# UHL Emergency Performance

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

# Executive Summary

## Context

University Hospitals of Leicester remains under acute operational pressure because of increasing emergency demand. Our current forecasts for next year are further increases in attendance and admissions. We need to work 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 fundamentally by an imbalance of demand and capacity. There are limited opportunities to increase bed capacity so the focus must continue to be on reducing admissions.
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 new approach set out in the report.

# For Reference

Edit as appropriate:

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

| | |
|---|---|
| Safe, high quality, patient centred healthcare | [Yes /No /Not applicable] |
| Effective, integrated emergency care | [Yes /No /Not applicable] |
| Consistently meeting national access standards | [Yes /No /Not applicable] |

| | |
|---|---|
| Integrated care in partnership with others | [Yes /No /Not applicable] |
| Enhanced delivery in research, innovation & ed' | [Yes /No /Not applicable] |
| A caring, professional, engaged workforce | [Yes /No /Not applicable] |
| Clinically sustainable services with excellent facilities | [Yes /No /Not applicable] |
| Financially sustainable NHS organisation | [Yes /No /Not applicable] |
| Enabled by excellent IM&T | [Yes /No /Not applicable] |

2.This matter relates to the following governance initiatives:

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

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

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

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

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

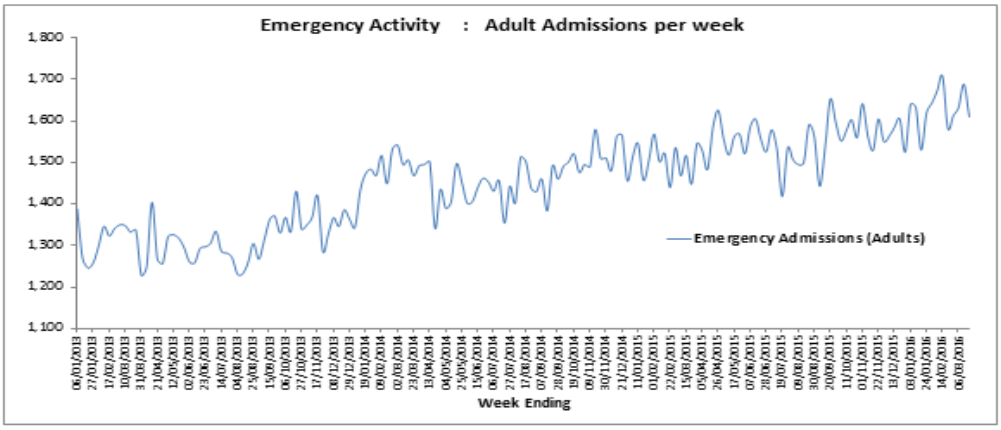
7.Papers should not exceed 7 pages. [My paper does comply]

| | |
|---|---|
| **REPORT TO:** | **Trust Board** |
| **REPORT FROM:** | **Samantha Leak Director of Emergency Care and ESM** |
| **REPORT SUBJECT:** | **Emergency Care Performance Report** |
| **REPORT DATE:** | **7 April 2016** |

Concerns about emergency care are increasing because four hour performance in March 2016 is likely to be the worst month ever at UHL and the first three months of this calendar year have all been worse than last year.

- As of (31/3/16) YTD performance is 86.9% and month to date is 77.8%.
- This time last year, YTD performance was 89.1% and March 2015 was 91.1%.
- YTD attendance 6.8% up on last year and continues to increase
- YTD total admissions 5.6% up on last year and continues to increase.

Our problems continue to be driven primarily by high attendance and admissions. The graph below shows weekly emergency admissions. Emergency admissions recently reached a new high and show no sign of abating.




The high level of demand has meant we have struggled to balance demand and capacity. This has resulted in very poor performance against the four hour standard and as discussed in detail at the recent Integrated Finance and Performance Committee it also has an impact on our RTT, cancer and on the day of surgery cancellation rate. Despite these pressures, we have seen some progress in reducing ambulance handover delays.

**Governance changes to the improvement plan**

In order to improve the response to the increasing levels of demand, the Leicester, Leicestershire and Rutland Urgent Care Board has reviewed its leadership structure and governance to ensure clearer management of operational, tactical and strategic issues. The LLR System Resilience Group will; lead system resilience, challenge across and between organisations, sign off strategic direction and support improvement plans at a high level, delegating delivery to the Operational Resilience Group (ORG) and the Urgent Care Programme Board (UCPB). The SRG will be the point of delivery for the Remedial Action Plan and other plans and Interface with NHS England and the Trust Development Authority. The Operational Resilience Group will deliver the RAP and tactical improvement plans, winter planning, surge resilience. The UCPB will develop overall strategy for SRG sign off and ensure clear links between BCT, BCF and Vanguard.

The most recent update to the LLR plan is attached.

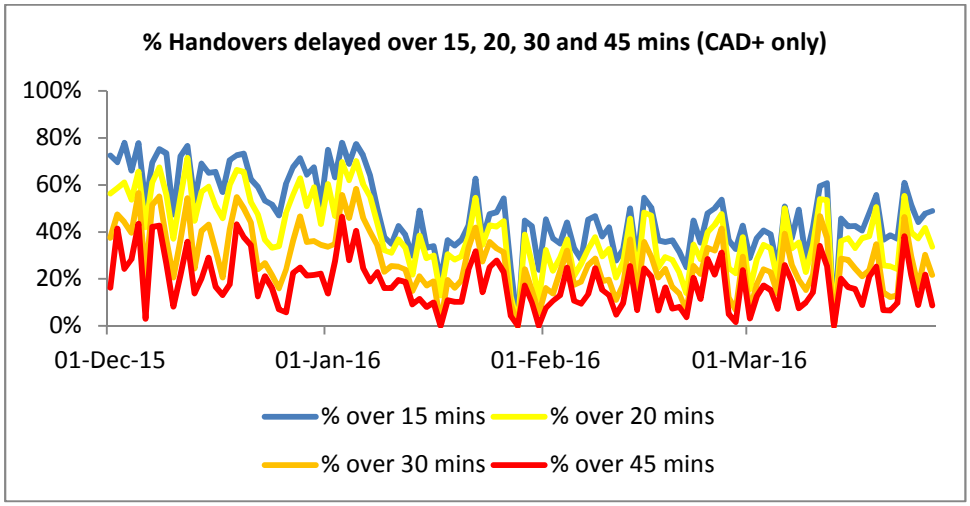
**Ambulance Handovers**

The Trust Board thinking day on 17 March 2016 spent time discussing current performance and further actions to improve performance. Our performance continues to improve despite the high levels of activity and very poor four hour performance.

| | % Delayed over 15 mins | % Delayed over 30 mins |
|---|---|---|
| Dec-15 | 65% | 25% |
| Jan-16 | 46% | 24% |
| Feb-16 | 40% | 22% |
| Mar 1-28th | 41% | 23% |

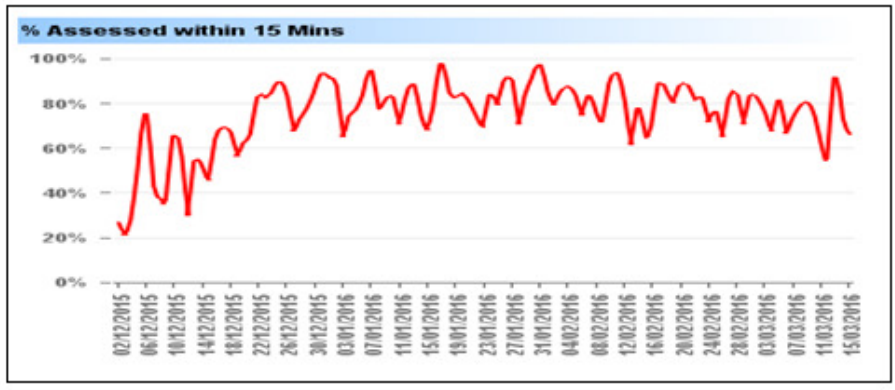
- Use of CAD+ is gradually increasing. CAD+ was used 53% of the time in December compared to 62% in February. Latest data shows performance at 70%.
- Handover delays have reduced from the peaks that we saw in November and December 2015 as can be seen in the charts below

Whilst indicating improvements, EMAS have also reported unprecedented increases in activity with a 30% increase in red calls (compared to previous year) from 111 to EMAS and 40% - 50% increase in Red 2 calls received from 999; this increase in acuity has an impact on time spent in ED.




**Time to Triage**

Time to triage continues to be a focus for the team. We are seeing peaks and troughs in our performance partly due to inflow but also due to internal processes. Our focus has shifted to team ownership and accountability when performance is below an acceptable level.



**Demand and capacity agreements**

A demand and capacity workshop took place in March and detailed feedback was provided to IFPIC. The key findings from the workshop are that we are currently forecasting the following capacity gap:

- LRI – A similar position to this winter ie days when we have insufficient capacity. Plan is dependent on benefit out of ICS (38 beds) and internal demand management works (6 beds). Without full delivery of these, our position deteriorates.
- LGH – Less concerned (as is)
- GGH – Ongoing shortfall of circa 40 – 50 beds if ICS (24 beds), cardiology LOS (6 beds) and BCT (4 beds) works. We have a similar position to this winter, ie days when we have insufficient capacity before the ICU reconfiguration.

The actions that came from the workshop were:

1. Refining the model – The priority is to feed in and update the refinements/adjustments to the model we agreed in the demand and capacity discussion. Chief amongst these is the ICS issue, where we need absolute clarity on the conversion rate issue and to refine the impact assumptions. (Richard Mitchell).
2. In parallel with that, we need to make sure that the conversations about the level of demand in our 2016/17 contract are fully reflected in the model, in particular identifying beds and theaters as separate units of capacity. (RM/Paul Traynor)
3. The model needs to be refined to distinguish between assessment and base ward beds. Essentially we need to have enough of both, or we risk flow blockage at the front end. (RM)
4. We need to factor in the volume of elective work that we are planning to outsource. (RM)
5. We need to factor in the impact of reducing readmissions, whilst ensuring that we don't double count with the likely impact of ICS. (RM)
6. In terms of reconfiguration, we identified a range of options in order to mitigate the operational impacts of reconfiguration. These should include the ideas we identified for freeing up space or creating more space at GGH as well as moving things on an interim basis from GGH to LGH. At the meeting we focussed on clinical services, which might be moved, but there may be options to free up non-clinical space at GGH and convert that to clinical use, either moving those non-clinical uses to LGH or off site completely. (PT)
7. We identified a need to look at infrastructure support at GGH (e.g. imaging). (PT)

Following the above being completed, a formal report will go to the Trust Board in May, with subsequent internal and external dissemination through CEO Briefing and other routes. It will also be presented to the next clinical senate. The report will be the final result of the D&C modelling and recommended decisions around reconfiguration in 16/17.

**Plan to reduce cancellations**

Due to emergency pressures, the cancellation rate for elective and cancer surgery has increased by 42% this winter. At a recent executive team we debated the merits and demerits of ring fencing elective and cancer beds at a time of such high emergency demand. We have made the following agreement with full support from the Clinical Directors and Medical Director:

- By 11 April 2016, we will have two bays back (ring fenced) for elective and ca surgical work.

- To deliver this, we need to make sure that at the back end of wc 8th April, when patients are discharged from the day ward, we are not putting more patients on the day ward – Julie Dixon will lead on this.
- This will give MSS CMG certainty about the volume of beds they can use.
- The only people who can authorise the use of those two bays for anything other than surgical patients is Andrew Furlong, Julie Smith or Richard Mitchell.
- Reducing medical outliers, reduces the medicine bed base at the LRI from circa 327 to 315 (3%) but it has a disproportionately positive impact on surgical throughput because over four days circa 100 surgical patients can go through the beds.
- We aim to follow the same process and by 25 April 2016, the day ward will be clear of medicine.
- By mid-May, ward 7 must be clear as well.
- The change isn't without risks, such as possibly extending waits for beds in ED, but these risks will be monitored through Gold command each day.
- To reduce ICU cancellations – we need to get back into the habit of managing the expectation that ICU discharges are back onto the wards with four hours. This clearly doesn't happen at the moment and will be monitored more thoroughly through gold.

**Conclusion:**

It remains essential that the health system focusses on delivering the actions detailed in the attached action plan. A massive concern is the rising levels of attendance and admissions. If we do not collectively deliver on progress to the plan, which delivers a reduction in demand this summer, winter 2016-17 will be even worse than this one. The three most important areas to focus on are:

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

**Recommendations**

The Trust Board is recommended to:

- **Note** the contents of the report
- **Note** the increasing concerns about four hour delays but recent improvements in ambulance handovers.
- **Note** the importance of reducing the mismatch between demand and capacity in 2016/17.

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

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

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

**Tab 2 - Discharge plan. March 2016**

| No | Objective | Actions | | Description | Benefit | Metric | Current performance | Target | Variance | KPI/Outcome measures | Accountable Officer / Organisation | Deadline | Milestones | RAG | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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: 4/3/16** **Document Owner: Samantha Merridale - Head of Operational Resilience**

| No | Objective | | Actions | Description | Benefit | Metric | Current performance | Target | Variance | KPI/Outcome measures | Accountable Officer / Organisation | Deadline | Milestones - for review W/C 7/3/16 | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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. CCG leads to contact individual private practices to discuss alternative services. CNCS to review Adastra patient outcomes to ensure consistency in patient pathways. | Reduction in frequency and numbers of attendances | No of patients, no of avoidable adm/attends. No fed back to practices. | | | | | R Vyas (LCCCG) K Tierney-Reid (WLCCG) D Eden ELCCG R Haines CNCS | Weekly | Review of data CNCS to review Adastra, agree formalisation of feedback of data and frequency. Catherine Free to send categories of patients to Angela. | |
| | | 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. | Increased utilisation of alternatives to admission above current baseline by front line staff | Increase in see and treat activity. Non conveyance rates - use of alternatives (UCC). Outcome metrics. | | | | | L Brentnall (EMAS) | 31/03/2016 | EMAS to confirm when trajectory available regarding supply/use of phones. CCGs to supply data to EMAS. | |
| | | 1.3 | Provide system navigation facility to referring GPs bed bureau EMAS OOH Care homes to promote alternatives to admission | Establish and implement a clinical navigation process that 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) | Non conveyance and increased use of alternatives to admission | | | | | | Dan Webster (EMAS) / R Haines (CNCS) | 29/02/2016 | JD to put date in for meeting regarding BB. | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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.<br>Reduction in emergency admissions | BB admissions. 3 months baseline - against no referred. | | | | | R Vyas (LCCCG)<br>K Tierney-Reid (WLCCG) D Eden ELCCG<br>R Haines CNCS J Dixon UHL | Weekly | Data from BB?<br>Data from SSAFA. | |
| 1.5 | Maximise utilisation of step up ICS capacity by Primary / Community Care. | Reduce conveyance of patients to UHL | Reduction in emergency admissions | Use of Step up by CCGs. | | | | | Primary Care Clinical Leads. | | Data from CCGs re no. of practices referring. | |
| 2.1 | Ensure that all EMAS crews have Pin numbers and use the CAD+ system for every handover. | CAD+ is the system through which handover times are jointly recorded by EMAS and UHL staff. It is therefore the data source that is recognised by both organisations. It is important that all arrival are recorded via CAD+ to avoid distraction from disputed data. | Reduction in handover delays | | | | | | R. Henderson | 29/01/2016 | | |
| 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 | 01/04/2016 | | |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2** | **Reduce delays in ambulance handover times at the LRI site** | 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 | Reduction in attendances. Rapid cycle test taking place 8/3/16. Handover data facilitated by EMAS / John Roberts. | | | | | EMAS (RH/JD) and UHL (SL) | 17/02/2016 | | |
| | | 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. | Reduction in handover delays | | | | | | UHL (SL) and EMAS (JD/RH) | 28/02/2016 | | |
| | | 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 | | |
| | | 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 | | |
| | | 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 | | |
| | | 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 | | |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 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 | ED attendances | | | | | Martin McGrath | 26/02/2016 | Review of data from RCT. | |
| | | 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. | Improvements in flow | Activity data | | | | | Julie Dixon | 01/04/2016 | Meeting to be arranged with CNCS. Analysis of activity data. | |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **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** | 3.3 | 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 | Reduction in number of patients attending main ED and therefore a reduction in ED occupancy | UCC referrals to ED. 3 month baseline | | | | | Julie Dixon | ~~08/02/2016~~ ~~11/04/2016~~ 01/06/2016 | SL to expedite equipment order if possible. RM to check whether UCC can access ICE to request diagnostics. | |
| | | 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 | | |
| | | 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. | Reduced occupancy in ED | No of patients going through AAU. No of patients discharged home. | | | | | Sam Leak | ~~29/02/2016~~ 28/03/2016 | | |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 3.6 | To accelerate the admissions process. | To implement accelerated flow, meaning that the lag time between beds becoming available on base wards and patients actually moving from ED is reduced. This has been subject to 2 successful RCTs. | Reduction in ED occupancy | | | | | | Julie Dixon | 29/02/2016 | Discussion within UHL re impact. | |
| 4 | **Reduction in emergency admissions** | 4.1 | Implement feedback loop to GPs regarding inappropriate admissions as a learning exercise | Provide themed feedback about patterns of inappropriate referrals. It is not logistically possible to do this in real time for individual patients. | Reduction in emergency admissions | Monthly review of inappropriate admissions, to include paeds | | | | | Lee Walker | 11/03/2016 | UHL to investigate 'red flag' coding | |
| | | 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. | Reduction in emergency admissions | Admission numbers | | | | | Ian Lawrence | 18/03/2016 | UHL to provide update. | |
| | | 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. | Reduction in emergency admissions | | | | | | Ian Lawrence | 18/03/2016 | Review of data | |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 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. | Reduction in emergency admissions | | | | | | Catherine Free | 01/05/2016 | Review of data | |
| | | 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. | Reduction in emergency admissions | | | | | | CCG | 31/03/2016 | SP to d/w RM | |