes support for patients who have fallen				SM	15/06/2016			SM to contact ST

Tab 2 - Discharge plan. March 2016

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

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

Last updated: 31/3/16 **Document Owner: Samantha Merridale - Head of Operational Resilience**

N.B. Data for 2014/15 has changed as for section 3.1 as it had included other CCGs - Error has been rectified

No	Objective	Related Action	Indicator No	Indicator	2014/15 Outturn	Current		Target	Variance	Date of Data	Source	Accountable Officer	RAG	Comments
1	Minimise presentations from primary and community care to LRI ED assessment services		1.1.1	UHL ED Attendances - Majors	55,555	49,091				28/03/2016	UHL local data			
			1.1.2	UHL ED Attendances - Minors	57,898	64,147				28/03/2016	UHL local data			
			1.1.3	UHL ED Attendances - RESUS	13,038	13,038				28/03/2016	UHL local data			
			1.1.4	Eye Casualty Attendances	17,673	18,879				28/03/2016	UHL local data			
			1.1.5	UHL UCC Attendances	90,103	92,771				28/03/2016	UHL local data			
			1.2	UHL ED and UCC - % 4 seen in hours	86.0%	85.1%		95%	9.9%	28/03/2016	UHL local data		R	
				GP OOH - Advice	1412	1269					GP OOH			Data not chaged since last update since we havent received updated data - we are actively chasing for
				GP OOH - Base visit	1396	1254					GP OOH			
				GP OOH - Home Visit	1379	1244					GP OOH			
				GP OOH - Admit to community hospital										Breakdown
				GP OOH - Admit to UHL										Breakdown
				GP OOH - 999 Ambulance										Breakdown
				GP OOH - Other										Breakdown
			1.3	Mobile DoS										
				EMAS - Other conveyances										
2	Reduce delays in ambulance handover times at the LRI site		2.1	EMAS Handover										
			2.2	Lost hours	484	655				20/03/2016	EMAS			
			2.3	*N* delayed over 15 minutes	35,497	36,985				20/03/2016	EMAS			
				N delayed over 20 minutes	27,083	29,643				20/03/2016	EMAS			
				N delayed over 30 minutes	14,361	19,605				20/03/2016	EMAS			
				N delayed over 45 minutes	6,883	11,822				20/03/2016	EMAS			
				UCC Disposal - No care, went home	583	1,626				06/03/2016	UCC activity data			Discharge fr
				UCC Disposal - Referred to UCC and treated										Breakdown
				UCC Disposal - Referred to UCC referred to ED/other UHL care										Breakdown
				UCC Disposal - Referred to ED/other UHL care and treated there	36,046	34,174				06/03/2016	UCC activity data			
				Inappropriate attendance Bounce Back to GP/Pharmacy/Self Care/streaming service	N/A	117				06/03/2016	UCC activity data			
				Other	399	306				06/03/2016	UCC activity data			Need to dis
			3.1	Number of Alternate Care Settings										
				ED Attends Disposal - Discharged	88,393	84,818				28/03/2016	UHL local data			
				ED Attends Disposal - Referred to A&E Clinic	242	290				28/03/2016	UHL local data			
				ED Attends Disposal - Referred to other OP Clinic	10,833	9,878				28/03/2016	UHL local data			
				ED Attends Disposal - Admitted	36,430	30,721				28/03/2016	UHL local data			
				ED Attends Disposal - Left before treatment	2,382	2,407				28/03/2016	UHL local data			
				ED Attends Disposal - Follow up by GP	228	237				28/03/2016	UHL local data			
				ED Attends Disposal - Transferred to other Health care provider	3,670	3,815				28/03/2016	UHL local data			
				ED Attends Disposal - Died in Department	274	241				28/03/2016	UHL local data			
				ED Attends Disposal - Referred to fracture clinic	1,159	1,178				28/03/2016	UHL local data			
4	Reduction in emergency admissions			Source of Admissions - A&E	35,999	35,991				28/03/2016	UHL local data			
				Source of Admissions - Other Emergency	16,886	18,040				28/03/2016	UHL local data			
				Source of Admissions - Bed Bureau	12,160	14,028				28/03/2016	UHL local data			
				Source of Admissions - GP	7,571	6,819				28/03/2016	UHL local data			
				Source of Admissions - Consultant clinic	2,200	2,248				28/03/2016	UHL local data			
			3.2	Emergency Admissions	81,881	85,717				28/03/2016	UHL local data			
			4.1	Emergency Admissions - 0-6 hours	63,586	67,670				28/03/2016	UHL local data			
			4.2	30 day readmissions	7,454	7,466				28/03/2016	UHL local data			
			4.3	Rapid Cycle Tests										
6	Review discharge processes to make the discharge process more efficient		5.1.1	Discharges before noon - Medical										
			5.1.2	Discharges before noon - Surgical										
			5.2	Transport available day before discharge				80%						
			5.3	TTO and EDD day before discharge										
			5.4.1	Weekend discharges - Medical										
			5.4.2	Weekend discharges - Surgical										
			5.5.1	DTOC - Complex										Can't split th
			5.5.2	DTOC - Other										Can't split th
				Number of patients who have date of discharge set within 48 hours of admission										