UHL Emergency Performance

Author: [Richard Mitchell] Date: [December 2015]

Trust Board paper J

Executive Summary

Context

University Hospitals of Leicester is under acute operational pressure because of the increasing emergency demand. We predict further increases in attendance and admissions this winter and are concerned about the impact this will have on elective and emergency care.

Questions

1. What reflections did Non-Executive colleagues have following their walk around on 26 November 2015?
2. What else should LRR be doing to improve care this winter?

Conclusion

1. The actions taken across LLR can be put into a two by two matrix: internal v external and short term v long term. We need to ensure that there are sufficient actions being taken in each of the four squares in this matrix. Whilst new actions are being taken, many of these are still focussed on the lower acuity patients who are not admitted and at best will provide marginal gains.

Input Sought

The Board is invited to consider whether internal and system-wide action is sufficient to address the issues raised.

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: December 2015

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

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

REPORT TO:	**Trust Board**
REPORT FROM:	**Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT:	**Emergency Care Performance Report**
REPORT DATE:	**December 2015**

High level performance review

- (As of 27/11/15) 90.1% year to date (+0.5% on last year)
- Attendance +4.2%
- Admissions +7.2%
- **November will be the fifth month in a row where performance is worse than the corresponding month last year**
- **Performance remains consistently below 95%.**

After a strong start to the year, four hour performance for five of the eight months in this financial year has been worse than the corresponding month last year. Wc 30 November 2015, will be the first time in the financial year when four hour performance drops below 90% year to date. After the first three months performance was above 92% and it has gradually deteriorated since then.

The biggest determinant of emergency performance remains the relationship between the level of admissions and capacity to care for these patients. Admissions and attendance both at the Emergency Department at the Leicester Royal Infirmary and the Clinical Decisions Unit at Glenfield General Hospital remain very high compared to previous years. Maintaining operational grip and standardised systems and processes is difficult when the services are under such sustained pressure. The increased pressures have meant that as well as a deterioration in four hour performance, ambulance handover times have become unacceptable, on the day cancellations and patients cancelled on the day before surgery have dramatically increased and we are averaging one to two major internal incidents every week.

The Non-Executive directors visited the Emergency Department and Medical Assessment Units at the LRI on 26 November 2015 and are invited to share their views and experiences with the Trust Board.

Actions being taken

Actions taken over the last month include:

- GPs with a specialist interest in emergency medicine joined UHL on 3 November 2015 and run a single front door service between 0900 and 2100 seven days a week. It is very early days in the change but colleagues in ED are pleased with how the changes have gone and are seeing a slight reduction in transfers from the front door and UCC.
- A joint protocol between EMAS and UHL has been updated agreeing the process for patients who cannot be offloaded immediately from ambulances at the LRI site.
- A protocol has been signed off for patients who are waiting for admission in majors ED. This involves the use of the TiA clinic located near the ED.
- Nursing numbers have been increased in main ED and paediatric ED.
- Many meetings have taken place between paediatric ED and the wider paediatric service and the UHL exec on call meets with the paediatric team every morning at 0900 to take stock of the previous 24 hours.
- All beds that can be opened across UHL have been opened.
- Paediatric and adult elective patients have been taken down in advance of the day of surgery to allow medical and emergency surgical outliers.

- At the Urgent Care Board on 26 November, the main focus was on the inflow plan. The agreements from this meeting will be circulated when available.

The most up to date UHL action plan is attached and this continues to be tracked every week either through work steam meetings or the fortnightly Emergency Quality Steering Group.

Vanguard
The draft LLR Vanguard proposition plan is attached and details the six strands to the work.

Winter 2015-16
Since the last Trust Board, emergency performance has deteriorated further and we are seeing the reality of a very challenging winter. We remain concerned that we have not reached peak winter yet which is historically when more patients attend and are admitted.

The actions being taken can be put into a two by two matrix: internal v external and short term v long term. We need to ensure that there are sufficient actions being taken in each of the four squares in this matrix. Whilst new actions are being taken, many of these are still focussed on the lower acuity patients who are not admitted and at best will provide marginal gains.

As a health system we need to strategically decide what our plan is going to be for dealing with the unrelenting demand. One option is to do everything possible to keep emergency patients away from the acute sites. The second option is to accept that UHL, especially the LRI, has huge pulling power for emergency demand, a problem that may only increase with the new emergency floor in 2016. There may be an option to accept the demand will come in and we need to concentrate on ensuring we provide an efficient hub type service.

Conclusion
Emergency performance is now worse than last year and in December 2015 is likely to drop below last years performance ytd. Emergency performance remains a key focus for UHL and LLR but we need to see all possible efforts taken to either reduce attendance and admissions and/ or increase acute capacity before we move to an improved position.

It is important this winter that we remain resilient, patient focused and work as a team.

Recommendations
The Trust Board is recommended to:

- **Note** the contents of the report
- **Note** the pressures that UHL are under
- **Note** the requirements for a reduction in emergency attendances and admissions before improvement is possible.

Organisation	Workstream	Action reference number	Link to 5 key improvement areas	Actions	Action lead within the organisation	Delivery date / Next Review	Delivery Status	Comments on delivery of the action, where closed what follow up actions are required
UHL	WHR	UHL-WHR12		Coordinate escalation plans between ED/AMU/CDU and articulate responsibilities of DM team with aim of sharing risk across areas in the safest possible way	Julie Dixon	11/11/2015	2. Significant delay – unlikely to be completed as planned	Agreement that ED and AMU will ensure plans are coordinated at ED and AMU Workstream meetings on 28/10/15. **Update on 28/10/15:** AMU workstream meeting cancelled due to operational pressures and ED workstream meeting focussed on UCC New Front Door issues. ED/AMU Liaison meeting arranged for 18/11/15 with escalation procedures as main agenda item, however this later date will delay delivery. **Update on 2/11/15:** First ED/CDU Liaison meeting organised for 11/11/15. **Update on 11/11/15:** ED/CDU Liaison meeting cancelled as ED only had 30 minutes available on the day. **Update on 13/11/15:** ED/AMU Liaison meeting cancelled due to ED Clinical Lead taking annual leave. Meeting rearranged for 25/11/15. Date
UHL	WHR	UHL-WHR13		Improve process for early outlying by sending out an early outlying plan with the bed state on Friday afternoon (4:30/6pm)	Julie Dixon	11/11/2015	6. Complete and regular review	**Update on 21/10/15:** This is happening reliably however when the plan isn't carried out this is due to staffing issues. **Update on 13/11/15:** Early outlying criteria has been updated but Bed Management Policy is still out of date and there is the process for outlying patients is not documented anywhere. Meeting to be arranged to establish what documentation requires updating and what is missing so that a plan to fill gaps can be drawn up. **update on 17/11/15:** Work is ongoing to improve process. This will be monitored weekly and tracked via the Workstream meetings with RM.
UHL	WHR	UHL-WHR6	Out of hours variability in the ED	Design and implement a robust management framework for monitoring & addressing actions taken when on escalation to ensure consistent, timely response	Julie Dixon	~~30/06/2015~~ 30/09/2015	6. Complete and regular review	Proposal to pilot new Operational Meeting structure and link with Trust wide work being led to introduce Safety Huddles across all Wards Working with the Patient Safety lead to design pro forma for approval at EQSG **Update on 07/07/15:** The functionality of the Gold Command Meetings and information flows to and from these meetings is a prioirty action for the next 12 weeks. This action will be reworded and updated to reflect this. **Update on 25/08/15**: Met with Aaron Vogel to link through to Major Incident management. Action plan in place to drive improvement in recording of decisions **Update on 18/09/15**: Lauching real time display of action log at Gold/Bronze meetings via use of electronic white board. Will trial from 21.09 **Update 21/10/15:** Real time display of action log is continuing. IT issues are being tackled gradually with support from IT. **Update 13/11/15:** Audit to be undertaken to understand to what extent actions are being completed on time
UHL	WHR	UHL-WHR14		Delivery of action plan relating to TDA escalation plan	Richard Mitchell		4. On track	Please see 'Escalation - Plan' tab
UHL	WHR	UHL-WHR15		Delivery of actions relating to notes audit	Richard Mitchell		4. On track	Please see 'Escalation - Plan' tab
UHL	WHR	UHL-WHR16		Create an "early warning" data setand support staff to use it to improve timeliness and consistency of escalation	Julie Dixon	~~30/10/2015~~ 1/12/2015	4. On track	Update on 17/11/15: First iteration of model completed and discussed with RM. Second iteration due for completion w/c 23/11.
UHl	GGH	UHL-GGH9		Improve imaging access to match AMU /AFU to reduce discharge delays	Dan Barnes	30/06/2015	7. Closed	Need clarity on CT utilisation going forwards Update on 27/05/15: This is amalgamated as part of 7 day working and reconfiguration. Update on timescales needed from AF Update on 07/07/15: This action is revisited once there is clarification around the future operating model with respect to Glenfield Update on 29/07/15: This might be possible to RCT using CCG winter funding. Potential also to explore with Radiology new ways of working - along lines of what was done at LRI ED. Update on 24/08/15: Working session with Radiology and Respiratory on 26th August to explore a number of process flow improvement options to be reported back in the Consulant meeting at the end of August. Options include urgent outpatient slots and changing the way inpatient slots are allocated. Update on 27/08/15: Considering whether list of contact numbers for consultants who can protocol requests can be made available on CDU Update on 14/9/15: Draft improvement plan for further discussion with Dan Barnes and initial analysis has been completed **Update on 17/11/15:** Improvements not able to be made without increasing capacity of service. No additional funding available. Action closed
	GGH	UHL-GGH11		Design and implement an escalation policy for CDU as part of the whole hospital response to improve flow through department	Kim Ryanna	01/09/2015	2. Significant delay – unlikely to be completed as planned	**Update on 22/07/15:** Escalation workshop planned for 18/8/2015. AMU and ED escalation plans shared. **Update on 14/09/15:** Escalation plan draft to be shared in CDU Ops meeting and working time is allocated to review this draft in the meeting **Update on 17/11/15:** Meeting to coordinate escalation plans between ED and CDU cancelled due to IMI. Meeting is being rescheduled
	GGH	UHL-GGH10		Increase numbers of monitored cardiology beds in base wards	Jan Kovac	30/06/2015	2. Significant delay – unlikely to be completed as planned	Scoped numbers required and applied for charitable funding aplication. Total cost of £110k. Charitable funds element £60k. **Update on 07/07/15**: Waiting for funding to be implemented **Update on 21/07/15**: Next charitable funding meeting is in August (waiting for confirmation on date). In the interim exploring using existing money to fund half of the additional beds. To mitigate pressures for monitored beds circulating the 'monitored beds policy' to cardiology team. **Update on 24/08/15**: There are not sufficient monies in the charitable fund to pay for the increase in monitored beds as well as capital work required. The application will be resubmitted in October. In the meantime the CMG is proceeding with procuring 50% of the monitored beds for which the CMG is funding. **Update on 27/08/15**: Reviewing whether monitors purchased for new ED floor can be used in interim. Exploring whether capital funds can be used.
UHL	Frail-Elderly Care	UHL-FE2		Review Geriatrician Job Plans to create consistent cover for EFU and ED in-reach 7 days a week	Richard Wong	01/12/2015	1. Not yet commenced	
UHL	Frail-Elderly Care	UHL-FE3		Work with the ED, admissions wards and IT to implement a Frailty Flag on EDIS	Richard Wong	18/09/2015	2. Significant delay – unlikely to be completed as planned	**Update on 28/07/15**: Confirmed with IBM team that a Frailty Flag could be added as part of the Nurse Orders. Need to work with the AMU workstream to introduce this to the staff
UHL	Frail-Elderly Care	UHL-FE4		Develop robust frailty in-reach services for those patients with a frailty flag and not currently on geriatric base wards based on tiered input from tracker nurses, PCCs, FOPAL	Richard Wong	18/11/2015	2. Significant delay – unlikely to be completed as planned	**Update on 28/07/15**: Initial proposal drafted and presented at EQSG on 29.07.
UHL	ED	UHL-ED15		Coordinated escalation process to be implemented in the ED	Ben Teasdale	19/12/2015	3. Some delay – expected to be completed as planned	**Update at 13/11/15:** This may be delayed as the process to coordinate escalation plans has been delayed.
UHL	ED	UHL-ED15		Create sustainable framework within which ED can implement continuous improvements going forward.	Rachel Williams	25/03/2016	4. On track	To kick off the process, a staff survey was conducted within ED and all feasible suggestions added to the ED Senior Team Action Log. **Update on 26/10/15:** As part of this process the existing meetings that take place in the ED are being mapped out so that attendees, purpose and frequency is understood for each meeting. Once the status quo is understood it will be reviewed in the context of planning implementation of a framework for continuous improvement in the department.

Organisation	Workstream	Action reference number	Link to 5 key improvement areas	Actions	Action lead within the organisation	Delivery date / Next Review	Delivery Status	Comments on delivery of the action, where closed what follow up actions are required
UHL	ED	UHL-ED6		Eliminate IT delays between visibility of results in imaging and in ED to reduce delays in decision making	John Clarke	30/05/2015	7. Closed	Sign off for ED to be able to see unverified images received. IT in process of making relevant changes although they have raised a concern around the impact of this on system processing time. Further work to be done to understand the driver behind delays in seeing Reports. Additional pilot run with Imaging in May/June to look at benefit from an exclusive ED CT scanner **Update on 06/07/15:** Current state is as above. IT has been chased for update. To be raised for escalation at EQSG if no progress on 07/07/15 **Update on 28/07/15**: Further investigation required to understand cause of delays in accessing radiology reports. This is being done as a priority action under the ED IT action plan. Update meeting planned for 06.08 and the delivery date for this action will then be revised as appropriate **Update on 11/08/15:** Outcome of meeting will be discussed when BT returns from leave on 17/8. **Update on 02/10/15:** Work on this was postponed to facilitate the New Front Door IT. To be followed up in next phase as part of the ED
UHL	ED	UHL-ED7	Out of hours variability in the ED	Work with each area in the ED to reduce time from bed allocation to departure from department	Ben Teasdale	30/09/2015	2. Significant delay – unlikely to be completed as planned	Requested data on current performance - by ED area - against time from allocation to departure **Update on 07/07/15:** Data from Jan - Apr 2015 showed that of all Majors and Minors patients, c.60% move within 30 minutes of a bed being identified. In Majors, 10% take over an hour to move from when a bed is identified. Work is being done in the patient journey meetings to understand what drives these delays and what can be put in place to address. **Update on 18/09/15**: This is likely to be picked up in root cause analysis on ED delays and may be re-prioritised. No action plan has yet been put in place to address
UHL	ED	UHL-ED11	Out of hours variability in the ED	Co-design with ED staff a process for having (?hourly) Situational Awareness updates from all ED areas to help with timely escalation	Ben Teasdale	28/05/2015	7. Closed	This was launched on 23/05. Meeting held with trackers 3/6/15. New reporting template agreed & will be rolled out by end of June. Work will start with Paediatric ED to ensure the process is fully embedded there. This will then be extended to each area of the ED in turn. Need to get agreement as to how this links to Gold Command reporting and escalation. **Update on 07/07/15:** this is highlighted as a key process to embed over the next 12 weeks **Update on 02/10/15:** Working with the Whole Hospital Response workstream to design a cross-area (ED/CDU/AMU) escalation strategy. This will then feed into a revised way of doing the Hourly Situational Awareness which still has to be embedded within the department.
UHL	ED	UHL-ED16		Deliver the 8 week RCT with unipart and EMAS	Julie Dixon	18/12/2015	4. On track	**Update on 17/11/15:** Unipart working with ED on improving handovers
UHL	Base Wards	UHL-BW1	Improve 7 day processes	90% of base wards to have 3 junior doctors per ward at 8am to facilitate one stop wards rounds and early discharges	Ian Lawrence	01/08/2015	6. Complete and regular review	Revised rota due for review mid June. Rapid cycle test of 8am - 4pm shift on ward 38. **Update on 07/07/15**: Clarification pending from IL and JDA re: August changover and staffing levels. **Update on 11/08/15**: Four rota combinations have been explored, none of which have delivered the required number of Junior Doctors per ward. IL to speak to JDAs **Update on 18/09/15**: Ongoing work with Matt Peatfield to progress **Update on 02/10/15**: New rota details shared by Matt Peatfield. This will be discussed at next BW workstream meeting on 05/10 and updated at BW workstream review meeting mid October. **Update on 13/11/2015:** There is a risk that there is a lack of resource to ensure there are is a minimum of 3 junior doctors on each ward. There are currently gaps in the junior doctor rota. Agreed to redistribute junior doctors to wards with the highest acuity. **Update on 17/11/2015:** Proposed change to 90% coverage of 3 Junior Doctors. This will be focussed on high acuity and discharge wards Weekly report being produced - recommendation to change to Complete with Regular Review.
UHL	Base Wards	UHL-BW2		Increase the accuracy of recorded discharge time to capture and encourage early discharges	Ian Lawrence	~~30/06/2015~~ 30/07/2015	7. Closed	This impacts upon BW1-3. Need more clarity as to next steps. Meeting scheduled for w/c 1/6/15. Needs more work to achieve results. **Update on 07/07/15:** Further clarification needed as to current status. **Update on 08/07/15**: This will be discussed at EQSG on the 5/8/15 **Update on 06/08/15:** Discussed the Flow Co-Ordinators and use of i-Pads to support flow, and want to implement as soon as reasonably possible. Need IM&T to either make the required changes or alternatively provide another solution. **Update on 17/11/2015:** This action has been closed as not high priority due to focus on improving discharges. Action closed as not high priority
UHL	Base Wards	UHL-BW3	Improve 7 day processes/ Reduce time from bed request to bed allocation (Improve flow from the Emergency Department to the Acute Medical Unit)	Implement "real-time bed state-'light' " to capture and encourage early discharges	Ian Lawrence	~~30/06/2015~~ 30/07/2015	7. Closed	This impacts upon BW1-3. Need more clarity as to next steps. Meeting scheduled for w/c 1/6/15. Needs more work to achieve results. **Update on 07/07/15**: Further clarification needed as to current status **Update on 08/07/15:** This will be discussed at EQSG on the 5/8/15 **Update on 06/08/15**: A form of real time bed state light now covers ward 34. Need IM&T to either make the required changes or alternatively provide another solution. **Update on 02/10/15**: A new Excel based system for capturing real time bed information has commenced in a trial from 21/09. An update is due at EQSG on 21/10. IT have been tasked with exploring what else is possible to facilitate this process. **Update on 17/11/2015:** Simon Pizzey doing an options appraisal for cost of Real Time Bed States to potentially to take to revenue and
UHL	Base Wards	UHL-BW6		Increase the availability of blood results by the end of the ward round to reduce discharge delays	Julie Dixon	~~30/06/2015~~ 30/07/2015	7. Closed	Budget issues. Meeting scheduled for w/c 1/6/15 with Chris Shatford Update on 3/6: Focus on time shifting the phlebotomist and taking to HOOs **Update on 07/07/15:** Talks have stalled due to budgetary issues meaning that full plans cannot be implemented. This action is for closure. **Update on 08/07/15:** RW and IL to speak to CS regarding stratifying blood results into urgent and less urgent **Update on 18/09/15**: Chris confirmed that this has been delayed since the request for further funding was not approved at EQB. Organising meeting to agree alternatives possible within current financial envelope **Update on 17/11/15:** Chris thinks that this isn't a problem. This is on the CIP list for 16/17 - Sam Leak is pursuing this. Looking to have a solution in place by April. Case for change will be made in November/December with revenue and investment committee in January. This action will be tracked via Beds Programme Board/CMG CIP and is therefore closed from UHL Action Plan.
UHL	Base Wards	UHL-BW7	Improve 7 day processes	Increase the proportion of nurse-delegated or therapy-delegated discharge at the weekend to 50 % to reduce length of stay	Maria McAuley	~~30/06/2015~~ 30/09/2015	2. Significant delay – unlikely to be completed as planned	Nurse delegated discharge pilot in progress on ward 37 with good clinical engagement. **Update on 07/07/15**: New action plan devised for wider roll out. This is identified as a priority action for the next 12 weeks & the delivery date has been changed accordingly **Update on 25/08/15**: Continuing with NDD on wards 37&38 - need to get cases for nurses in order for them to be signed off as competent. In addition, Gill Stanton has approved work with the matrons to get them to lead on NDD in outlier wards (7, 18 and 24). **Update on 02/10/15**: Working to quantify number of nurses who can be trained & signed off by ward for all medical wards. This sign off process can then be done by the matrons of each ward. Simon Pizzey / Ian Lawrence are engaging with the Consultant group to increase number of patients being identified as suitable for NDD. **Update on 17/11/15:** Ian Lawrence to push this in Consultant Meetings and put a feedback loop/confirm and challenge in place based on tracking how many stickers are being used. RM to discuss with IL.
UHL	Base Wards	UHL-BW8	Improve 7 day processes	Improve utilisation of the discharge lounge between 8am and 12pm.	Ian Lawrence	18/12/2015	4. On track	**Update on 13/11/2015**: Driven increased discharges to the discharge lounge on oncology and day wards by visiting outlying patients, and encouraging staff to use the discharge lounge Designed a 'meet me in the discharge lounge' project. This includes staff phoning relatives to collect patients in the discharge lounge, where they can drive through gate 9 and get free parking for 20 minutes. Funding has been requested to improve the discharge lounge (buy partitioners, book cases, tables etc.).

Organisation	Workstream	Action reference number	Link to 5 key improvement areas	Actions	Action lead within the organisation	Delivery date / Next Review	Delivery Status	Comments on delivery of the action, where closed what follow up actions are required
UHL	AMU	UHL-AMU7		Implement Ambulance/Transport service to convey GP referrals that need to attend within 1 hour of GP request for transport to increase the utilisation of the AMC	Julie Dixon	13/05/2015	5. Complete	Trial of UHL ambulance crew bringing in GP referral patients unsuccessful due to requirement for technical crews. Discussions with EMAS revealed issue to be with GP understanding of criteria. Will aim to address at GP Event on 23/6 To review 27/6 - currently being managed in existing resource **Update on 11/08/15:** The CCG will be funding a 4 month pilot over Winter (starting in October) for a 1 hour ambulance. **Update on 17/11/15:** This is in place
UHL	AMU	UHL-AMU8		Increase number of patients being seen through AAU by holding workshop to agree ways of working with Consultants	Lee Walker	27/10/2015	5. Complete	**Update on 17/11/15:** Workshop has taken place and actions identified to increase numbers. Next step is to test all GP referrals going through AAU using Simulation Model. New actions will be added to the plan.
UHL	AMU	UHL-AMU9		Identify causes of and reduce delayed discharges due to TTO process through holding a workshop and devleloping an action plan	Lee Walker	06/11/2025	5. Complete	**Update on 17/11/15:** Workshop has taken place and actions identified to reduce discharge delays due to TTOs including a new safety round process and ICE summary status screen. New actions will be added to the plan.
UHL	AMU	UHL-AMU10		Identify causes of and reduce delayed discharge due to specialist review process through holding a workshop and developing an action plan	Lee Walker	17/11/2015	2. Significant delay – unlikely to be completed as planned	**Update on 17/11/15:** Workshop cancelled due to lack of attendees. Will be rescheduled for 4/12/15.
UHL	AMU	UHL-AMU11		Deliver a consistent model for change within AMU by creating a sustainable RCT approach with data request and manipulation guidlines.	Lee Walker	25/11/2015	4. On track	
UHL	Ambulatory Care	UHL-AMB5	Increase internal and external awareness of ambulatory pathways at UHL	Work with CDU to develop ambulatory clinic to streamline flow through department	Catherine Free	~~30/06/2015~~ ~~30/09/2015~~ 14/12/2015	4. On track	Exploring potential staffing models. **Update on 18/5/15:** Paper submitted for discussion at respiratory consultant meeting on 29/5 **Update on 15/6/15:** Staffingoption being presented on 24/6 at EQSG **Update on 30/6/15:** Rapid Cycle tests of Consultant led and Nurse led model have been tried. This is likely to be supported by the CDU simulation tool modelling work. Recommendation that this action is rolled into phase 2b Update on 07/07/15: This is a priority action for the next 12 weeks. Further nurse led trial planned for week commencing the 27/7/15. **Update on 11/08/15:** Nurse led trial successful. Benfits of model limited by access to Consultants and lack of co-ordinating nurse. Business case in development and being linked to Glenfield Outreach programme to reduce readmissions. **Update on 24/08/15:** Business Case complete awaiting updated finances. CQUIN documentation submitted and in conversation with CCG regarding nursing funding. The model will be trialled for 6 months over Winter. The success or otherwise of the model will be evaluated and a
UHL	Ambulatory Care	UHL-AMB3	Increase internal and external awareness of ambulatory pathways at UHL	Produce ambulatory pathway repository for UHL staff and GPs to increase use of existing pathways	Catherine Free	~~27/05/2015~~ 17/6/2015	6. Complete and regular review	Existing directory located. All services listed on directory being contacted to provide updated information. New services identified for inclusion in directory. **Update on 26/5/15**: This is a larger piece of work than anticipated due to need to meet with each service. This is on track for sharing with the GPs at event on 23rd June and being finalised following this.

Origin	Organisation	Workstream	Action reference number	Actions	Action lead within the organisation	Delivery date / Next Review	Delivery Status	Comments on delivery of the action, where closed what follow up actions are required
TDA Escalation Plan	UHL	Flow	F-2	Joint EMAS/UHL handover delays Unipart initiative complete	Julie Dixon	10/12/2015	3. Some delay – expected to be completed as planned	Process has commenced with a review meeting scheduled 16th December. **Update 18/11:** Focus needs to be on reducing variation + recommendations for change
TDA Escalation Plan	UHL	Flow	F-3	Proactive arrangements to manage anticipated demand surge on Fridays and Mondays	Ian Lawrence	05/11/2015	5. Complete	Actions implemented and new arrangements being refined in line with feedback **Update 18/11:** Proactive plans in place to outly. Limitations in capacity
TDA Escalation Plan	UHL	Flow	F-4	Reschedule some elective activity from Mondays to weekends to create bed flexibility (from January)	Richard Mitchell	01/01/2016	4. On track	Second discussion next week **Update 18/11:** This is already happening across Paediatrics and some specialties. In January there will potentially be a designated surgical ward for medicine + 3 days between christmas and NY
TDA Escalation Plan	UHL	Flow	F-5	Introduction by UHL of new bank working incentives (from 1 Oct).	Maria McAuley	01/10/2015	6. Complete and regular review	UHL have stopped using Thornbury but this is having an impact on fill rates. As such UHL will be keeping this under constant review. Ratio of bank to agency workers has improved from 50/50 to 60/40
TDA Escalation Plan	UHL	Flow	F-6	Finalisation of CAMHS in-reach/handover protocol	Andrew Furlong	21/10/2015	5. Complete	Rolled out **Update 18/11:** Continuing to escalate where policy isn't adhered to. This will be discussed with Sam Jones 19/11.
LLR Recovery Plan	UHL	Inflow	F-7	Review referral activity from those GP practices who do not arrange for a face to face consutlation with their patient prior to referral to acute care	Julie Dixon	20/11/2015	3. Some delay - expected to be completed as planned	Initial generic information on two days worth of referrals presented to UCB on 30/10. More detailed update on specific practices to be shared within next week **Update 18/11:** Identified specific practice - South Wigston (althoiugh not enough data to be statistically significant). This needs to be fed back to UCB
LLR Recovery Plan	UHL	Inflow	F-8	1. Agree and implement appropariate onward referral pathways from UHL ED. 2. Review activity and outcomes of the ED weekly for the first month to establish effectiveness and any unexpected barriers to streaming patients 3. Consider use of volunteers to assist patients in obraining a suitable appointment prior to leaving the UHL campus	Julie Dixon	04/12/2015	4. On track	
LLR Recovery Plan	UHL	Flow	F-9	Accelerated flow admissions model - scope feasibility of introucing earlier movement of patients from ED to base wards at earlier stage of bed idenitfication to streamline admission process	Richard Mitchell	26/11/2015	4. On track	Identified as a new action at 12/11 UCB. Will require UHL and CQC sign off **Update 18/11:** Need to have an agreed protocol to take to UCB/CQC. JS conversation with CQC - CQC supportive as long as bed is available at end of the chain. Gill/Ian/Carole to complete ahead of EPB
LLR Recovery Plan	UHL	Flow	F-10	Optimising the use of sub-acute/rehab beds on a daily basis through multi-disciplinary ward round, whole system DTOC calls, maximiising new reablement capacity and LPT and UHL to jointly agree target number of daily patients for discharge to community services by 15 Oct UCB.	Rachel Bilsborough	30/11/2015	2. Significant delay - unlikely to be completed as planned	Joint agreement on notional number of 'target' discharges from UHL to LPT community services to support daily focus on maintaining flow **Update 18/11:** 36 patients discharged to ICS, occupancy running at 88%. Rachel Bilsborough to provide target number.
Notes Audit	UHL	Flow	1-6.1	Increase access to specialty input via hot clinic or ambulatory pathway	Catherine Free	Meeting 28/10/15	6. Complete and regular review	Potential option is trying to ringfence a greater proportion of time in hot clinics **Update 18/11:** Comprehensive range of ambulatory pathways now available. Further work needed to maximise utilisation.
Notes Audit	UHL	Flow	1-6.2	UCC able to request X rays	Julie Dixon	03/11/2015	5. Complete	

Notes Audit	UHL	Flow	1-6.3	Increase capacity on AMU for GP access	Lee Walker	02/12/2015	4. On track	RCT to trial taking all GP referrals taken place. TTO and Specialty Input workshops scheduled for October and early November **Update 18/11:** Looking at increasing overall no. of patients through AAU, looking at live TTO state/ comms to patients, moving MSS out, time to specialty review
Notes Audit	UHL	Flow	1-6.4	UCC able to refer directly into services	Julie Dixon	03/11/2015	5. Complete	
Notes Audit	UHL	Flow	1-6.5	Improved signposting/utilisation of community based services	Ian Lawrence	18/12/2015	4. On track	Comms roll out plan of 'think community' in train **Update 18/11:** Work ongoing to flag community services + utilisation increasing correspondingly. Meeting needed with Consultants - potential to use Friday Lunchtime slot
Notes Audit	UHL	Flow	1-6.6	Explore awareness of community based services and confidence in using them of ED staff	Ben Teasdale	Meeting 28/10/15	5. Complete	
Notes Audit	UHL	Flow	1-6.7	Provide GP letters for all patients who have been seen and referred or where appropriate patients routed back to GP	Ben Teasdale	Meeting 28/10/15	3. Some delay - expected to be completed as planned	**Update 18/11:** Query to be raised at UCB for discussion re. effectiveness/practicalities
Notes Audit	UHL	Flow	1-6.8	Where possible, avoid streaming back into ED where pathways and other services can be achieved- e.g. diagnostics, hot clinic and assessment areas	Lee Walker	02/12/2105	4. On track	As I-6.3
Notes Audit	UHL	Flow	1-6.9	Avoid GP referrals going through ED unless for clinical need with direct access to consultant advice, hot clinics and Assessment Units	Lee Walker	02/12/2105	4. On track	As I-6.3
Notes Audit	UHL	Flow	1-6.10	Audit of GP referrals	Rachel Williams	13/10/2015	5. Complete	Audit complete. Initial generic information on two days worth of referrals presented to UCB on 30/10.
Emergency Care Actions	UHL	Flow	F-11	Add 4 beds to Ward 42 (Gastro)	Richard Mitchell	21/11/2015	2. Significant delay – unlikely to be completed as planned	**Update 18/11:** Limitations are moving equipment and access to nurse staffing. Discussions ongoing with Estates and Carole Ribbins
Emergency Care Actions	UHL	Flow	F-12	Decision on bed bureau pats going through Ed to be taken by AMU Consultant and SMOC	Richard Mitchell	18/11/2015	5. Complete	**Update on 18/11:** Agreed at EQSG. To be communicated to staff.
Emergency Care Actions	UHL	Flow	F-13	Determine capacity to increase beds at Glenfield by adding beds to bays	Julie Smith	27/11/2015	2. Significant delay – unlikely to be completed as planned	**Update on 18/11:** RCT of chairs in bed areas during late November at GGH.
Emergency Care Actions	UHL	Flow	F-14	Develop proposal to create cardio-respiratory capacity at Loughborough	Kate Shields	04/12/2015	1. Not yet commenced	
Emergency Care Actions	UHL	Flow	F-15	ED establishment and skill-mix review	Julie Smith	31/01/2016	4. On track	JS to meet with ED team on return from leave to review skill mix, numbers of staff and roles in place currently with a view to refreshing this if indicated.
Emergency Care Actions	UHL	Flow	F-16	Ensure that ambulance patients are routing to UCC where appropriate	Richard Mitchell	19/11/2015	4. On track	**Update 18/11:** RM to speak to EMAS re. appropriateness of diversion of patients to UCC
Emergency Care Actions	UHL	Flow	F-17	Get data on impact of new Streaming Service	Richard Mitchell	19/11/2015	5. Complete	Particularly rate of transfer to ED. To be reported to UCB
Emergency Care Actions	UHL	Flow	F-18	Implement pathway co-ordinators in ED	Sarah Smith	TBC	1. Not yet commenced	To complement Bed Bureau scheme to maximise use of alternatives to admission
Emergency Care Actions	UHL	Flow	F-20	Implement RCT of acute physicians reviewing ED admitting decisions	Andrew Furlong	04/12/2015	4. On track	
Emergency Care Actions	UHL	Flow	F-21	Implement transition area in TiA room (capacity 4)	Richard Mitchell	As soon as staffed	3. Some delay – expected to be completed as planned	
Emergency Care Actions	UHL	Flow	F-22	Include instances of Bed bureau flows going through ED on Capacity Report	Richard Mitchell	18/11/2015	7. Closed	Will be in place 19/11.

Emergency Care Actions	UHL	Flow	F-23	Increase ED Nursing establishment to 28 to maintain 5/6 assessment bays + 2/3 for transition area	Julie Smith	ASAP	3. Some delay – expected to be completed as planned	Long lines of work for Agency nursing staff increased to 5 RN LD and 5 RN ND, these posts are being filled, and are in place until 11th January 2016
Emergency Care Actions	UHL	Flow	F-25	Review potential for re-commissioning space on wards being used for non-clinical purposes	Darryn Kerr	04/12/2015	4. On track	**Update 18/11:** Review in progress
EQSG	UHL	Flow	F-26	Provide paeds with data analyst linking in with EY and Rachel Williams to support simulation modelling	Richard Mitchell	25/11/2015	5. Complete	
EQSG	UHL	Flow	F-27	Speak to estates re work on expanding into reception area	Richard Mitchell	25/11/2015	5. Complete	
EQSG	UHL	Flow	F-28	Look at ways in which CNSs can help support paeds	Richard Mitchell	02/12/2015	4. On track	
EQSG	UHL	Flow	F-29	Ensure gold command attend 0900 paediatric meeting	Richard Mitchell	25/11/2015	5. Complete	
EQSG	UHL	Flow	F-30	Speak to CCGs re earlier GP referrals each day	Richard Mitchell	02/12/2015	4. On track	
EQSG	UHL	Flow	F-31	Meet with Sam Jones	Richard Mitchell	25/11/2015	5. Complete	

Status	RAG
1. Not yet commenced	
2. Significant delay – unlikely to be completed as planned	Red
3. Some delay – expected to be completed as planned	Amber
4. On track	Green
5. Complete	Green
6. Complete and regular review	Blue
7. Closed	Grey

Organisation	Workstream	Action reference number	Link to 5 key improvement areas	Actions	KPI trajectory	Accountable lead to the UCB	Action lead within the organisation	Delivery date / Next Review	Delivery Status	Comments on delivery of the action, where closed what follow up actions are required	For EQSG this week?
	Base Wards	UHL-BW10		Review nursing staff cover and processes to provide safe and efficient care	Reduce number of patients with length of stay greater than 10 days		Maria McAuley	30/06/2015	5. Complete	Done through optimising D2A work, engagement events with nursing staff, and rolling roadshows on discharge	
UHL	Base Wards	UHL-BW4	Improve 7 day processes	Implement the 'home first' principle to reduce discharge delays	Reduce number of patients with length of stay greater than 10 days	Richard Mitchell	Julie Dixon	30/06/2015	5. Complete	Achieved through D2A work and conference calls. Further work contiuning and will also tie in with proposed frailty stream.	
UHL	Base Wards	UHL-BW5	Improve 7 day processes	Review internal processes (including discharge 2 assess) to reduce discharge delays due to internal processes	Reduce number of patients with length of stay greater than 10 days	Richard Mitchell	Julie Dixon	30/06/2015	5. Complete	Diagnostic completed. D2A process now being shortened. More opporunities for improvement can be identified.	
UHL	Base Wards	UHL-BW9		Review transport booking process to reduce discharge delays	Reduce number of patients with length of stay greater than 10 days Increase in the proportion of discharges between 8am and 12pm	Richard Mitchell	Julie Dixon	30/06/2015	5. Complete	Healthy reduction in time taken to process and book transport. Update on 07/07/15 - Training will continue in background to new staff to maintain online booking system	

Workstream	Action reference number	Link to 5 key improvement areas	Actions	KPI trajectory	Accountable lead to the UCB	Action lead within the organisation	Delivery date / Next Review	Delivery Status	Comments on delivery of the action, where closed what follow up actions are required	
Base Wards	UHL-BW8		Review bed bureau processes to reduce discharge-delays	Reduce Los by 10%	Richard Mitchell	Julie Dixon	~~30/05/2015~~ 30/06/2015	7. Closed	Pushback from community re: bed bureau processes. This is now sitting with community providers and there is a risk that this will not be achieved. **Update on 07/07/15:** This action is for closure. **Update on 08/07/15:** This action is now closed due to need for external partners to be involved and the limited impact on performance against the 4 hour standard.	
ED	UHL-ED12		Look at each stream within the ED separately to determine if their independent staffing patterns can cope with 85 percentile of activity (including number of staff, skill mix and rotas) to increase robustness of staffing cover	Patients with decision for onward care within 120 minutes 95% patients seen within 4 hours	Richard Mitchell	Ben Teasdale	30/06/2015	7. Closed	This action has been marked as complete given the funding limitations to put in place additional staff. There will be ongoing work using the Simulation Tool to establish if there are changes that can be made with Skill Mix.	
ED	UHL-ED13		Work with EMAS and UCC to improve patient information (signage / meet & greet). Improve time to pain relief.		Richard Mitchell	Rachel Williams	30/06/2015	7. Closed	**Update on 30/06/15:** Progress on this has been made. Need additional time to look into the Design Council Patient Information Leaflets & Boards that were designed by best practice Design Consultancy Pearson Lloyd **Update on 07/07/15:** Decision needed at EQSG regarding funding available for signs for new floor. Further query regarding interim signage/leaflets. Recommendation that following this decision this is closed and passed onto New Floor project group. **Update on 08/07/15:** To be taken off EQSG action plan. Costs to be provided by ops manager.	
WHR	UHL-WHR2	Out of hours variability in the ED	Complete "ED Road Tour" to improve links between specialties and ED and promote understanding of 'Exit Block'	95% patients seen within 4 hours Specialties responding to consult / bed requests within 30 minutes	Richard Mitchell	Julie Dixon	30/06/2015	7. Closed	Wrote to MSS Transformation Lead to understand best way of getting meetings with relevant clinicians/managers in Plastics/Orthopaedics/ENT/Max-Fax Looking to agree times with ITU **Update on 07/07/15:** Priority is for ED/CSS/ Medicine interface to be robust ahead of focussing on other specialties. This action will be reworded to reflect this and is a priority action for the next 12 weeks.	
GGH	UHL-GGH8		Develop SLA with CSI to optimise therapy cover in CDU to reduce discharge delays	CDU occupancy to remain below 40 at 95% of the time	Sam Leak	Jodie Billings	~~30/06/2015~~ 25/11/2015	7. Closed	Wider therapy recruitment issues to address. Extended physio support in interim. Note: From July, CDU occupancy metric changed to 40. **Update on 07/07/15:** Pending discussions between Sam Leak / Jodie Billings re: the new SLA **Update on 22/07/15:** This action is being redated as it is not a priority for the next 12 weeks. **Update on 27/08/15:** This action is closed as therapy cover is no longer identified as materially affecting CDU performance and flow.	
GGH	UHL-GGH2		Design a robust system to ensure that patients receive clinical assessment within 60 minutes	75% of patients to receive clinical assessment within 60 minutes	Catherine Free	Catherine Free	~~03/06/2015~~ 24/6/2015	7. Closed	Options to be presented at EQSG around optimal staffing based on modelling work. Kim meeting Tim Coates Thursday 18/6/15. Note: From July, metric changed from 95% to 75%. **Update on 07/07/15:** Update pending wider discussion regarding simulation tool **Update on 22/07/2015:** Due to delay of sign off for Simulation tool due to TDA funding work is progressing without waiting. Workforce planning meeting has been scheduled. An Acute/Respiratory post is going out to advert which will support this. **Update on 24/08/15:** The increase in staffing on CDU to deliver ambulatory care will improve the time to clinical assessment for patients across the unit. It is proposed that this action is placed on hold until the efficacy or otherwise of the new model has been trialled.	
GGH	UHL-GGH3		Design a robust system to deliver cardiology consultant review within 14 hours to 95% of patients	95% of patients to receive senior (consultant) review within 14 hours	Sam Leak	Jan Kovac	~~03/06/2015~~ 24/6/2015	7. Closed	CDU Medical Workforce Planning in progress **Update on 07/07/15:** Update pending wider discussion regarding simulation tool **Update on 22/07/2015**: Due to delay of sign off for Simulation tool due to TDA funding work is progressing without waiting. Workforce planning meeting has been scheduled. **Update on 24/08/15:** 1 additional cardiology post appointed to. The increase in cover on CDU and increase in number of clinical nurse specialists (cardiology) should improve the time to consultant review. It is proposed that this action is placed on hold until the efficacy or otherwise of the new model has been trialled.	
GGH	UHL-GGH4		Design a robust system to deliver respiratory consultant review within 14 hours to 95% of patients	95% of patients to receive senior (consultant) review within 14 hours	Jon Bennett	Kim Ryanna	~~03/06/2015~~ 24/6/2015	7. Closed	CDU Medical Workforce Planning in progress **Update on 07/07/15:** Update pending wider discussion regarding simulation tool **Update on 22/07/2015:** Due to delay of sign off for Simulation tool due to TDA funding work is progressing without waiting. Workforce planning meeting has been scheduled. **Update on 24/08/15**: The increase in staffing on CDU to deliver ambulatory care will improve the time to consultant review. It is proposed that this action is placed on hold until the efficacy or otherwise of the new model has been trialled.	
WHR	UHL-WHR10	Reduce time from bed request to bed allocation (Improve flow from the Emergency Department to the Acute Medical Unit)	Create rapid bed turnaround (cleaning) team to reduce time from bed request to bed allocation	Time from bed request to bed allocation within 30 minutes	Richard Mitchell	Julie Dixon	30/06/2015	7. Closed	**Update 09/06/15:** Unit Support Workers in post - 9 x band 1 until 31/10/15 Data being gathered on volume & nature of requests handled by this team; initial indication that they are filling a key gap in service provision not covered by Domestic, Porter or Nursing staff Low likelihood that this team could be equipped to handle steam clean but it is felt that they could still provide a vital cleaning service for low risk patients **Update 06/07/15**: Zoe Bliss is in the process of pulling together a business case to maintain this team. It will include costs, benefits, breakdown of activity **Update 28/07/15**: The Unit Support team business case still in draft stage. This team's remit is also being discussed with respect to them being able to support e.g. transfers for patients requiring oxygen. **Update on 25/08/15**: Waiting on decision as to whether this team will qualify for CMG funding over winter **Update on 18/09/15**: Forming part of ESM Draft Winter Plan. Lead Duty Manager developed	

WHR	UHL-WHR9		Look into improving efficiency during handover times	95% patients seen within 4 hours Specialties responding to consult / bed requests within 30 minutes	Richard Mitchell	Julie Dixon	30/06/2015	7. Closed	Initial step to review data on bed breaches by hour to identify if this is a significant issue **Update on 24/06/15:** To progress this action, a survey needs to be sent to the wards to understand their processes during the handover period. **Update on 07/07/15:** Email sent to priority areas (CAU,AMU, SAU, CDU) with survey **Update 28/07/15**: Feedback on handover/breaks processes received from CAU, CDU, AMU and ED. **Update on 29/07/15**: Next step is to review the findings and see if as a first step the handover times for ED and AMU can be better aligned. **Update on 25/08/15:** Discussion on handover & break times concluded that breaks were not an issue for further exploration. With regards to handovers, further analysis requested to look at	
WHR	UHL-WHR11	Out of hours variability in the ED	Introduce iPorter across the Trust to reduce portering delays	95% patients seen within 4 hours	Richard Mitchell	Julie Dixon	01/09/2015	7. Closed	**Update on 25/08/15**: It is recommended that this action be closed. The wards use a system similar to iPorter in the sense that they have a designated number to log portering requests. Further changes would be difficult given current negotiations with Interserve.	
ED	UHL-ED2	Reduce delays due to ambulance handover delays	Use insight gained from analysis of EMAS / ED Auditors data to further reduce handover delays between EMAS and ED. Data from the Mar audit found average (max) handover times of:EMAS - 22 (59). ED - 14 (49)	Ambulance Handover Hours Lost	Richard Mitchell	Rachel Williams	15/09/2015	7. Closed	**Update on 13/05/15**: Assessment Bay Action Plan presented at EQSG Assessment Bay auditors will begin monitoring compliance with the SOP from 25/05 **Update on 26/05/16**: Medical lead for Assessment Bay identified **Update on 25/08/15**: Report produced by Unipart which outlines suggested improvements to both EMAS & UHL ways of working. The ED are agreeing who best to take forward this work **Update on 14/09/15**: Awaiting outcome of Unipart's bid to undertake further diagnostics work. Assessment Bay action plan reviewed and is in line with Unipart initial findings. Need to agree with EMAS if they could share data on calls received to give the ED earlier oversight of likely activity. **Update on 02/10/15:** Updates made to the Assessment Bay action plan and this will be picked up by during the next phase	
WHR	UHL-WHR5	Out of hours variability in the ED/Reduce time from bed request to bed allocation (Improve flow from the Emergency Department to the Acute Medical Unit)	Work with specialties to update their whole hospital response and design role cards to improve confidence / consistency in performing escalation protocols	95% patients seen within 4 hours	Richard Mitchell	Julie Dixon	~~31/07/2015~~ 30/11/2015	7. Closed	Following WHR training, each CMG has been asked to review their section in the WHR document. **Update on 07/07/15**: Priority is for ED/CSS/ Medicine interface to be robust ahead of focussing on other specialties. This action will be delayed until post September following work between Medicine/CSS/ED **Update on 18/09/15**: Work agreed with senior duty manager to design prompts for each area to be used at Gold / Bronze. Introducing new terminology in terms of level of escalation (business as usual, local response, Trust support, external support).	
WHR	UHL-WHR1		Work with key specialties to improve the referral process when ED is an appropriate route and reduce numbers of patients which are inappropriately sent via ED	95% patients seen within 4 hours Specialties responding to consult / bed requests within 30 minutes	Richard Mitchell	Julie Dixon	~~01/08/2015~~ 30/11/2015	7. Closed	Wrote to MSS Transformation Lead to understand best way of getting meetings with relevant clinicians/managers in Plastics/Orthopaedics/ENT/Max-Fax Looking at Bed Bureau process to evaluate best way of managing diverts to ED **Update on 07/07/15**: Priority is for ED/CSS/ Medicine interface to be robust ahead of focussing on other specialties. This action will be delayed until post September following work between Medicine/CSS/ED. **Update on 18/10/15:** This is still not considered a priority.	

Workstream	(All)
Action reference number	(All)
Delivery date / Next Review	(All)

Row Labels	Count of Actions
1. Not yet commenced	1
2. Significant delay – unlikely to be completed as planned	8
3. Some delay – expected to be completed as planned	1
4. On track	8
5. Complete	3
6. Complete and regular review	4
7. Closed	6
Grand Total	31

ACTION	LEAD	BY WHEN	Comments/Update
Increase ED Nursing establishment to 28 to maintain 5/6 assessment bays + 2/3 for transition area	Julie Smith	ASAP	
Implement transition area in TiA room (capacity 4)	Richard Mitchell	As soon as staffed	
ED establishment and skill-mix review	Julie Smith	31/01/2016	
Implement RCT of Accelerated Flow protocol	Richard Mitchell/ Anı	w/c 23/11/15	Requires UCB approval and copy to CQC
Include instances of Bed bureau flows going through ED on Capacity Report	Richard Mitchell	18/11/2015	
Decision on bed bureau pats going through Ed to be taken by AMU Consultant and SMOC	Richard Mitchell	18/11/2015	
Get data on impact of new Streaming Service	Richard Mitchell	19/11/2015	Particularly rate of transfer to ED. To be reported to UCB
Implement pathway co-ordinators in ED	Sarah Smith	TBC	To complement Bed Bureau scheme to maximise use of alternatives to admission
Ensure that ambulance patients are routing to UCC where appropriate	Richard Mitchell	19/11/2015	
Implement RCT of acute physicians reviewing ED admitting decisions	Andrew Furlong	04/12/2015	
Develop proposal to create cardio-respiratory capacity at Loughborough	KS	04/12/2015	
Determine capacity to increase beds at Glenfield by adding beds to bays	Julie Smith	27/11/2015	
Add 4 beds to Ward 42 (Gastro)	Richard Mitchell	21/11/2015	
Review potential for re-commissioning space on wards being used for non-clinical purposes	DK	04/12/2015	
Maximise use of expanded ICS capacity	KS/RM	27/11/2015	

Leicester, Leicestershire and Rutland Value Proposition

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Preface

Whether it's a walk-in centre, A&E, NHS111, pharmacist or an out of hours GP, there are so many options it's no surprise that many of our patients are confused.

The people of Leicester, Leicestershire and Rutland our patients have a wide range of urgent and emergency care needs, from heart attack to severe tooth ache. Every day more than 650 patients access the A&E and other emergency services at the Leicester Royal Infirmary, making the emergency department one of busiest in the NHS.

Our population is diverse across the city and counties with many different communities and requirements for health and social care.
Over recent years we've set up some great new services to respond to these needs, many of which have been funded through our Better Care Fund.

Our acute visiting service gives our GPs the option to send an emergency care practitioner immediately to a patient who requires an urgent home visit. And we now have a crisis response team which brings together adult social care, community nursing and therapy, and mental health services for older people in crisis so we can help keep them in their own home.

Our older persons' unit offers immediate geriatric assessment as an outpatient, while our falls service works with the ambulance and social care services, helping vulnerable older people to avoid hospital admission by attending sessions which improve their balance and address the cause of falls.

We're also offering GP support to residents in care homes to treat their most vulnerable residents, along with many other new services.
But it has become increasingly evident that many of the services we have in place to support these communities are operating in isolation, not as an integrated network. Patients struggle to access care because, as we hear from our local Healthwatch as well as our own engagement work, they find the service fragmented and often aren't aware of the options available to them, or how to choose between them.

Paramedics from our ambulance service and NHS 111 call handlers tell me that they also struggle with the best ways to refer a patient because not all services are available in all areas, and those that are can vary greatly in opening times and consistency. We need to address this as a system.

Our vision as a vanguard is to simplify things for patients, and get them the care that they need, without having to worry about having to navigate a complex and sometimes disjointed system and we would like to achieve this by supporting our workforce and building the infrastructure that allows them to deliver the best care.

This model will bring together all our providers of health and social care to work as one network.

People in crisis don't differentiate between clinical and social care, acute or primary care, and we don't believe they should have to. The care they receive should be seamless and we want to provide a 24/7 clinical care advice hub – a new 'virtual front door' for all urgent health services where patients can access health and social care.

Another vital part of providing seamless care is ensuring parity of esteem for mental health is a priority. Our goal is that, wherever a patient accesses urgent services, we will have the facilities and staff in place who can treat any mental health issues with the same priority as physical ones.

So, for example, if a patient comes to our emergency department having taken an overdose, we won't just treat their physical symptoms, but have a psychiatry team on hand to help support and treat their mental health, and refer them to the correct services.
One of the reasons that we were selected as a vanguard was the momentum that we have already gained in improving our urgent and emergency care services. Delayed transfers of care were one of our biggest issues last winter, and the work that we have done around the way patients are discharged from hospital means we are now among the lowest in the country.

We didn't put ourselves forward to be a vanguard because we think we've got it all right already though. There are many challenges facing us, as there are nationally, and we applied because we know how important it is to keep our momentum going as we continue to try to make improvements.

Being a vanguard means we have the opportunity to further improve our services and the system, to draw on expertise from across the NHS as well as share our own experiences as we go along but most of all our vision is to keep improving, simplifying and getting things right for the people of Leicester Leicestershire and Rutland.

Executive Summary

The vision for LLR is of an urgent and emergency care system which is organised to deliver person-centred care that wraps around the individual; promoting self-care and independence, enhanced recovery and enablement, and reducing harm through integrated services that exploit innovation and promote care in the right setting at the right time.

It is a vision founded on the consistent provision of care across linked settings, each with defined outcomes and the ability to respond to the physical and mental health needs of our diverse population in a way that blurs organisational boundaries. It is a vision which recognises the need to work together and ensure local consistency, whilst interacting with neighbouring healthcare economies to realise benefits at scale.

A comprehensive whole system improvement plan has been developed along with the five-year Better Care Together (BCT) strategy will go out to public consultation in early 2016.

18 months ago we were identified as a 'challenged' health system with major financial and operational issues including unacceptably low performance against A&E targets. It is recognised that the system still has poor performance and real risk to patients emerging specifically from ambulance handover delays.

The Vanguard seeks to build system improvement, progress and momentum to develop an integrated Urgent and Emergency Care service across the system, containing mental health parity of care and 7 day services as key planks for the delivery of the vision.
Urgent Care is one of eight clinical workstreams in the local BCT programme; a transformation agenda which sets out a vision to improve health and social care services across LLR.

The Vanguard Value proposition is submitted by the Leicester, Leicestershire & Rutland (LLR) System Resilience Group (SRG). The SRG serves a large mixed urban and rural area with a population of 1.1 million people including the City of Leicester and surrounding towns and rural areas. The main acute hospital serving our urgent and emergency care system is the University of Leicester Hospitals NHS Trust (UHL) which runs the largest single site A&E department outside of London.

Our plans are owned by the LLR SRG and the following Urgent Care Board (UCB) partners and have the support of our senior clinicians (doctors, nurses and therapists) and managers:

- The three LLR CCGs (Leicester City,
- University Hospitals of Leicester NHS Trust

East Leicestershire & Rutland, and West Leicestershire)

- The three upper tier local authorities (Leicester City, Leicestershire County, and Rutland County)
- Arriva (patient transport service)
- East Midlands Ambulance Service (EMAS)
- Leicestershire Partnership NHS Trust
- CNCS (GP out of hours/Loughborough UCC)
- DHU (NHS 111)
- SSAFA (acute visiting services)

The Vanguard Programme has patient and public backing from the three LLR Healthwatch's who attend our UCB, as well as Lakeside (existing MSCP Vanguard site), IBM and our local GP provider groups (including Federations/hubs and Prime Ministers Challenge Fund site) who will all be involved in delivering specific schemes.

Despite facing significant challenges in meeting key national performance standards the local health economy has a good track record of partnership working together in an effective Urgent Care Board (UCB). The system has received support from the Emergency Care Intensive Support Team (ECIST) who identified key processes that need to be improved to deliver an effective emergency pathway. Further work undertaken by Dr. Ian Sturgess has provided wide ranging recommendations across the urgent and emergency care pathway following a 3 month review, and we have taken learning from this review into the UCB improvement plan.

Introduction

National Drivers

The national Keogh review of Urgent and Emergency care (Nov 2013) summarised the key issues with current systems[1]:
It is confusing system for patients and health and social care professionals: Fragmentation of the system and inconsistent service provision means patients do not how to access alternatives to A&E.

[1] High quality care for all, now and for future generations: Transforming urgent and emergency care services in England - Urgent and Emergency Care Review End of Phase 1 Report

There are missed opportunities for meeting people's urgent and emergency care needs closer to home: patients can be cared for closer to home outside of hospital if innovative technology & virtual ward care models are adopted.
There is a high level of variability between A&E departments and urgent and emergency services.

Nationally and locally, the number of people using the emergency care system has contributed to the challenge of achieving the national 4-hour A&E standard. This is an indicator that is critical to the success of flow within the hospital and which nationally trusts are struggling to achieve and maintain. This increase in demand is also linked to the fact that the urgent and emergency care system is complex and fragmented and patients cannot easily understand where they can access urgent and emergency care. The system needs to ensure suitable alternatives are in place that are as readily accessed and easily understood by the public to positively impact this position.

Local Drivers

LLRs urgent and emergency care system also experiences the above issues which it must tackle in order to deliver safe, effective and high quality emergency care. To tackle these issues a review of the local urgent and emergency care services was undertaken. This was led by Dr. Ian Sturgess, an internationally renowned expert in the area of emergency care improvement. The report found that the local system has the potential to be "high-performing" but is "relatively fragmented with barriers to effective integrated working". Moreover, he found there was an over reliance on Leicester's Emergency Department which highlights the "lack of resilience in the rest of the health and social system and how it responds to urgent care needs in the community" (November 2014).

The review also found that the current system is complex and different depending on where people live in LLR. This creates difficulties for providers to achieve consistent connections to community services. It also demonstrated that the system is unable to consistently identify and support patients at risk of hospital admission i.e. those patients who are older with one of more long-term health conditions. This results in patients often being admitted to hospital in an emergency as their worsening condition was not able to be predicted and could not be managed effectively within the community. This was reflected in the increasing trend in attendances and admissions in 2014/15 against plan.

Services cannot continue to be delivered in the same way and hospitals cannot be expected to cope with rising demand and sicker patients; LLR must change to meet the needs of the changing ageing population and address the £398m funding gap predicted locally by 2018/19. The LLR health and social care economy is working to address these challenges to ensure that high quality, effective and efficient emergency and urgent care services are in place.

The system has experienced variable performance in the past and can be described as challenged financially, but over the past 18 months and following last year's difficult winter, relationships have improved and a good team approach is developing. A lot of work has been done on DTOCs and support from Ian Sturgess has supported improvement work within UEC, with a focus now on attendances and working with EMAS.

Local Urgent and Emergency Care Landscape

CCG's	East Leicester and Rutland CCG- population c323,000 West Leicestershire CCG – population c.376,000 Leicester City CCG- population c384,000	There has been a reshuffling of lead responsibilities amongst the 3 CCGs which will enable a focused lead on the development of the vanguard
Acute Hospital	University Hospital Leicester (UHL)	Services are provided from 3 sites: Leicester Royal Infirmary (LRI), where the main A&E department is based, Glenfield and Leicester General Hospital (LGH)
Community Services	Leicestershire Partnership Trust	
Mental Health Services	Leicestershire Partnership Trust	With hospital sites at LRI and Glenfield
NHS 111	Derbyshire Health United Ltd (DHU)	
Ambulance Service	East Midlands Ambulance Services (EMAS)	
Urgent Primary Care Services	Loughborough UCC – Central Nottinghamshire Clinical Services (CNCS), Leicester UCC – UHL & Lakeside, UCC's at Rutland, Market Harborough, Melton Mowbray and Oadby are run by Northern Doctors. Merlyn Vaz walk in service – SSFA and there are 4 GP hubs in Leicester City developed through Prime Ministers Challenge Fund	
Social Care	Leicester City Council Leicestershire County Council Rutland County Council	

Current performance

The health economy is experiencing high demand for urgent and emergency care and system pressures are highlighted and monitored by the following key metrics (current performance slides are in appendix 5):

- A&E attendances (84,555 Apr 15 to date) and waiting times (86.65% against target)
- Emergency admissions (47,906 Apr 15 to date).
- Ambulance handovers (365 hrs lost year to date).
- Ambulance conveyances (47%)
- Delayed transfers of care (Nov 2015; 38).

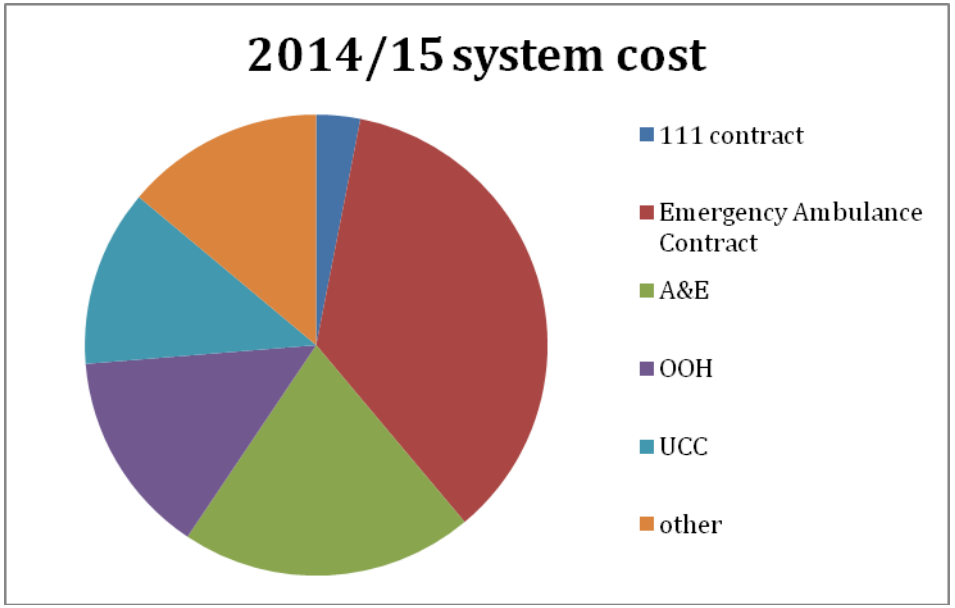
Baseline Costs 2014/15

In the baseline year 2014/15 the urgent and emergency care system cost £71million. 21% of this activity was based within UHL activity and 36% was ambulance based activity.

Background & Journey to date

18 months ago we were identified as a 'challenged' health system with major financial and operational issues including unacceptably low performance against A&E. Since then we have come together around our Better Care Together and UEC Plan. Our achievements are measurable across three levels:

- **Designing and implementing innovative models of care to start our transformational change**:
    - New Older Peoples Unit providing geriatric assessment at Loughborough Community Hospital
    - New mental health Crisis House
    - Crisis response services providing mobile out of hospital emergency care
    - New 7 day Urgent Care service directly bookable across four sites
    - Enhanced community health Single Point of Access answering calls in 30 seconds
    - Specialist support to nursing homes.
- **Delivering quantifiable improvements in quality and patient responsiveness:**
    a. A&E performance improving to 92% (av. YTD) from av. 89% in 2014/15



b. UHL DTOC rate reduced from 5.5% to 1.5%
c. Highest non-conveyance rate across the EMAS; YTD for 15/16 is LLR 48% against EMAS total of 44%

- **Building strong system-level leadership for improvement across organisations**:
  a. A whole system 5 year plan in Better Care Together signed up to by all partners and recognised by NHSE and NTDA as a major progress
  b. Strong clinical leadership and engagement across BCT & UCB programmes
  c. New provider models including all GP practices in at scale federations/hubs
  d. New large Alliance Contracts (planned care) involving UHL/LPT/GP providers & CCGs
  e. 15/16 contracting round completed without external arbitration.

Problem statement:

- There are major challenges in capacity and resources available within the Urgent and Emergency Care system
- UHL has a forecast deficit this year of £36.1m
- Demand for services is high and rising, UHL A&E has seen a 2.62% increase, UCCs a 5.52% increase, total 3.58% rise of the system as a compared to 2014/15
- Providers arenot t incentivised to work together in a networked way within current commissioner/provider system
- 24/7 access to appropriate urgent and emergency interventions is expected by patients
- LRI estate site constraints and fragmented services on the LRI site hindering patient flow
- Current poor system performance and real risk to patients emerging from ambulance handover delays at LRI
- The current system is in distress and is too complex for patients to effectively navigate, is inefficient and contains duplication. A&E is perceived as the 'default option', for when the system is too complex or appointments are not easily accessed. The system as a whole needs to evolve to meet demand.

- Lack of consistency across different urgent care services and across geographies
- Geographical layout of LLR and physical location of a city centre Emergency Department/county town UCCs
- Lack of capacity in the right place to meet demand at the right time
- Lack of staffing to meet demand
- Ineffective integration of services
- Physical space limitations within LRI
- Demand Management based on service utilisation
- Sustainable use of available resources
- Delivering affordable, appropriate care that delivers value

Patient Challenges

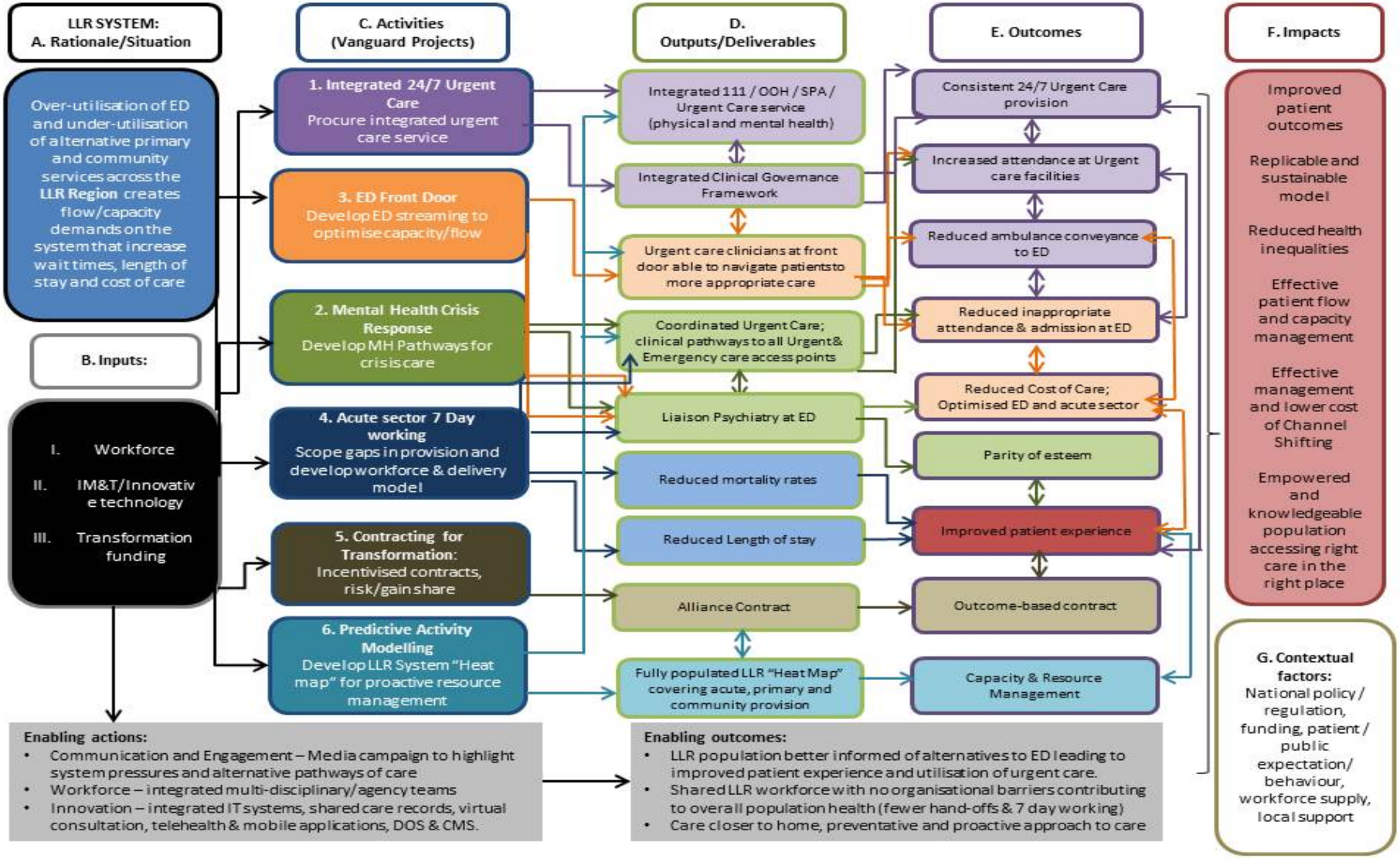
- Patients accessing the right services at the right time, caused by;
  - Urgent care services which are are complex to navigate
  - Patients knowing which services to go to
  - Demand and flow unmanaged causing 'log jams' within services
- A need to increase self-care
- Rising demand within the population linked to demographic growth in elderly population and young children

Strategic Aims of the Vanguard

Aim	Description	Objective
Reduced duplication and fragmentation of services, simplification of patient pathways	Development of services and pathways that minimise patient handoffs, that are readily understood and accessed by patients and enable efficiencies within the system through integration	• Improved patient outcomes and experience • Patient receives the right care in the right place at the right time • Decreased costs to the health economy • Improved system resilience
Aligning providers to work towards common system goals	Service offers that blur organisational boundaries and enable patient care to be wrapped around the patient not constrained by organisations	• Improved patient outcomes and experience • Patient receives the right care in the right place at the right time • Decreased costs to the health economy • Improved system resilience • Integrated clinical governance

		• Integrated workforce plans
System Management	Understanding patient flow, resources and capacity in a real time way will enable the system to flex and respond, providing resources and moving capacity to ensure that the right care is available in the right place	• Improved patient outcomes and experience • Patient receives the right care in the right place at the right time • Decreased costs to the health economy • Improved system resilience

Macro Logic Model



What will the Vanguard Achieve

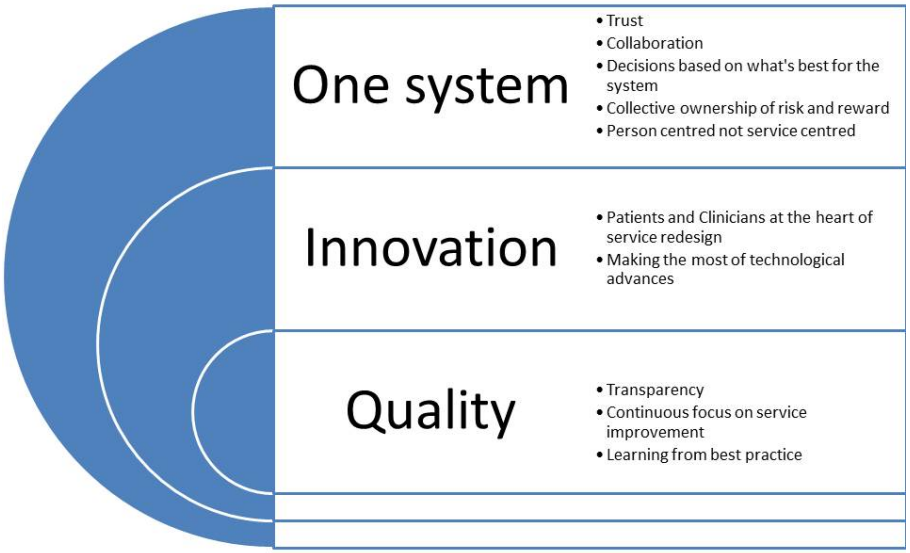
Strand 1	
By April 2016 we will have…	By April 2017 we will have…
• **Increased % disposition to alternative services by EMAS Clinical Assessment Team** • **Re-specified the NHS111 service in line with developing integrated urgent care model** • **Initiated re-procurement with regional partners** • **Invested £1m+ of secured NHSE capital in new telephony capability** • **Have scoped an integrated community health service and adult social care SPA that supports wider integrated model** • **Piloted primary care 7 day working and virtual consultation models with Federations/hubs** • **'tiered' specification for consistent Urgent Care Centre model** • **Standardised & accessible care plans** • **Implemented new urgent care payment models**	• Re-procured fully integrated NHS111 • Implemented 1st stage of SPA integrated with community navigation hubs • Connected triage services with real time activity information to inform resource deployment and hard scheduling of referrals • Re-procured fully integrated OOH 'plus' model • Established care plan sharing platform
Strand 2	
• **Developed and embedded the streaming service at LRI** • **Improved ambulance handover times** • **Increased patient numbers attending ACS and hot clinics** • **Reduced ED wait and have a more consistent achievement of the 4 hour target** • **Reduced ED attendances**	• Have a re-developed UCC model operating and embedded • Have a new developed and embedded Single front door process • Changed behaviour for our frequent attenders • Reduced inappropriate attendances at ED • Improved hospital flow • Have a system wide IM&T solution leading to reduced duplication and improved patient outcomes
Strand 3	
• **Have a developed model and algorithm for community mental health triage covering**	• Achieved parity of care for community triage of patients with mental health within 111, police and ambulance services

o **111** o **Ambulance** o **Police** • **Have a developed model for the increased access to crisis support and home treatment for children and young people** • **Have an upgraded Place of Safety Assessment Unit (PSAU) that is fit for purpose for all age groups** • **Have commenced the phased implementation of the Core 24 service model for Liaison Psychiatry**	• Have equitable access for Adults, children and young people to crisis support • Achievement of clinical standard 7 for access to Psychiatric Liaison • Reduced A&E attendances for Mental Health patients
Strand 4	
• **Have an analysis of current state of services against the clinical standards** • **Have identified current gaps against standards** • **Have completed analysis of the variation in services across 7 days** • **Developed options appraisals and business cases on actions to achieve the clinical standards**	• Delivered implementation plans and achieved 7 days services across clinical standards 2,5,6 and 8 • Established a dashboard to measure the standards and variation across 7 days • Have an established audit process to review achievement of standards
Strand 5	
• **Have developed a new 3 part payment model and contract for the University Hospital Leicester** • **The new 3 part contract with UHL is live** • **Have developed a contract for the integrated community urgent care service**	• Have further developed the UHL contract from the lessons learned • Have the new 3 part contract live for the integrated community urgent care service
Strand 6	
• **Have an initial temporary heat map of the urgent and emergency care system operational** • **Have developed initial system triggers based on the heat map** • **Have started the scoping and development of the system design for the permanent heat map for the system**	• Have a live system heat map for the urgent and emergency care system • Flow is dynamically managed using the heat map and triggers to ensure resources and capacity are where they are needed within the system • The use of the heat map has seen a consistent achievement of the 4 hour target and reduced ambulance wait • There has been a reduction in A&E attendance through patient

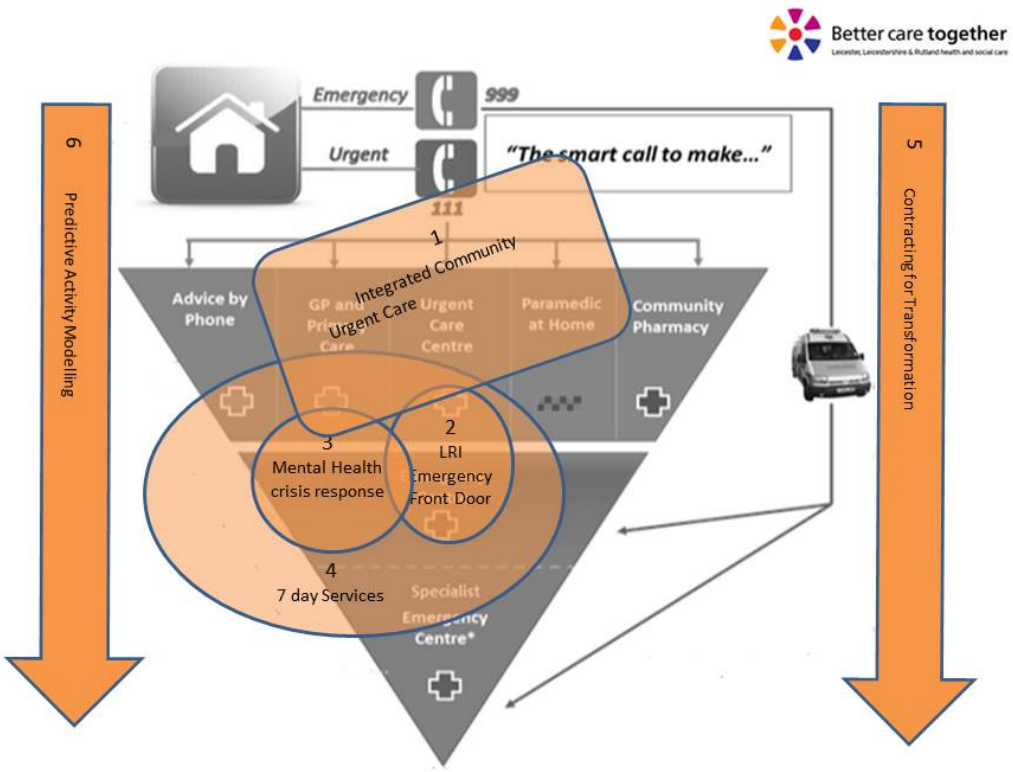
	information and access to wait times at throughout the urgent and emergency care system • A dynamic system wide simulation model has been developed to inform commissioning and enable the testing of new practices and approaches.

Programme Values

The Vanguard Partnership will develop and commit to adopt a set of principles and values to achieve these aims and to work together on a 'Best for Programme' basis in order to achieve the Vanguard objectives. Figure 4 shows our draft key values, which underpin the way that the Vanguard operates, are:



***Draft values for the Vanguard Programme are based on the existing Alliance Values**



New Care Model

The future model will ensure that system improvements tackle the issues patients are currently facing. It will provide patients with equitable and prompt access to services wherever they are in LLR and whichever 'tier' of care setting they enter the system at. It will ensure that local variation will not disadvantage patients or complicate the system aim for patients to be able to Choose Well. Patients will be signposted to the most appropriate service through a locally focused and responsive single point of access which incorporates clinical triage. Patients will be supported at every stage.
Our vision is of an integrated urgent and emergency care system which is organised to deliver person-centred care that wraps around the individual; blurring organisational boundaries, promoting self-care and independence; enhancing recovery and reablement, delivering parity of care, 7 day services and; reducing harm through integrated services that exploit innovation and promote care in the right setting at the right time. (Figure 3 shows the logic model used to develop our thinking)

Vanguard Strands

In order to achieve these aims the Programme will be managed via 6 key strands:

- **Integrated Community Urgent Care**

This project will see the integration across EMAS, NHS111, OOH and the local Single Point of Access (SPA) services for health and social care. In addition to this we will create and link a same day response team comprising general practice, home based acute visiting and crisis response services, community nursing services, Older Peoples Unit and urgent care centres to provide an extended delivery service. This will all be underpinned by care planning and record sharing.

- **LRI Front Door**

We will redesign the access to urgent and emergency care at the LRI site to provide an enhanced senior clinical assessment team with direct referral access to ambulatory clinics, UHL assessment beds and the ability to refer patients to the UCC, ED or back into primary/ community services. The project scope covers the streaming service, UCC and 'single front door'. In early 2016 the new ED floor layout opens at LRI. The work carried out by this project is essential in ensuring that the use of the reconfigured estate, clinical resources and pathways has the best possible outcomes for patients, the A&E service and the wider system.

- **Mental Health**

We will develop our mental health services to better meet the demands of patients and enable parity of care. This will be delivered through investment in Psychiatric Liaison within the acute trust, mental health workers embedded within the police and paramedic services and improved access and referral processes to crisis support.

- **7 day service**

We will deliver standards 2,5,6,7 and 8 of the Clinical standards for Urgent and Emergency Care and Supporting Diagnostics. In addition we will seek to deliver standard 9, enabling support services, both in the hospital and primary, community and mental health settings so the next steps of a patients care pathway can be taken.

- **Contracting for Transformation**

Using our experience of Alliance contracting we will develop a new urgent and emergency care alliance based model that incentivises providers to work as a network. This will be underpinned with new measures of clinical quality and patient experience increasingly focussing the whole system on a clinical outcome focus and the implementation of the new payment model.

- **Predictive modelling**

We will work to develop a demand and activity model with a view to informing operational resource/capacity levels. We will use real time data to inform our navigation services (1 above) and to provide direct information to the public about service pressure and waiting times to enable informed choices.
Vanguard Strand Logic Models

Our approach to change

The implementation of the vanguard model will be based on taking a system based approach to change, aiming to develop teamwork across the Urgent and Emergency Care system. The Vanguard team will be led by key members of partner organisations, with clinical leadership a central force within the programme.

Service models and pathways will not be developed in isolation but will be shaped by a network of clinicians and front line staff from partner organisations and explored with patient groups, using feedback to further develop pathways.. This is central to our approach and will ensure a holistic view of the service and pathway changes and allow us to explore any unintended consequences. These groups will be empowered to own the transformation, bring innovation and personal experience to further the integration of services and aims of the Vanguard programme. We will use improvement methodologies and rapid cycles of change to test and refine new ways of working before spreading service change. Our approach will be based on the NHS change model.

With confirmed service models, detailed system modelling can be completed and workforce plans developed in order to progress the mobilisation of these changes. The workforce plans that we will develop will cover both the PMO requirement to manage the change and the clinical workforce considerations for delivery of services.

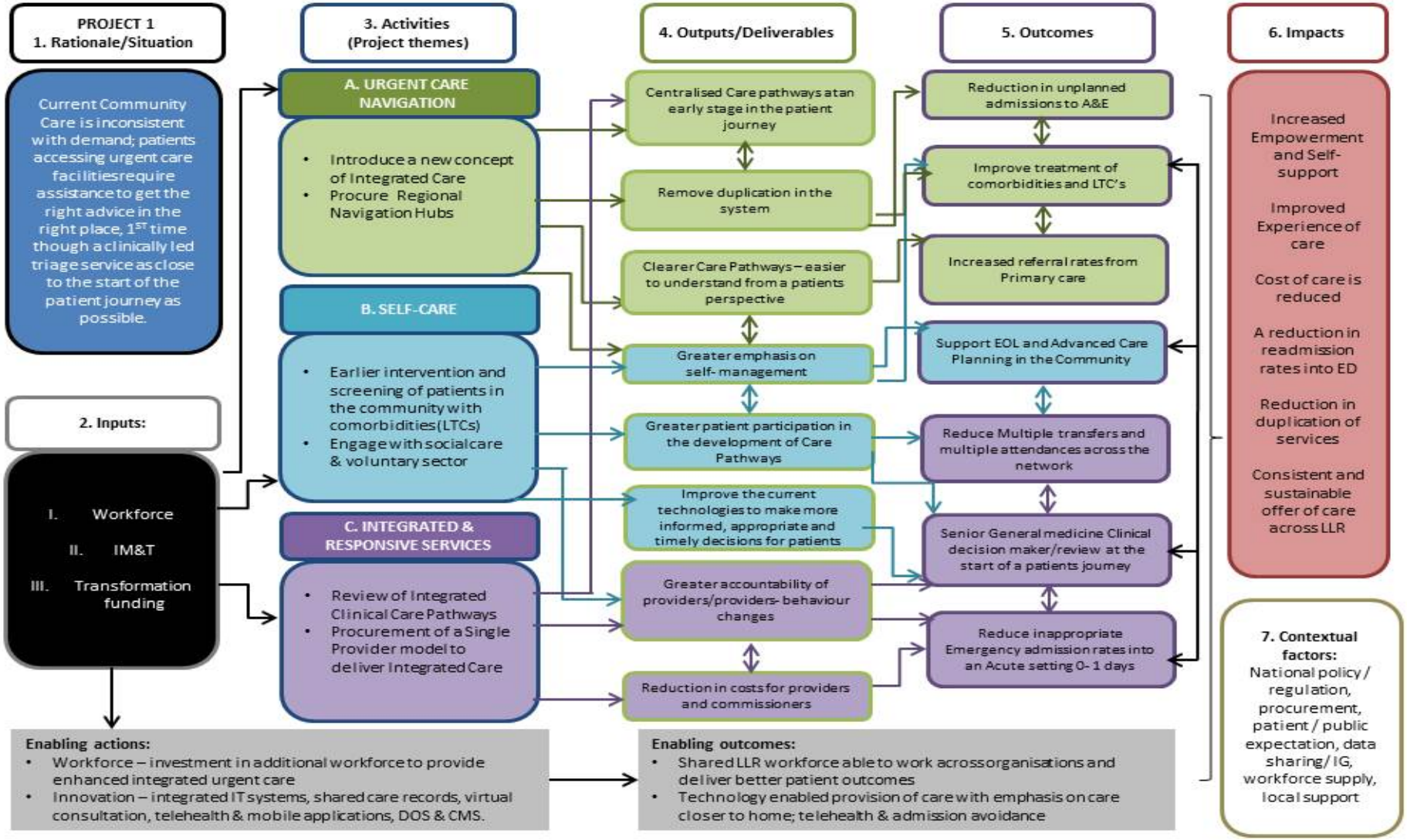
Key Programme Metrics

In order to measure the success of the Vanguard, we will develop a set of key metrics aligned to the logic models and strategic objectives of the programme. The measures will be both at a project and programme level to understand what is working well and what areas need additional support. A full set of these metrics has not yet been establish but initial thinking has identified 5 key metrics that we will be exploring further to measure the programmes success at a macro level:

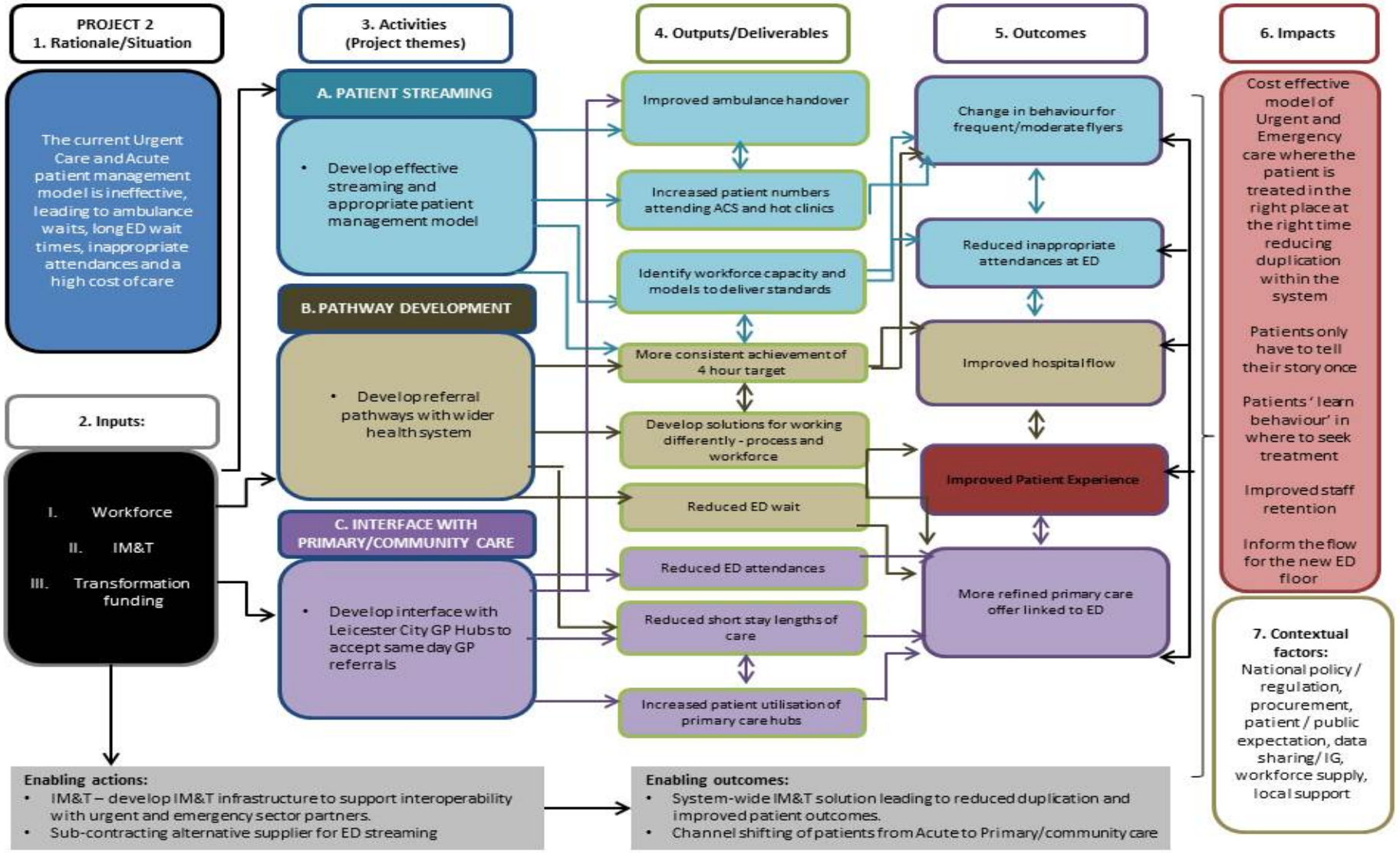
- Reduced A&E attendance
- Reduced hospitalisation rate across the population (stratified by age group)
- Reduced re-attendances (including A&E and UCC)
- Reduced re-admissions
- Reduced hand-offs and inter-provider referals

Further work is required in the development of a complimentary set of staffing and patient level metrics.

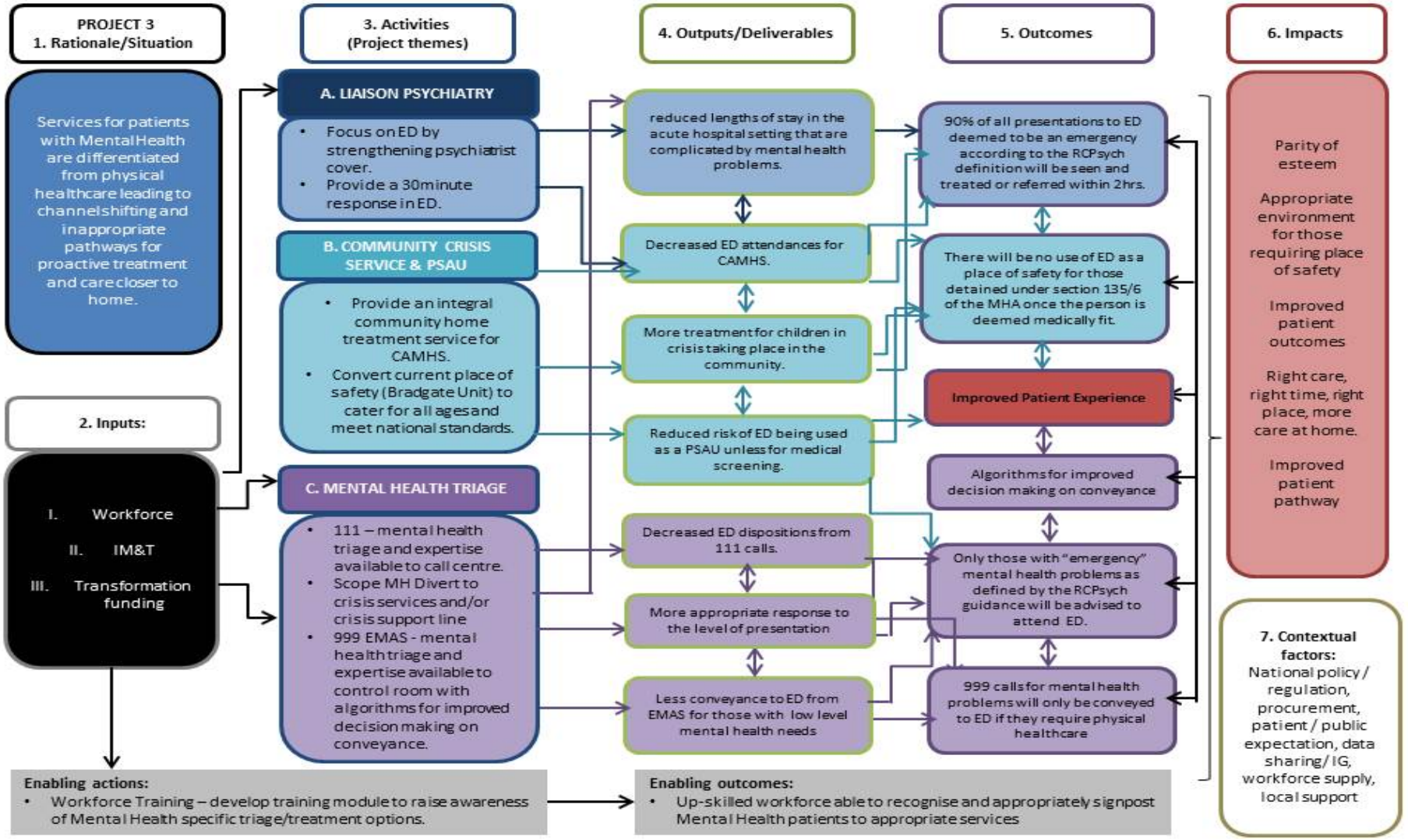
Strand 1 Integrated Community Urgent Care



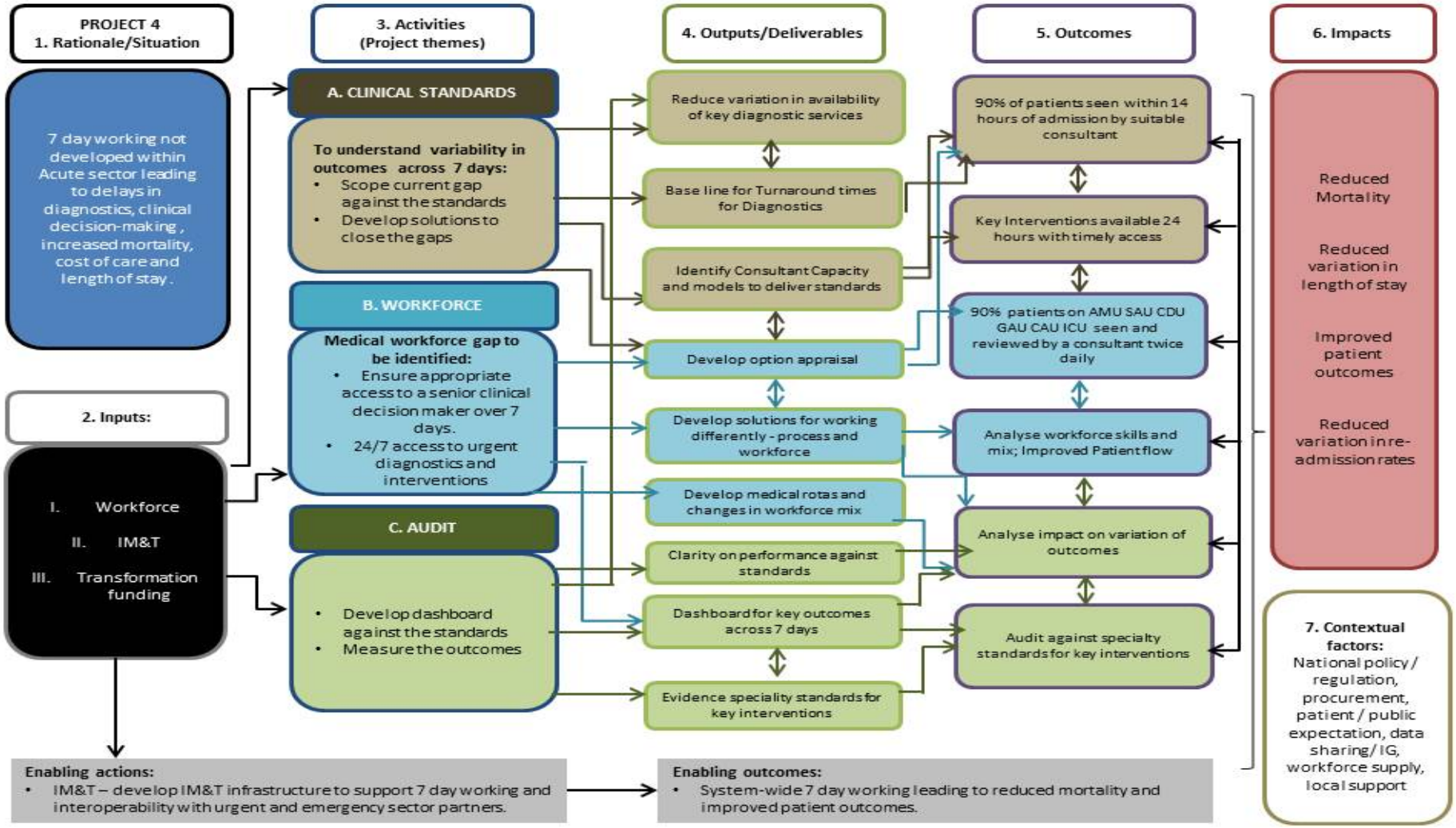
Strand 2 LRI Front Door



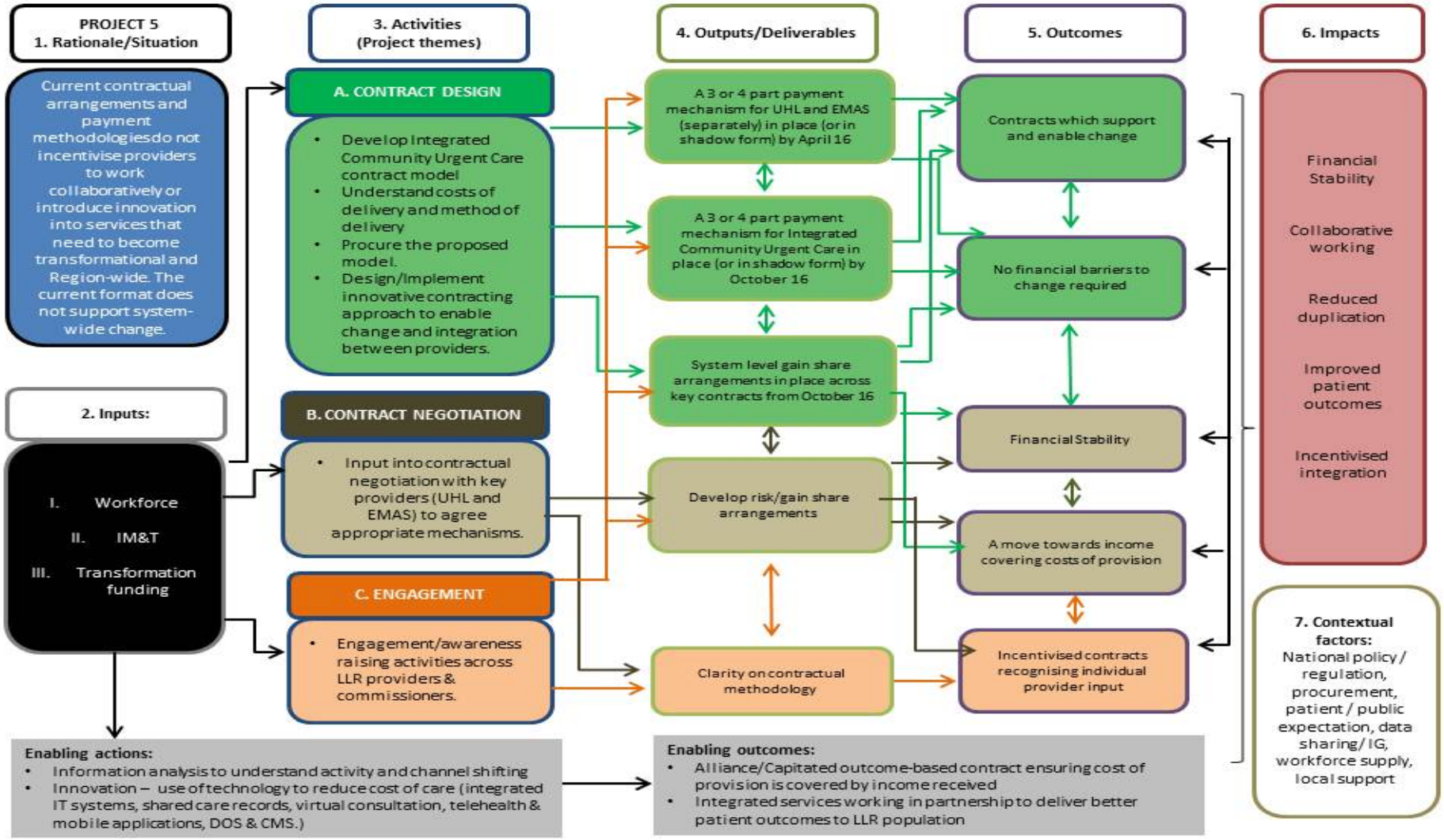
Strand 3 Mental Health



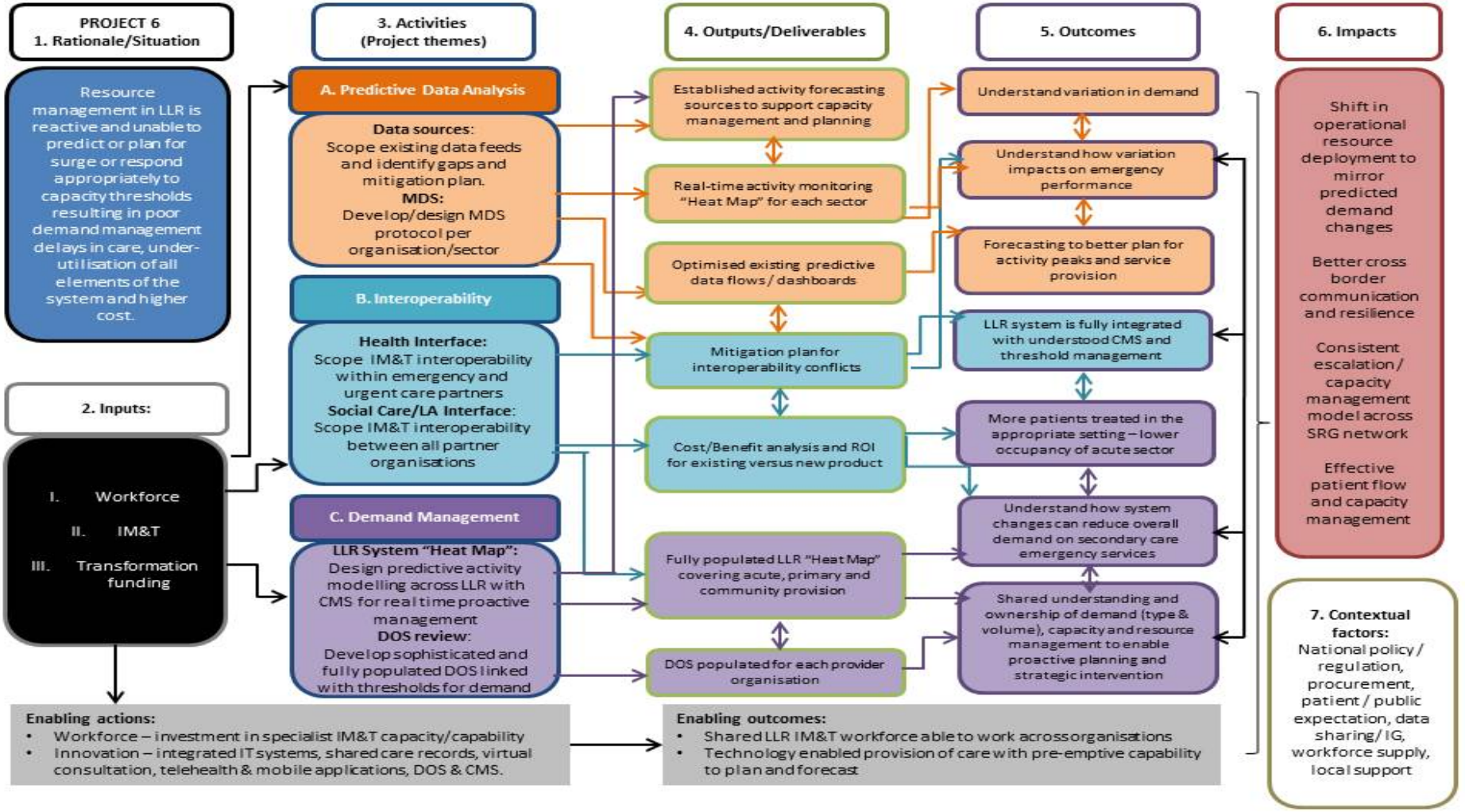
Strand 4 7 day services



Strand 5 Contracting for transformation



Strand 6 Predictive Modelling



Value Proposition

The Leicester, Leicestershire and Rutland CCG's currently spend approximately 8% of its funding on non-admitted emergency and urgent care related services over and above those associated with core GMS contracts. The services involved in the system are varied both in terms of current provider, payment terms, point of access and maturity.

Over the coming years without radical change to the whole system these costs will grow in terms of general inflation, workforce shortages and to accommodate increasing activity resulting from a growing, older and more demanding general population.

Over the coming five years the aim of the Leicester, Leicestershire & Rutland System Resilience vanguard is to change the system in ways that alter where and how that money is invested to help the system remove duplication, reduce costs, shift activity channels and reduce admissions. This transformation is laid out in the programme logic model and supported by the project models that underpin it.

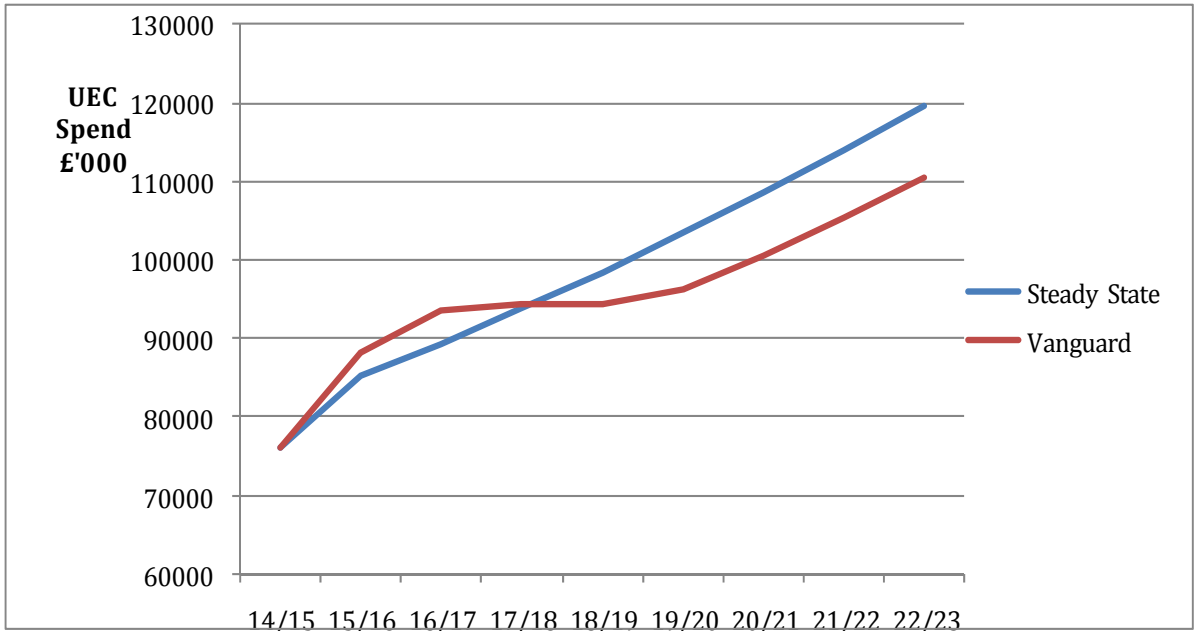
These changes are not going to be achieved easily or quickly. However it is essential to move towards this goal at every opportunity and bring the system together.

In the short and medium term additional funding will be required for robust transformation programmes, this will be utilised in a way that encourages the whole system to work together to reduce overall costs while meeting the needs of the population. By working with the system to reward the behaviour we need, through potential gain sharing, new commissioning methodologies and forced system congruence we stand a chance of success. Without it we will only be able to make small incremental changes to services, which will, in the meantime continue to operate in silos, duplicate resources and pass people around the system.

2015/16

Specific investment has already been made in 15/16 with the aim of bringing providers together, solidifying the system wide vision and changing certain areas of service delivery in a "safe" way, the vanguard status for this health economy has given us the impetus to speed up our original timetable.
Investment in 15/16 has included:

- Front door at UHL – funding of double running costs for the trial of a new front of ED system – the new system started on 1st November as a result of 6 months of negotiation with current UCC providers, UHL, GP's and patients. The trial will run for 12months to fully assess its strengths, enable changes to remove weaknesses and a full review of surrounding service requirements without destabilising the system.
- Various services are being piloted within community and primary care settings to assess impact, understand interactions and provide stability to the system. Some of these have been funded from the prime ministers challenge fund, some through better care fund arrangements and others from council or CCG main stream funding.



- Specific schemes have been fast tracked over the last six months on the back of the vanguard status and funded at risk by the health economy.
- Investment of significant time from local clinical and managerial resources has stepped up as the year has progressed with additional resources being brought in to release internal capacity as well as assist with structured project management. Workshops involving representatives from all aspects of the system are being held to ensure total inclusivity in the design of the transformation required and the timescales for its delivery.

Modelling of the impact of the vanguard programme is underway; the crude model available at this point indicates a saving of approximately 7m against the steady state forecast by financial year 2019/20. IT is currently estimated that £4m will have been delivered through channel shift while a further £3m will be delivered via system efficiency savings. This represents an approximate 7% reduction in steady state costs and delivers a continual reduction in annual growth from then on.

Resources have been made available from all parties to the health economy in an effort to change the current system, these include significant clinical time from consultants, GP's nurses and pharmacists as well as managerial time at director, senior officer and general management level.

A programme team has been set up to support delivery of the required changes at a cost of £445k, £300k of this has already been funded through the vanguard scheme. Management support is also being provided by the health economy from existing resources to supplement and lead this team. Specific funding is being requested to support the double running investment made into UHL in order to facilitate a major system change both internal to UHL and with significant impact on associated services. This investment will allow the economy to trial new ways of working on the ground in real time with sufficient clinical backup to the processes and systems operating at the hospital front door to maintain patient safety and clinical stability. The additional

funding from the vanguard will allow a total investment of £2.5 million into this project and will cover costs associated with diagnostic access, portering, and clinical development
The advancement of 7 Day working within UHL has been agreed by the health economy as contributing the release of capacity across the trust and as such being of significant benefit to the programme. Funding is being requested from the vanguard programme of £150k. This funding will be used in the first instance to support project management and clinical engagement – funding will be matched by the Trust.

The community integration strand of the programme has already incurred costs connected to the expansion of an integrated (health and social care) SPA. Although the request for support in 15/16 is relatively small (£335k in 15/16) it will allow us to channel funding to the further development of the DOS and support electronic data sharing work, this will provide a solid groundwork for system change implementation over future years.
Predictive modelling project has been brought forward to an attempt to capture information and data from this winter which will assist with development over the coming years. The funding requested will support the project management already in place within the CCG and Ambulance Trust to bring some specific IT support into the project.

The contract and procurement strand will require additional input from both clinicians and managers with the support of specialist advice to deliver a significant change to working methods in 16/17 contracts. This funding will help support that engagement and fund the specialist advice to support change.

Funding Requested from Vanguard for 15/16

Community Urgent Care system	£335,000
Front door	£1,567,000
Advancement of 7 day working	£150,000
Predictive modelling	£50,000
PMO	£145,000
Contract and Procurement	£50,000
Total	**£2,297,000**

Our Communications and Patient Involvement approach

The local health economy has a good track record of partnership working together and will continue to work together to develop and implement a co-ordinated marketing, communications and engagement strategy that works with a full range of audiences including the public and patients, providers, clinicians and the voluntary and community sectors.

A full marketing, communications and engagement strategy will be developed to support the key success measures of the Vanguard. The marketing, communications and engagement plan will engage audiences, develop and build an awareness of the changes in Urgent and Emergency Care across LLR, stimulate behaviour change to ensure the new services are accessed by the right people at the right time and engage the local media to support the narrative of change and inform the public.

Key Aims of the Communications and Patient involvement approach

- Communications and engagement teams across LLR working in new ways which break down organisational boundaries, understanding their roles and responsibilities and collectively supporting the health and wellbeing of patients and their carers
- Clarity, maximum reassurance and confidence among health and social care professionals and voluntary and community sector in the processes and new and enhanced services which support urgent care services
- Deeper understanding of peoples' experiences of urgent care and what matters most to them
- Deeper understanding of wider stakeholders and their influence and interest
- Involvement of patients, carers and health care professionals in the transformation of the urgent care system which delivers person-centred care and achieved parity of esteem across the population
- Well informed patients and carers who know where to get information, advice and guidance and understand how to get the right treatment, at the right place and at the right time
- Focus on prevention - designed a different experience which is focused on teaching people to spot the signs early; have anticipatory coping strategies; family carer involvement; social support; crisis prevention
- Equal focus on mental and physical wellbeing
- Sufficient resources in place to ensure a rolling programme of communications and engagement
- Know what success looks like through clear metrics including person-centred outcome measures
- Established reciprocal process of sharing best practice and learning across Vanguards

Evaluation Framework

A clear evaluation framework is essential to monitoring the beneficial impact that the programme has on the LLR Urgent and Emergency Health Economy. In order to achieve this, the LLR will agree a baseline dataset previous to the commencement of the Vanguard Programme from which it will measure the impacts that the Programme has had. The evaluation framework will seek to measure the benefits achieved from the work and if it was in line with the predicted outputs, outcomes and where possible if it has had the desired impact.

The outcome measures and information collection methods will be confirmed ahead of project mobilisations as part of the projects initial start-up works in order to ensure that the best measures are being used. These will be informed by subject matter experts on the Project and Programme teams.

At a Programme level a workstream will be established to populate the below table setting out clearly the framework for how we will measure success. The key targets for the programme have yet to be agreed but some of the initial thinking is shown in the table contained in appendix 5- evaluation framework.

Appendix

Appendix 1: Programme Governance

Governance

The 6 strands of the LLR Vanguard programme represent a comprehensive approach to the main themes within the Urgent and Emergency Care improvement plan. It will have a clear interrelationship with the work of the UCB. The Vanguard will be governed in a way that aligns to the SRG and UCBS existing responsibilities, so that it is not seen as something additional or separate to the work of the UCB.

The programme structure is based on having an SRO, Clinical Lead and Project Lead for each of the Vanguard Programme strands. The structure chart sets out the overall programme structure. Each strand will have a clearly identified project lead who is responsible for co-ordinating activities to take the

scheme forward and reporting to the SRO on progress. They will also act as the day to day Programme link to the strand.

Figure 1

The Urgent Care Board acts as the overarching Project Board for the 6 strands (each with their own project team). The ability for the Programme and Project strands to share ideas and garner the views of the patients within LLR is key to the programme's success. As such an overarching Patient Involvement and Communications group will be established.

The governance structure has been designed to recognise that the Vanguard is owned by the SRG and UCB and relates closely to much of the 'business as usual' work of the UCB.

In addition to this structured governance approach there will be a concerted effort to work closely with clinicians and staff at the 'coal face' to develop further the service models, to sense check proposed changes, encourage innovation and change behaviour.

Appendix 2: Project Strand details

Strand 1- Project outline

The Project will deliver:

- An consistent and integrated community and urgent emergency care response to patients across the LLR area
- 24 hour health care over 7 days across the LLR area
- Localised Navigation Hubs that will offer a consistent health care package including senior hospital clinical review triage at the beginning of the patient journey
- Health Care solution nearer to the homes of patients
- Early screening of comorbidities and prevention
- Improved Management of LTC's
- Reduction in health inequalities
- A reduction in avoidable and preventable A & E attendances and admissions
- Improved Health Workforce Solutions by developing Alternative Workforces including Assistant physicans and ACPs.
- Improved patient data sharing solutions ahead of referrals
- Patients will be signposted to the most appropriate service through a clinically led, locally focussed and responsive single point of access which incorporates senior hospital clinical triage.
- Provide better support for people to self-care. Patients will be supported to look after themselves when appropriate without needing to access urgent care services. This includes Mental Health and Social Services provision as early as possible in a patients journey.

Value

The potential savings within the system are 2 fold.

Efficiency:

The delivery of an integrated service will enable access to the right care in a safe and timely manner for the patient , through the removal of duplication within the system and refocus the system on the delivery of more appropriate and integrated care. This will enable process and system savings through both the number of services and contracts, but also through the number of contacts that patients have within the system. The overall well-being for both patient and provider should be a more streamlined and efficient journey.

Channel Shifting:

A review of the current system of working will offer a timely opportunity for the "how" we deliver our current and future services to be forensically reviewed with the view to tighter integration and better responsiveness to the demographic changes of the growing and aging population with the patient at the heart of the review. We shall build on existing good practises; including the development the Urgent care Hubs across the region and step up and step down services during local specific peaks and troughs. The inclusion of the hospital senior clinical review at an early stage supports and builds on the national multi-community provider model (MCP). This Project has a cross cutting theme across all 6 Strands.
The financial value of these two elements is being modelled and will be dependent upon the final system model agreed.

Scope:

The initial scope of services included within the integration project are:

- 999
- 111
- Out Of Hours (OOH)
- Urgent Care Centres (UCC)
- Minor Injury Units (MIU)
- Urgent Care Centre
- Senior Clinical Triage Review
- Single Points of Access (SPA's)
- Same day response teams:
    - general practice
    - home based acute visiting
    - crisis response services
    - community nursing services
    - Older Peoples Unit

The project will have cross cutting key interdependencies with the strand 2, the LRI front door, ensuring that the most effective and efficient pathways are in place, strand 3, Mental Health, ensuring patients have parity of care and efficient access to crisis support services, strand 5 contracting for transformation, to enable a legal framework that will encourage the change needed within the system and strand 6, predictive modelling to enable the management of capacity and resources within the system and unlock the capacity management capabilities of the integrated urgent community care system.

High Level Implementation Plan

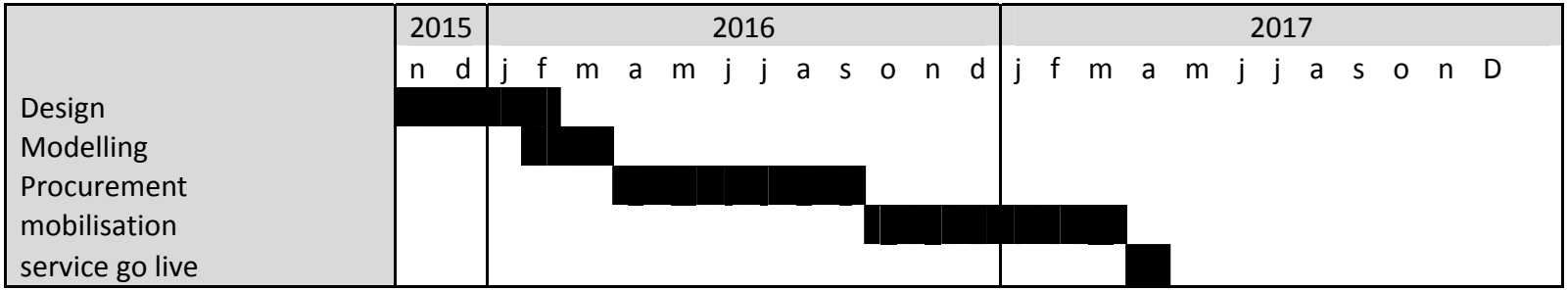


Figure 2

Strand 2 – Project outline

The former model of Urgent Care and Acute patient management was ineffective and required development to ensure patients received the best care and the system required a more effective delivery model. As such the LRI front Door model was proposed whereby patients are more robustly streamed and channel shifted where possible. Since 3rd November the UCC at LRI has been managed by UHL, enabling them to have control over Urgent and Emergency care resources on site.

Lakeside Plus have been sub contracted by UHL to provide the streaming service 10am-10pm 7 days a week. The early focus of the new process is to ensure that the data is correctly gathered to enable a detailed insight into the streaming of patients. This will then inform the learning and development of future models for the new Emergency Floor and supporting services provision required across LLR.
Further work is required in the development of relationships between primary care and the acute trust to ensure patients are correctly signposted and communications work is required to enable patients to make the best decision on their care choices. In addition work is required to created stronger linkages and referral pathways between the acute and social care services.
One of the chief impacts anticipated from the pilot is to inform the models of care in the new ED floor at LRI which is due to be completed in winter 2016.

High Level Implementation Plan

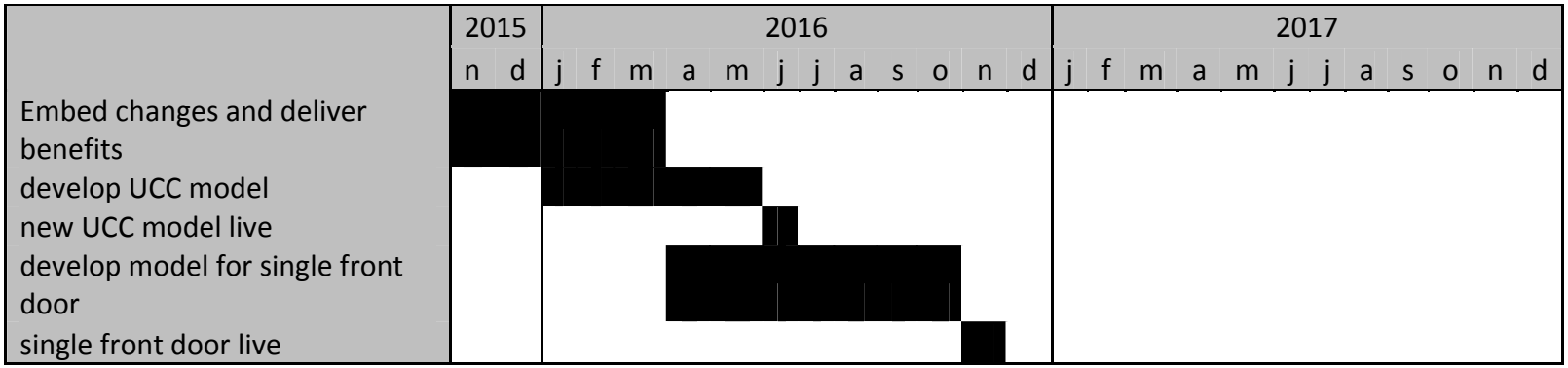


Figure 3

Strand 3 - Project outline

The mental health project has 3 areas of focus:

- Liaison Psychiatry Core 24
- Community mental health triage (EMAS/111/Police)
- Crisis support and home treatment for children and young people

Liaison Psychiatry

Developments within the acute hospitals will see mental health services providing the Core 24 service model. This will build upon the already well established mental health triage nurse service in the emergency department and the Frail Older People's Assessment and Liaison Service by providing consultant psychiatrist input and allow initial treatment and prescribing to take place as well as assessment. It will increase the current two hour response time to one hour in the emergency department. The clinical standard for 7 days services within Urgent and Emergency care will be met whereby; "Where a mental health need is identified following an acute admission the patient must be assessed by a psychiatry liaison within the appropriate timescales 24 hours a day seven days a week: within 1 hour for emergency care needs, within 14 hours for urgent care needs." The Core 24 service will align with the alcohol workers in the emergency department commissioned by Public Health for those people with mental health and alcohol problems. There will be a newly designed Mental Health Emergency Decision Unit in the emergency department staffed by an expansion of the mental health triage nurse team. This will improve flow through the acute hospital and allow time for decision making on those presenting with complex mental health problems.

Community Mental Health Triage

The community triage element will see the development of best practice with ambulance and police triage pilots and work with 111 to ensure that Mental Health patients receive parity of care. There will be development of an algorithm to ensure correct dispatch of vehicles for ambulance services and mental health expertise available to the 111 call centres including appropriate signposting to reduce any non-emergency cases being directed to the emergency department.

Crisis support and home treatment for children and young people

The increased access to crisis support and home treatment for children and young people element will see the development of a new service offering a crisis support service and home treatment. The service will work closely with social care and education. The designated Place of Safety Assessment Unit (PSAU) will be upgraded to meet national standards in order to accommodate people of all ages ensuring that it is fit for purpose for all age groups. This will be operational by April 2016 and there will be no risk of children or young people being inappropriately held in police cells or the emergency department.

Value

The development of the community triage will enable parity of esteem for mental health within urgent care. The development of an algorithm will see the merging of best practice from an ambulance mental health triage pilot service in Lincolnshire and the police mental health triage service in LLR. This will be linked with the work from strand 1 to develop a community triage service for patient requiring an intervention from the mental health crisis team and ensure that the police/ambulance are dispatched in a coordinated way to best treat the presenting disposition. Financial modelling needs to be completed on this element based on the algorithm developed to better understand the potential savings. Impact would be expected to be felt within EMAS through faster resolution of MH dispositions through having trained staff, reduction in A&E attendances and on a wider scale will also have a positive impact on the Police service resources.

The national guidance for services based on the RAID model, is that for every £1 invested £4 is saved. A workstream is to be established to understand how different the LLR approach is from the original RAID model to be able to estimate potential savings. The national RAID model shows savings are made through the FOPALS element of Liaison Psychiatry. Within LLR there is already a substantial FOPALS element of Liaison Psychiatry in place. The financial modelling will also factor in its impact on the whole system solution and value that can be achieved.

Implementation plan

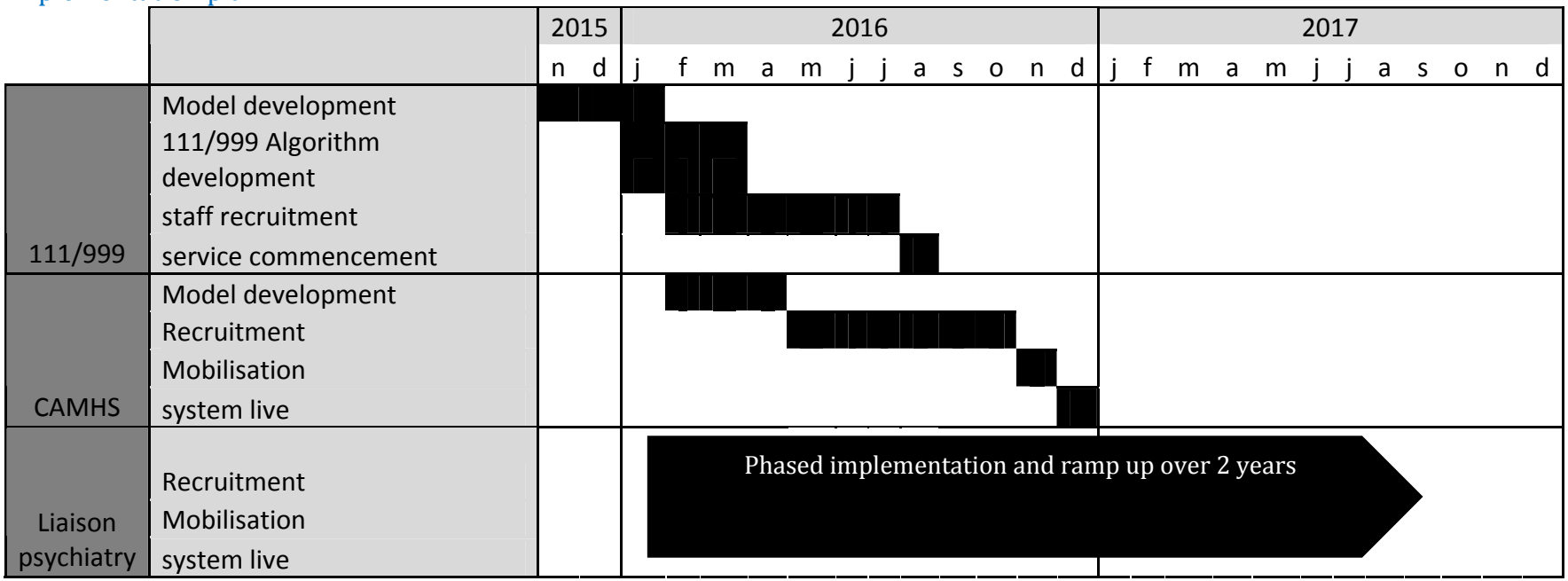


Figure 4

Strand 4 - Project Outline

The project will be focused on the acute 7 day service requirement and achieve standards – 02, 05, 06, 08 from the Keogh review by March 2017. These are:

2-Time to first Consultant Review: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital.

5- Diagnostics: Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: Within 1 hour for critical patients, Within 12 hours for urgent patients, Within 24 hours for non-urgent patients

6 -Intervention /Key Services: Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols, such as: Critical care, Interventional, radiology, Interventional endoscopy, Emergency general surgery
8 – On-going Review: All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks. Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.
Through dependencies on other schemes we will also achieve
7 – Mental Health: Where a mental health need is identified following an acute admission the patient must be assessed by psychiatric liaison within the appropriate timescales 24 hours a day, seven days a week: Within 1 hour for emergency care needs, Within 14 hours for urgent care needs,
And will seek to work towards
9 - Transfer to Community, Primary and Social Care: Where a mental health need is identified following an acute admission the patient must be assessed by psychiatric liaison within the appropriate timescales 24 hours a day, seven days a week: Within 1 hour for emergency care needs, Within 14 hours for urgent care needs

Value

Further work is required to define the exact impact and financial benefits however initial work provides some guidance on what is expected from this project.

It is anticipated that there will be an impact on reduced mortality, reduced variation of Length of stay, reduced variation of readmission rates. However it is to be noted that this modelling is not evidenced as yet. The impact in mortality is proving to be particularly hard to model and develop a financial model for. On the other elements though initial targets have been established and the financial modelling is set to proceed.

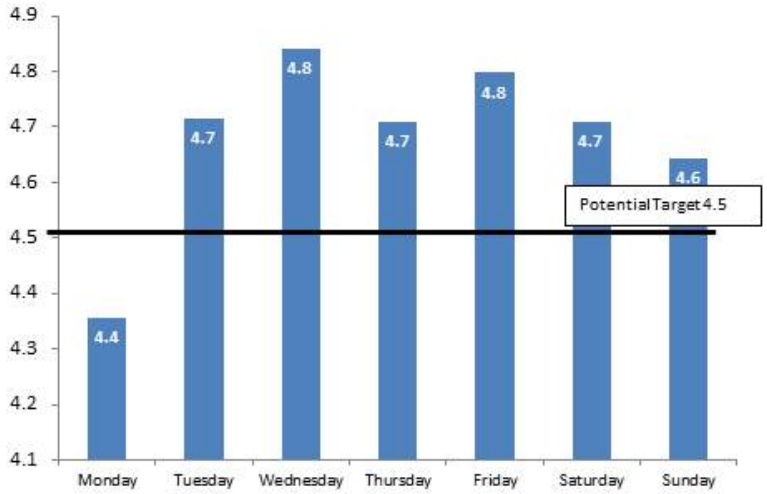
Across 7 days we are looking to reduce variation in, length of stay (LoS), average length of stay (ALoS), death by day of admission and readmission rates (7 and 30 days)

The targets are being established around achieving minimal variation and to move towards every day meeting our current "best day" outcomes in these areas. The graphs show current status with a potential target –(this target has not yet been formally agreed and work to look at the "mean" rather than "average" is currently taking place)

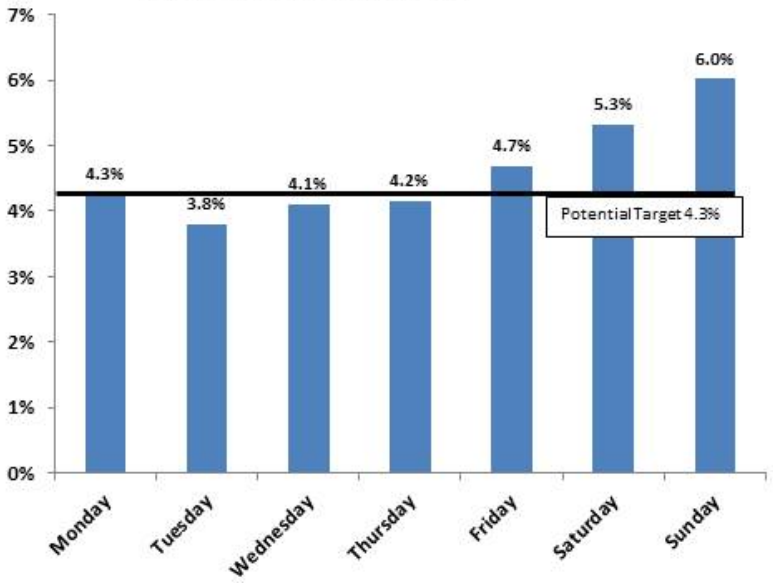
It is noted that these potential targets need to be revisited once more work has been completed on understanding the variation across the 7 Days.
Once further modelling has been completed it, costs benefits may be realised from potential reduction of length of stay.

The value lies in the Quality Commitment for Patient Care in ensuring that patients entering the hospital through the emergency and urgent care pathway receive the same level of senior clinical intervention and have the same access to key diagnostics and interventions no matter what day of the week it is. Nationally this has been linked to reducing the variation in morality from week days and weekends.

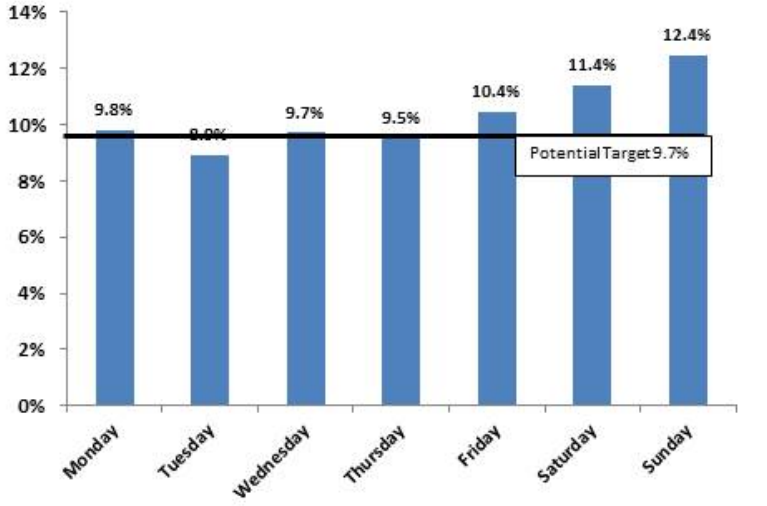
Average Length of Stay following an Emergency Admission to UHL



7 Day Readmission Rate by Day of Discharge

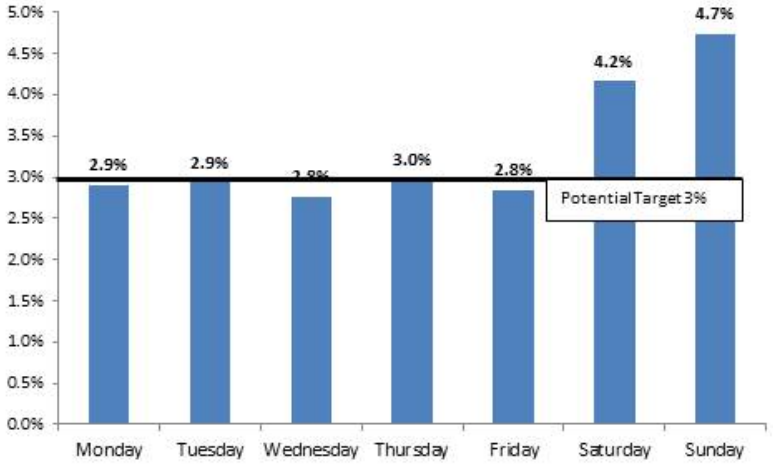


30 Day Readmission Rate by Day of Discharge



% Died by Day of Discharge

(NB Fewer discharges at the weekend)



Project implementation

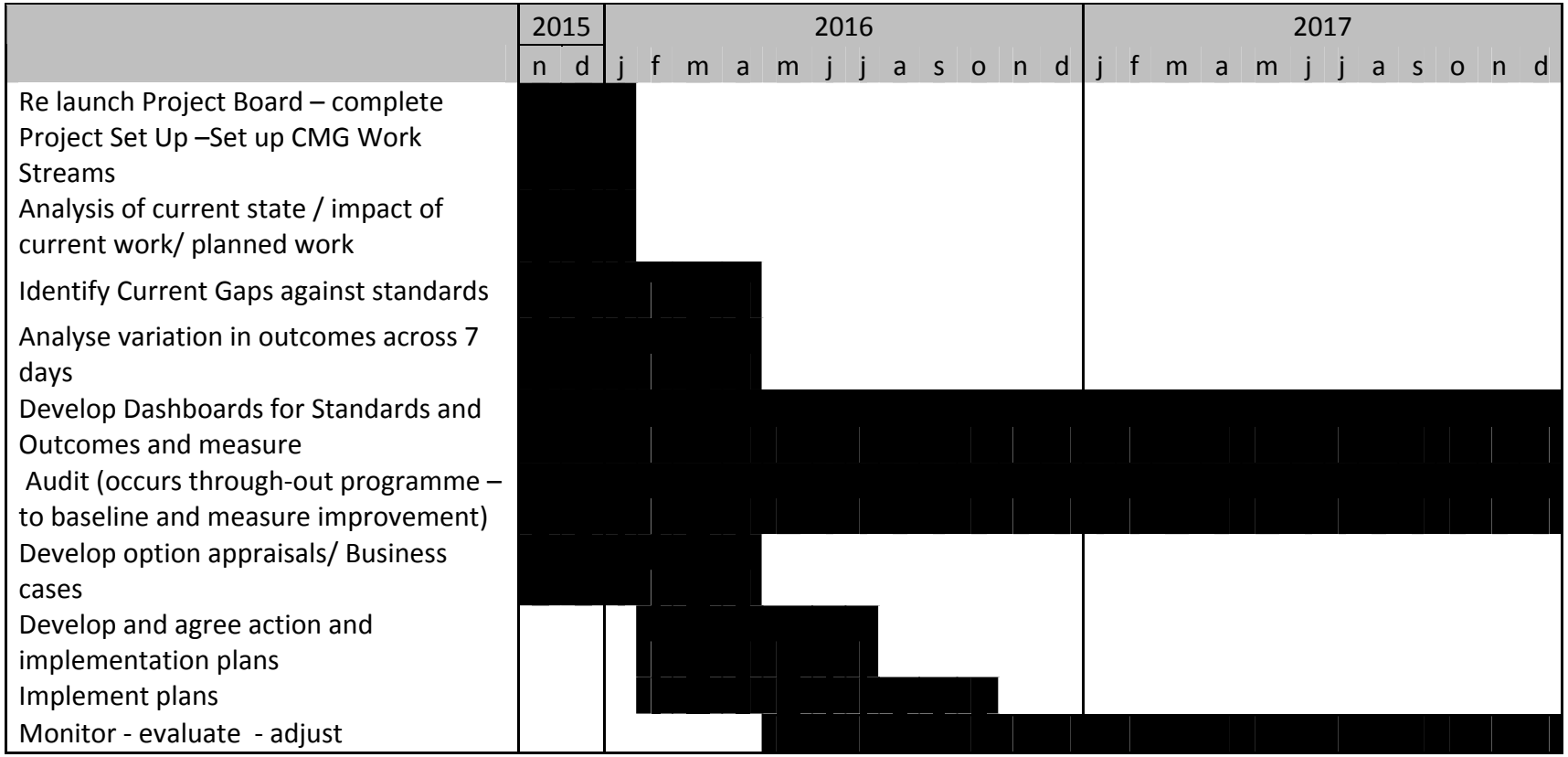


Figure 5

Strand 5 Project outline

Contracting for transformation is focused on the development of the new 3 part contracts to incentivise the change required within the system.

Value

The modelling of the impact that these contracts will have directly is not possible. The new contracts will be a tool that will enable the delivery of the financial savings, both encouraging and enforcing change. The expected impact of the new contracts and payment models will be:

- Risk/ gain share associated with the vanguard transformation
- Supporting integration of services across the vanguard, both operationally and clinically
- Reducing hand-offs and encouraging innovation
- Supporting delivery of financial targets through incentivising best practice and transformation agenda
- Improved productivity

The new contracts and payment models will be developed hand-in-glove with the project strands to ensure that the best outcomes are achieved.

Implementation plan

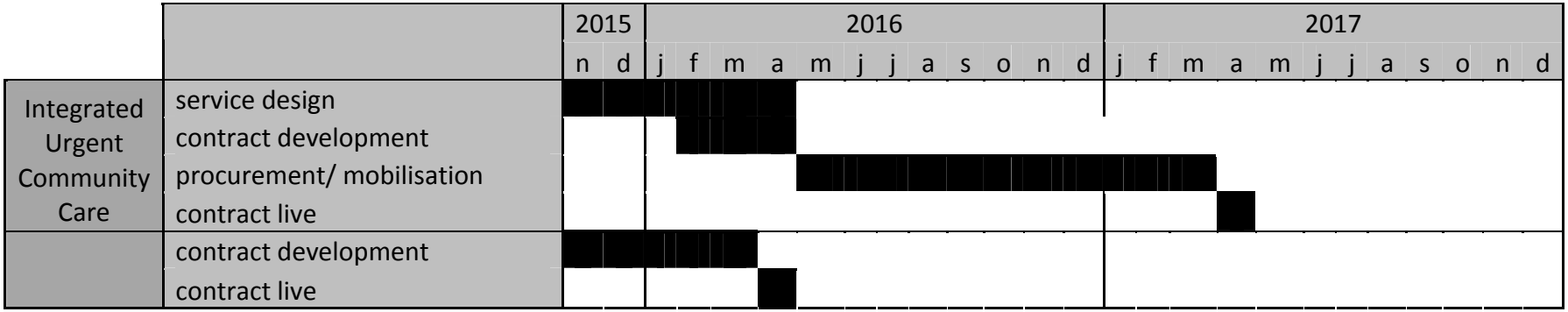


Figure 6

Strand 6 - Project Description

The aim of the project will be to deliver a real time heat map of the whole urgent and emergency care system and develop triggers and escalations within the system to manage patient flow before wait times become unsustainable. In addition the project will develop a simulation model of the system that will allow for a better informed commissioning process. There are 3 main phases to the project. Phase 1: The delivery of a heat map based on available data

and systems. Phase 2: The development of a solution to provide real time data to the heat map that links into the 111/999 DOS. Phase 3: The development of an Urgent and Emergency Care System simulation modelling tool to enable commissioning based on system pinch points and to allow for the development and testing of concepts and their impact.

Value

- How will these changes be delivered?
  - Redesign of service following review of analytics
  - Joint ownership of system pressures and its alleviation

The development of the predictive modelling strand will enable a number of changes in the management of system flow and capacity. The real time data heat map will allow the following benefits to the system and patients:

- Enable patients to make an educated choice on their best care pathway
- Combined with strand 1, enable a shift in activity to primary care where appropriate to make best use of resources
- Enable the system to provide responsive care ; right care, right place, right time
- Enable the system to provide a consistency of care 24/7
- Less delay – appropriate care delivered through demand management and interface with schemes 1, 2, 3, and 4.
- Reduced patient wait
- Clinical risk managed effectively outside hospital environment
- Better management of Channel Shifting
- System behaviour change in the management of flow
- Enables whole system team working through understanding and ownership of system capacity

Implementation

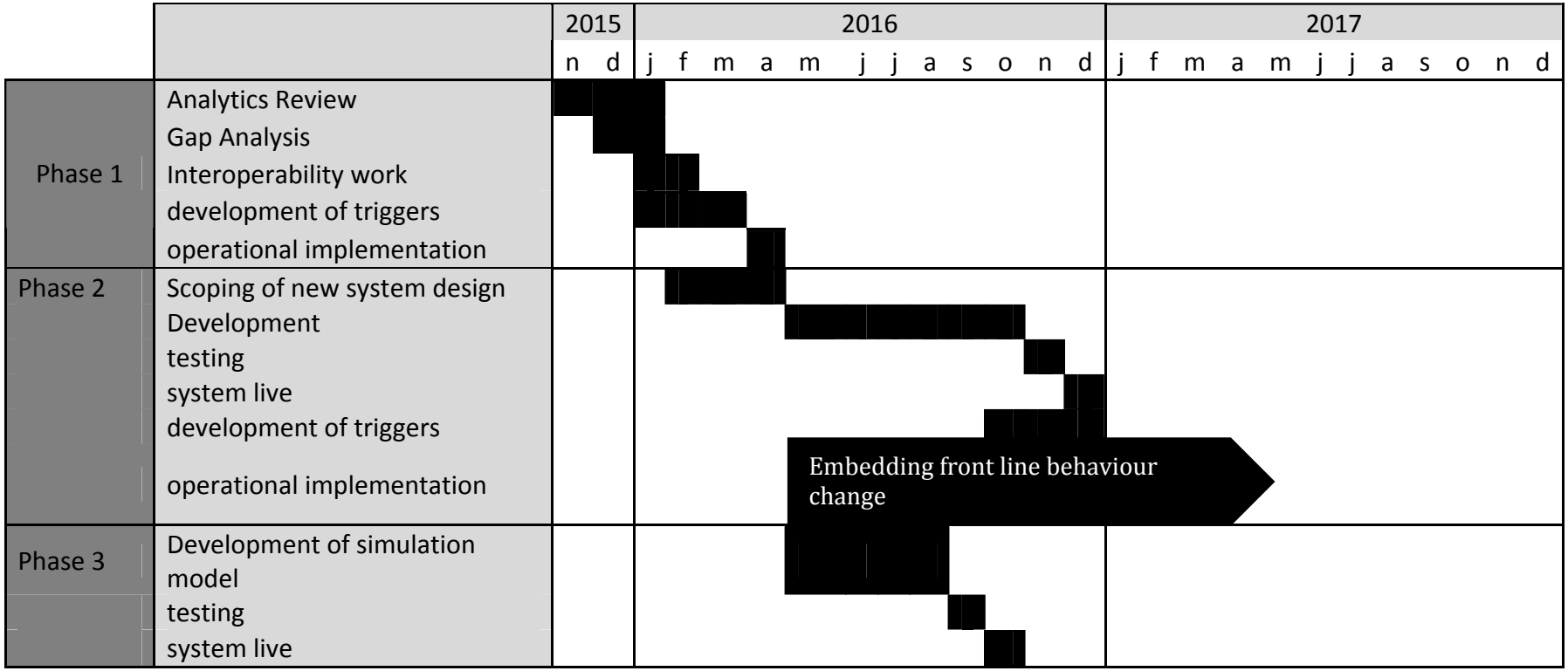


Figure 7

Dependencies

The project has key dependencies with strand 1. Although the tool will be used across the system linkages to the initial streaming of patients will be key to managing the flow.

Appendix 3: Interdependencies

Dependencies

As you would anticipate with a scheme of this scale there exist a number of dependencies between the programme strands. These are highlighted at a high level in the dependency matrix

Dependency Matrix

	Strands 1: Integrated Urgent Community Care	Strand 2 LRI Front door	Strand 3: Mental Health	Strand 4: 7 Day services	Strand 5: Contracting for transformation	Strand 6: Predictive Modelling
Strands 1: Integrated Urgent Community Care		Pathway development (referral)	Pathway development (referrals) Development of workforce	Pathway development (referrals) 7 day service access to primary, community and social care	Contract development for new services	Data on the resources and capacity of services to enable flow management
Strand 2 LRI Front door	Pathway development (receiving referrals and diverting patient flow)		Pathway development (referrals)	Improved Access 7 days a week	Contract Development to incentivise transformational change	Sharing data on resources and capacity Receiving information on demand to manage flow
Strand 3: Mental Health	Pathway development (receiving referrals) Providing advice	Pathway development (receiving referrals) Increased service capacity		Improved Access 7 days a week	Contract Development of new contracts and to incentivise transformational change in existing contracts	Sharing data on resources and capacity Receiving information on

	and guidance					demand to manage flow
Strand 4: 7 Day services	Enable achievement of clinical standard 9		Enable achievement of clinical standard 7		Contract Development of new contracts and to incentivise transformational change in existing contracts	
Strand 5: Contracting for transformation	Contract development for new services	incentivise transformational change in existing contracts	Contract Development of new contracts and to incentivise transformational change in existing contracts	incentivise transformational change in existing contracts		
Strand 6: Predictive Modelling	Provide data on capacity, resources to manage flow Receives data on demand	Provide data on capacity, resources to manage flow Receives data on demand	Provide data on capacity, resources to manage flow Receives data on demand			

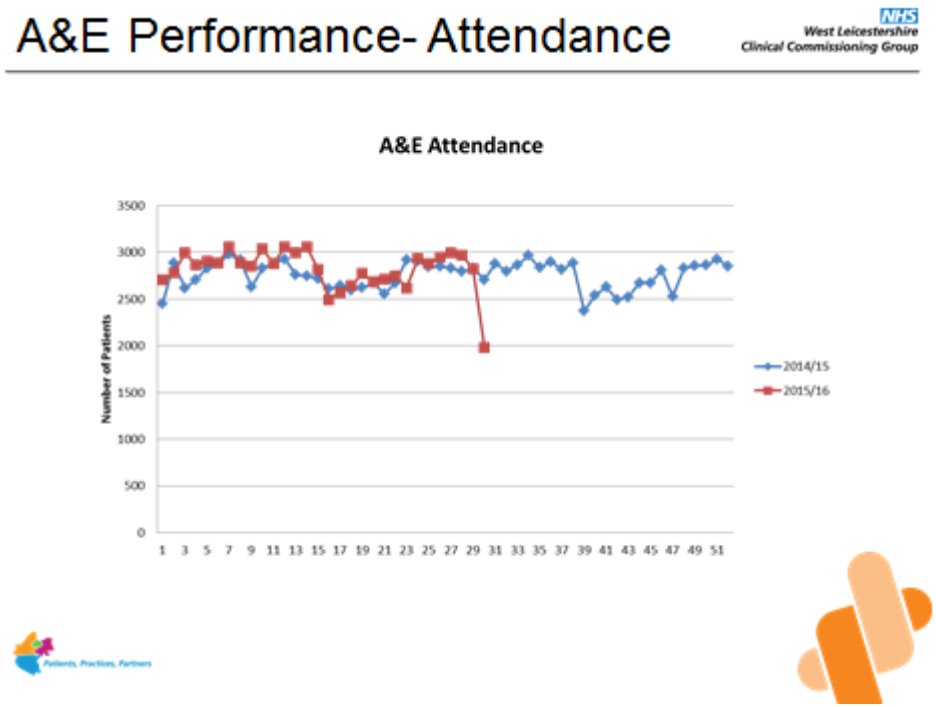
Figure 8

Appendix 4: Evaluation Framework – sample

Specific Aim	Outcome (actual)	Outcome Indicator	Information collection methods	When and by whom	How to report and use	Baseline	Target Variation	What 'Success' looks like/ acceptable improvement

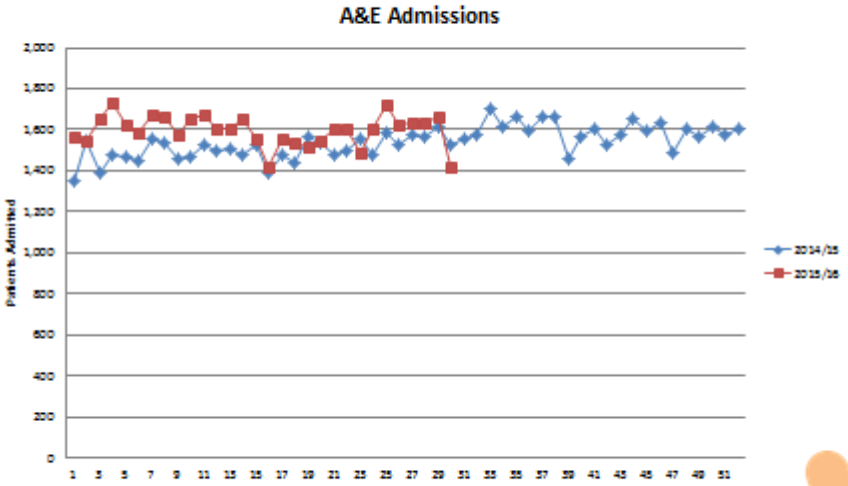
Figure 9

Appendix 5 – additional data



A&E Performance – Admissions

NHS West Leicestershire Clinical Commissioning Group



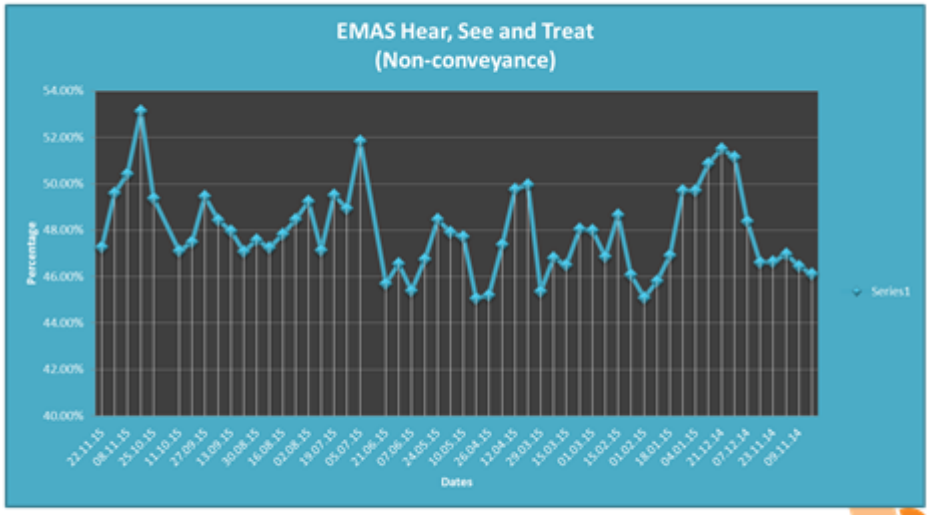
A&E Performance – 4hrs

NHS West Leicestershire Clinical Commissioning Group

- 2014/15 209'396 patients were seen within the 4hr target
- 2015/16 115'563 patients have been seen within the 4hr target so far this year.

Ambulance Handovers-Conveyances

NHS West Leicestershire Clinical Commissioning Group



Ambulance Handovers-Hours Lost

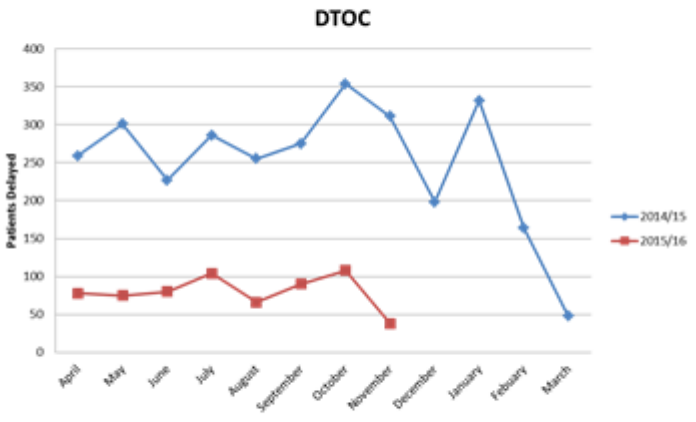
NHS West Leicestershire Clinical Commissioning Group

Hours Lost 2014/2015 – 484hrs

Hours Lost so far 2015/2016 – 365hrs

DTOC

NHS
West Leicestershire
Clinical Commissioning Group



APPENDIX 6 – Financial working document

Document produced by the System Resilience Group for Leicester Leicestershire & Rutland.

C/O West Leicestershire Clinical Commissioning Group 55
Woodgate
Loughborough
Leicestershire
LE11 2TZ