UHL Emergency Performance

Author: [Richard Mitchell] Date: [Thursday 6August 2015]

Executive Summary

Trust Board Paper U

Context

Although non-compliant, emergency performance continues to improve. July will be the fourth month in a row with performance over 92%. UHL remains under pressure because of the continuing and unseasonably high levels of attendance and admissions. The continued pressure is atypical when compared to the national picture. We (UHL) need to work more effectively with Leicester, Leicestershire and Rutland partners (LLR) to resolve this key problem.

Questions

1. What more can UHL do to resolve this problem?
2. What more can our partners do to resolve this problem?

Conclusion

1. The proposed change to the front door is a positive development but more is required to improve performance in time for winter 2015-16.
2. Being recognised as an Urgent and Emergency Care System Resilience Group will support improvement but we need to work more effectively with partners to identify the attendance/ admission avoidance schemes that are working in some parts of the health economy and then need to develop an urgent plan to roll them out across the health system. This has remained an unresolved issue for a number of months.

Input Sought

We would welcome the board's input regarding the pace and scale of change in the attendance and admission avoidance schemes.

For Reference

Edit as appropriate:

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

Safe, high quality, patient centred healthcare	[Yes /No /Not applicable]
Effective, integrated emergency care	[Yes /No /Not applicable]
Consistently meeting national access standards	[Yes /No /Not applicable]
Integrated care in partnership with others	[Yes /No /Not applicable]
Enhanced delivery in research, innovation &ed'	[Yes /No /Not applicable]
A caring, professional, engaged workforce	[Yes /No /Not applicable]
Clinically sustainable services with excellent facilities	[Yes /No /Not applicable]
Financially sustainable NHS organisation	[Yes /No /Not applicable]
Enabled by excellent IM&T	[Yes /No /Not applicable]

2.This matter relates to the following governance initiatives:

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

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

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

5.Scheduled date for the next paper on this topic: 2 July 2015

6.Executive Summaries should not exceed 1page. [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:	**August 2015**

High level performance review

- 92.3% year to date (+4.0% on last year)
- Attendance +6.9%
- Admissions +7.3%
- Average time in the ED -17% (compared to last year)
- Average time to treatment -45%
- Average time from arrival to bed request -19%
- Medical length of stay -9%
- **Performance remains consistently below 95%.**

Performance continues to improve. July will be the fourth month in a row with performance above 92%. Overall performance in July has been reduced by very high attendance (+11% compared to last year) and admissions (+15%) in the first week of the month (w/e 5/7/15) which was at a time when we had sub optimal medical staffing one weekend. It took us ten days to recover from this which indicates how fragile we remain. The table below shows the impact the high levels of admissions had on performance. Performance was weaker last week because of staffing levels in the emergency department.

24/05/2015	31/05/2015	07/06/2015	14/06/2015	21/06/2015	28/06/2015	05/07/2015	12/07/2015	19/07/2015	26/07/2015
93.5	94.6	92.0	95.2	94.4	92.9	85.4	91.3	96.3	91.4

Update on UHL plan

We continue to make progress on our internal flow plan. The plan is monitored through the weekly Emergency Quality Steering Group and of the 59 actions identified most are on track or complete. Details are below.

Row Labels	Count of Actions
1. Not yet commenced	3
2. Significant delay – unlikely to be completed as planned	7
3. Some delay – expected to be completed as planned	18
4. On track	6
5. Complete	20
6. Complete and regular review	5
Grand Total	**59**

LLR KPIs

LLR KPIs are attached and are tracked through the fortnightly Urgent Care Board.

Successful Vanguard application

LLR partners have successfully been appointed as one of the eight vanguard sites that will launch the transformation of urgent and emergency care for more than nine million people across the country. The new Vanguard status will give us access to expertise and support from national clinical leads that will bring new cutting edge ideas to help us to develop our local health and care services. One of the proposals at the moment is to create a new alliance-based urgent and emergency care system where all providers work as one network. This will bring together ambulance, NHS 111, out-of-hours and single point of access services to ensure that patients get the right care, first time. It will also mean we will be able to redesign the urgent and emergency care front door to include an assessment team. The application is attached for further information.

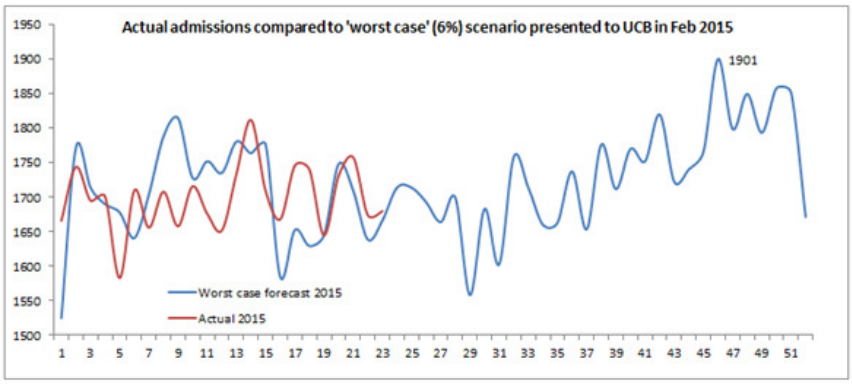
Urgent Care Board Improvement Plan

Health and Social care partners have worked collectively through the Urgent Care Board to articulate a vision for the Urgent and Emergency Care Pathway to provide a direction and focus for 2015/16 and this plan is attached as an appendix to the report. We have worked together to identify the system challenges and the high impact areas identified nationally and the plan clearly defines the actions required by the five work streams: Inflow; hospital flow; Transfers of Care, Future vision/Strategy and Communication.

Each of the work streams has identified five priority areas for action with the outcomes monitored through a system dashboard. The Plan sets out an ambitious programme of work which will require commitment of all partners to focus on outcomes and sustain pace behind the actions.

Conclusion

Emergency care performance continues to improve across LLR. However the level of admissions remain the primary cause of concern. A paper went to the urgent care board in early February 2015 forecasting the admission rate for the rest of the calendar year. As of early July, this forecast was +99% accurate and unless admissions reduce UHL will be admitting over 1900 patients per week this winter (table below). This is an 18% increase on two years ago.



As stated in previous months, the fragile nature of the pathway means that slow adoption of improvements in one part of the health economy stops overall improvement. We must set challenging expectations for all parts of the health economy (including UHL) and work to ensure these expectations are met. Current progress is insufficient to provide a higher quality of care to our patients in winter 2015-16. Whilst there has been progress on a joint understanding that the front door needs to improve, this will not be enough. We also require dramatic improvements to primary care.

Recommendations

The Trust Board is recommended to:

- **Note** the contents of the report
- **Note** the UHL update against the delivery of the new operational plan
- Seek **assurance** on UHL and LLR progress

Report to: Leicester, Leicestershire and Rutland (LLR) Urgent Care Board

Report Title: Urgent Care Dashboard to 21st July 2015

Report by: Urgent Care Team

Meeting Date: 23rd July 2015

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1. Introduction

The following highlight report supports the 'Summary Urgent Care Dashboard' and draws out the key metrics and trends for discussion at the Urgent Care Board.

2. Inflow

The total number of 111 calls last week was 3191, a slight drop on the previous week's figure of 3582. Similarly, after a period of regular incremental rises, the percentage of calls sent through to ED/999 also saw second week of reduction, a drop by almost 2% to 10.1%. The total number of calls in to EMAS also saw a slight reduction from 2413 calls to 2278.

The position on EMAS ambulance hours lost improved with target rate being achieved of 162 hours, that's a reduction of over 100 hours on the previous week. EMAS disposition for non-conveyance improvedby 1% to 49.4% just shy of the 50% target rate.

LRI attendances saw a reduction of 338 on the previous week to 2642.

There percentage of UHL Emergency admissions that were avoidable dropped by almost 4.5% to 7.1%, the lowest rate by far since April.

3. Flow

The percentage of UHL & UCC attendances seen within 4 hours stands at 93.5%, an improvement of almost 2% on the previous week.

Discharges before 12 mid-day continues to hover around the 10% mark, a level which it has more or less maintained since April.

The percentage of UHL ED with decision about onward care within 120 minutes has improved by around 7.5% to 38.5%.The percentage of UHL Ward response to ED/Bed requests within 30 mins has also improved by 2% to just shy of 70%.

The stranded patient metric for 75+ saw a very minor increase but continues to be steady around the 80 mark aligned reasonably close to target levels.

4. Discharge

There were 48 more discharges than admissions from UHL for the period covered.

The average number of community beds available at the start of the day last week increased to 26 per day from the previous weeks average of 19 per day. ICS bed utilisation stands at 89.5%.

The 30 day readmission rate has seen a positive reduction to 135 patients, a reduction of 21 on the week before.

Number of patients discharged both from UHL and LPT saw reductions, this is likely to be linked to the reduced admission rates for last week.

5. Further Information on metric data

- Delayed discharges data are based on a snapshot of midnight census of every Thursday
- UHL Admissions data submission arrived after the report production cut off time and so is up to Saturday 18 July 2015 i.e. only shows 6 days' worth of data
- Week 14 data are missing for Urgent Care Centre
- Avoidable Emergency Admissions data will show sudden decrease due to the data provided. This normally corrects itself each week

The Urgent Care Board is asked to:

- **Receive the report**
- **To consider the actions within the next steps and discuss further action to enable further improvements to delivery.**

Urgent Care Board - Dashboard

Updated to Sunday 19/07/2015

Arden&GEM

Inflow

- 111 Total Calls
- % of 111 Calls sent to 999/ED
- Total Calls to EMAS
- EMAS Disposition - Non Conveyed
- EMAS Ambulance Handover: Hours Lost
- GP OOH Activity
- ED: LRI Attendances
- ED: UCC Attendances
- UHL Emergency Admissions
- GP Referrals to Bed Bureau that are Diverted to ED
- % of UHL Emergency Admissions that were Avoidable

Flow

- % of UHL & UCC Attendances seen within 4 Hours
- % of UHL ED with Decision about Onward Care within 120 mins
- % of UHL Ward Response to ED/Bed Requests within 30 mins
- % of UHL GP Referrals Direct to AMU
- UHL Empty Beds at Start of Day on AMU Ward
- % of UHL wards Achieving Targeted Weekly Discharges
- Aged 75+ with Length of Stay >10 Days at UHL
- % of Discharges before 12pm at UHL

Discharge

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

Information

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

UHL Admissions data is up to Saturday 18 July 2015

Latest Week meets the Target

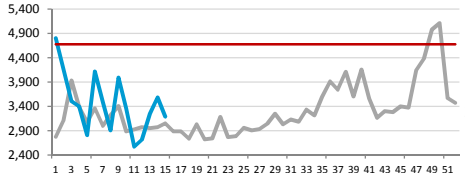
Latest Week is within 5% of the Target

Latest Week is > 5% from the Target

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

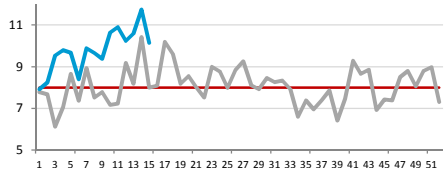
INFLOW

111 Total Calls



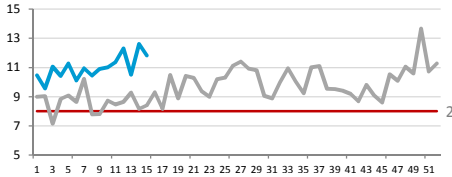
Current Wk
3,191
2015/16 AVG
3,456

% of 111 Calls sent to Emergency Department



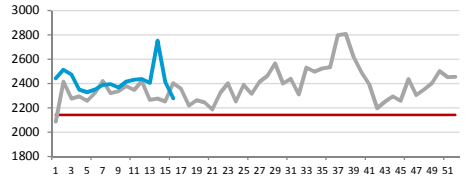
Current Wk
10.1%
2015/16 AVG
9.8%

% of 111 Calls sent to 999



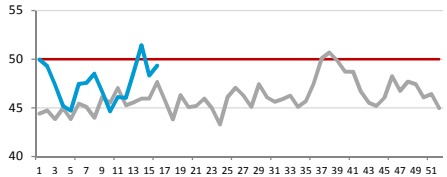
Current Wk
10.1%
2015/16 AVG
9.8%

Total Calls to EMAS



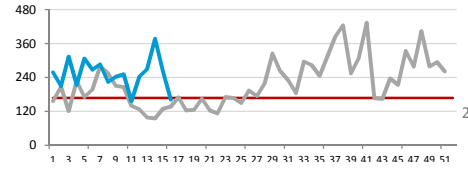
Current Wk
2,278
2015/16 AVG
2,422

EMAS Disposition



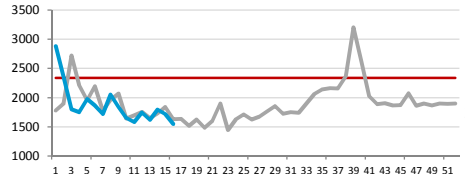
Non Conveyed
Current Wk
49.4%
2015/16 AVG
47.6%

EMAS Ambulance Handover: Hours Lost



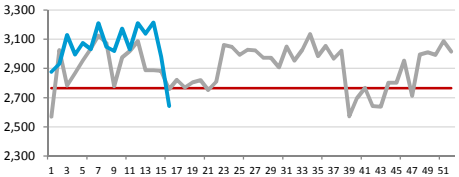
Current Wk
162
2015/16 AVG
252

GP Total OOH Activity



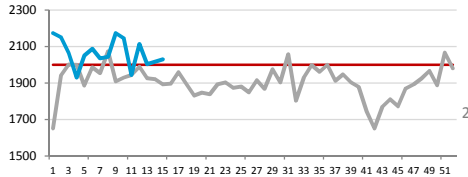
Current Wk
1,549
2015/16 AVG
1,869

ED: LRI Attendances



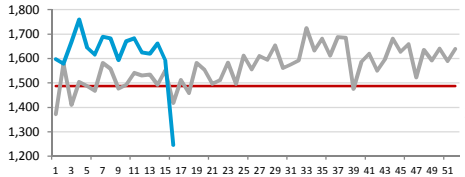
Current Wk
2,642
2015/16 AVG
3,044

ED: UCC Attendances



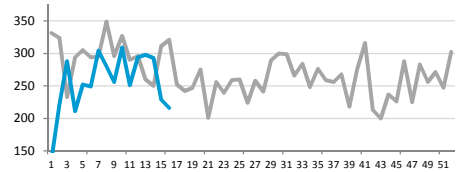
Current Wk
2,029
2015/16 AVG
2,068

UHL Emergency Admissions



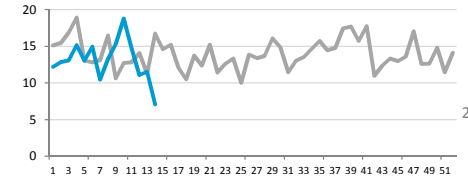
Current Wk
1,246
2015/16 AVG
1,620

GP Referrals to Bed Bureau that are Diverted to ED

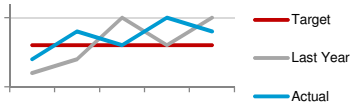


Current Wk
216
2015/16 AVG
255

% of UHL Emergency Admissions that were Avoidable



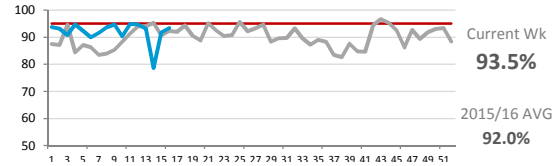
Current Wk
7.1%
2015/16 AVG
13.1%



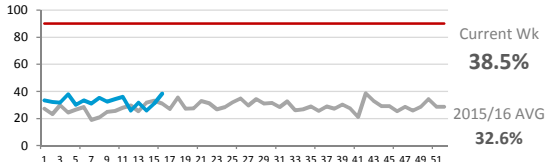
All Metrics are shown Weekly with the Year Running from 1st April

FLOW

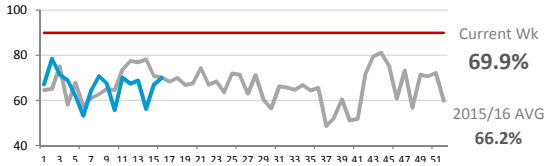
% of UHL and UCC Attendances seen within 4 Hours



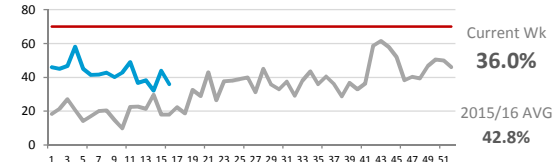
% of UHL ED with Decision about Onward Care within 120 mins



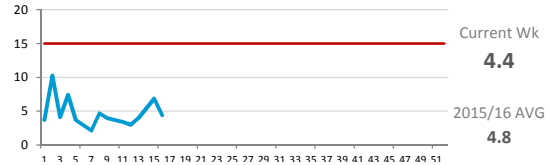
% of UHL Ward Response to ED/Bed Requests within 30 mins



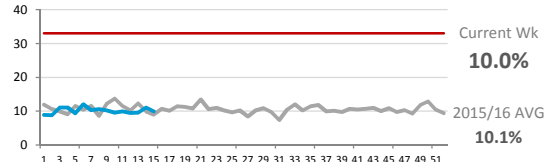
% of UHL GP Referrals Direct to AMU



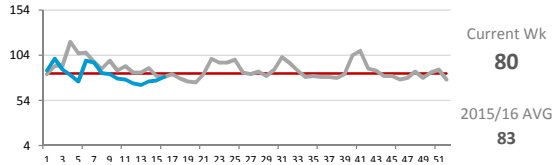
UHL Empty Beds at Start of Day on AMU Ward

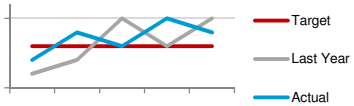


% Discharges before 12pm at UHL



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

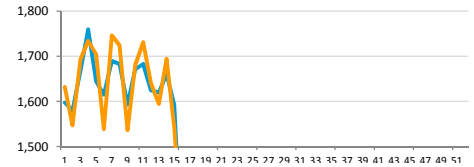




All Metrics are shown Weekly with the Year Running from 1st April

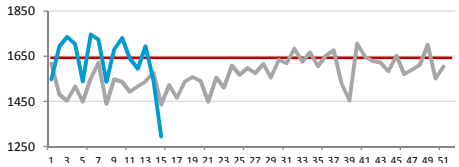
DISCHARGES

Patients Admitted to & Discharged from UHL



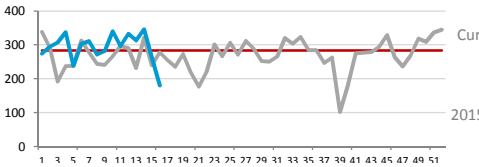
	ADM	DIS
Current Wk	1,246	1,294
2015/16 AVG	1,620	1,627

Patients Discharged from UHL



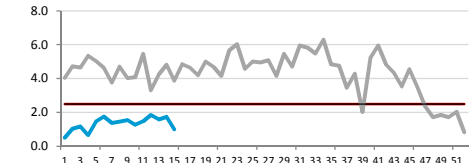
Current Wk **1,294**
2015/16 AVG **1,627**

Patients Discharged from LPT



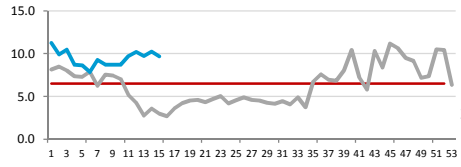
Current Wk **180**
2015/16 AVG **293**

% UHL Delayed Transfers of Care



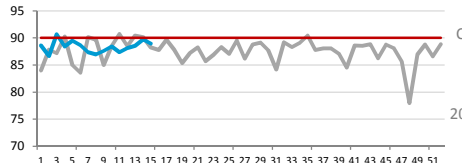
Current Wk **1.0%**
2015/16 AVG **1.3%**

% LPT Delayed Transfers of Care



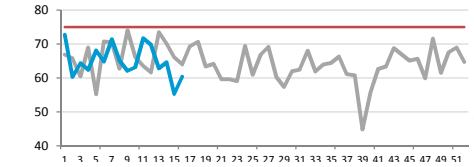
Current Wk **9.7%**
2015/16 AVG **9.4%**

% of UHL Patients Discharged To Admitting Address



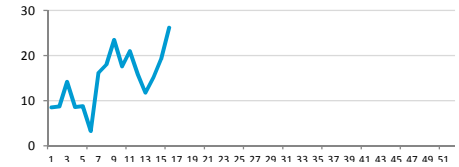
Current Wk **89.0%**
2015/16 AVG **88.4%**

% of LPT Patients Discharged to Admitting Address



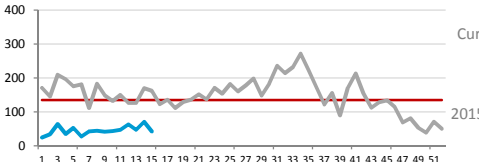
Current Wk **60.4%**
2015/16 AVG **65.0%**

Average Patients Community Beds Available at Start of Day



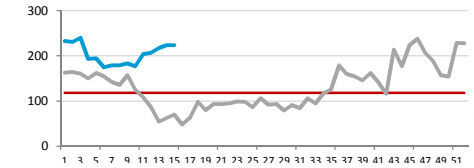
Current Wk **26**
2015/16 AVG **15**

UHL Delayed Transfers of Care - Bed Days Lost



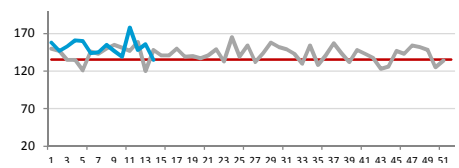
Current Wk **42**
2015/16 AVG **45**

LPT Delayed Transfers of Care - Bed Days Lost



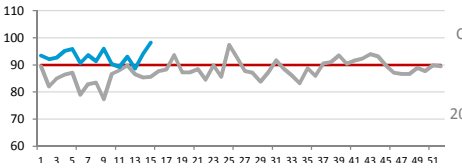
Current Wk **224**
2015/16 AVG **204**

30 Day Readmission Rate

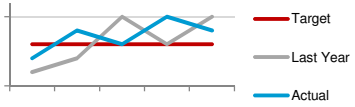


Current Wk **135**
2015/16 AVG **152**

% of LPT ICS Beds Used by Patients



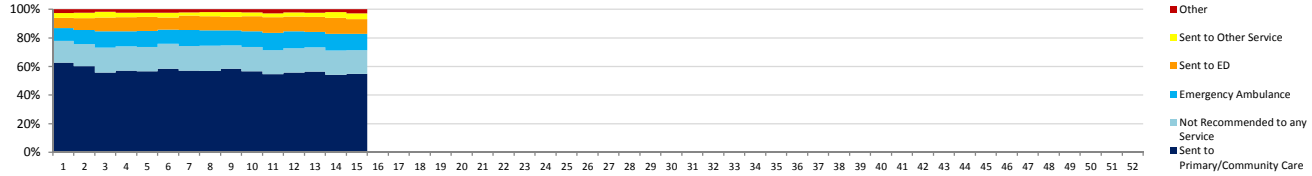
Current Wk **89.5%**
2015/16 AVG **87.9%**



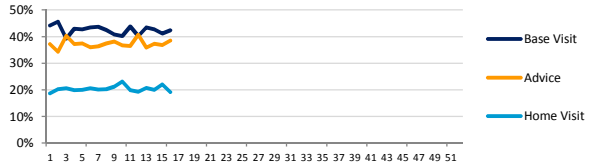
All Metrics are shown Weekly with the Year Running from 1st April

111 or 999

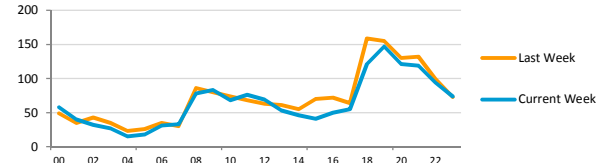
% of Dispositon of 111 Calls



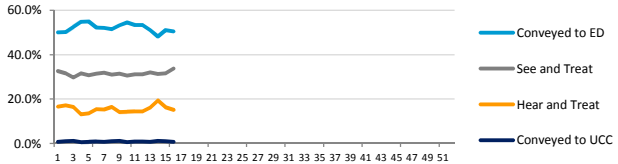
% of Disposition from Out of Hours

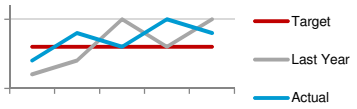


Time Profile of Out of Hours Patients



% of Disposition of EMAS Calls

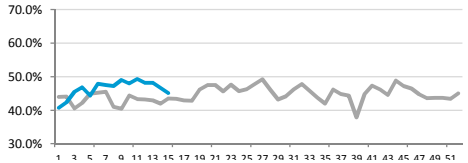




All Metrics are shown Weekly with the Year Running from 1st April

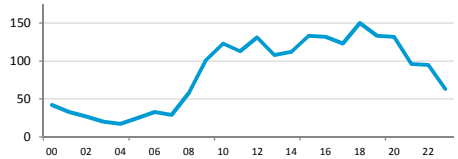
AE Interface

% of Outcome at LRI UCC



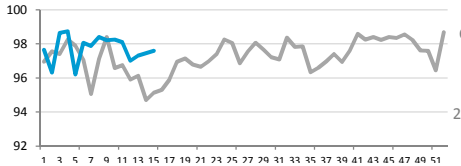
Referred
Current Wk
45.1%
2015/16 AVG
46.4%

Time Profile of LRI UCC Attendances



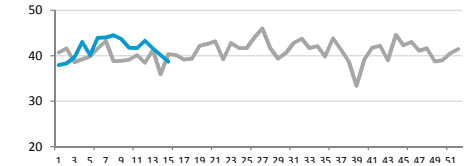
Last week affected by Incorrect UCC Data.

% of LRI UCC Triaged within 20 minutes



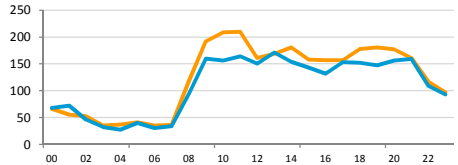
Current Wk
97.6%
2015/16 AVG
97.7%

% of Patient Transfers from LRI UCC to LRI ED

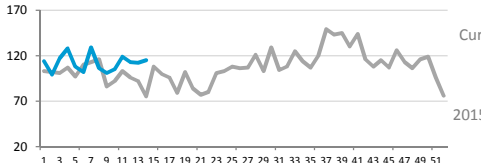


Current Wk
38.6%
2015/16 AVG
41.6%

Time Profile of UHL AE Attendances

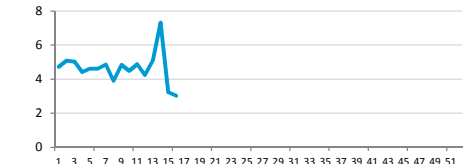


UHL Admissions with Ambulatory Care Sensitive Conditions



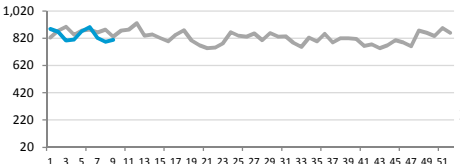
Current Wk
115
2015/16 AVG
112

% of AE VB11Z: No investigation with no significant treatment



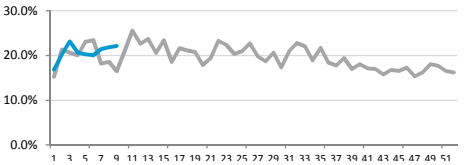
Current Wk
3.0%
2015/16 AVG
4.6%

Loughborough UCC Attendances



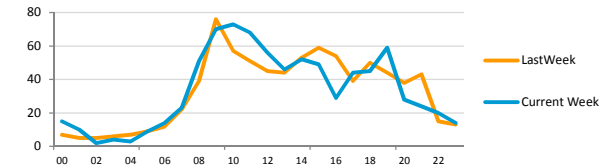
Current Wk
808
2015/16 AVG
841

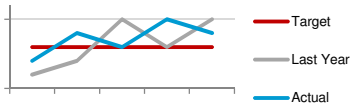
% Loughborough UCC Outcome



Referred
Current Wk
22.2%
2015/16 AVG
20.7%

Time Profile of Loughborough UCC Attendances



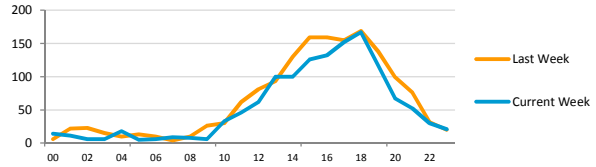


All Metrics are shown Weekly with the Year Running from 1st April

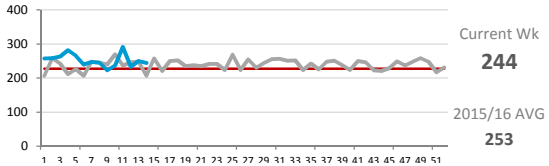
Updated to Sunday 19/07/2015

Additional Discharge

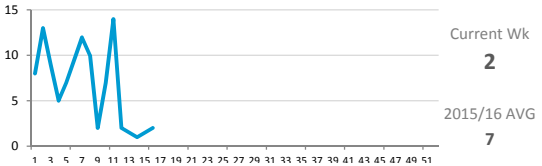
Time Profile of UHL EM Discharges



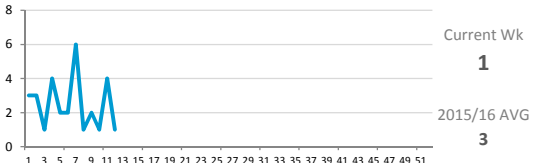
90 Day Readmission Rate



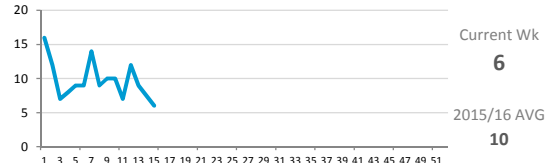
Number of Re-Beds (Arriva Aborts)

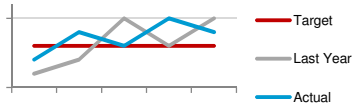


UHL Discharge to Assess Number of Patients - Pathway 1 & 2



UHL Discharge to Assess Number of Patients - Pathway 3

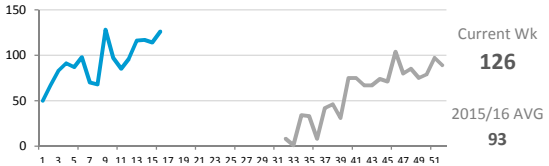




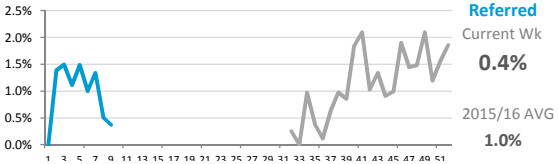
All Metrics are shown Weekly with the Year Running from 1st April

Crisis Resolution

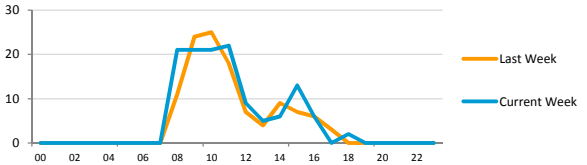
Patients Referred to Leicester City CCG Crisis Resolution Team Utilisation

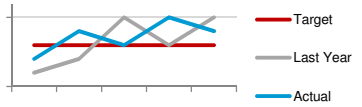


% of Outcome at Leicester City CCG Crisis Resolution Team



Time Profile of Leicester City CCG Crisis Resolution Team





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

Urgent and Emergency Care SRG Vanguard
Registration of Interest

Total word count (excluding Q1 and tables) = 1,153

Q1. Which network or system is making the application?

This is a System Resilience Group (SRG) level application from Leicester, Leicestershire & Rutland (LLR).Our SRG serves a large mixed urban and rural area with a population of 1.1 million peopleincluding 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, East Leicestershire & Rutland, and West Leicestershire)
- The three upper tier local authorities (Leicester City, Leicestershire County, and Rutland County)
- Arriva (patient transport service)
- University Hospitals of Leicester NHS Trust
- East Midlands Ambulance Service (EMAS)
- Leicestershire Partnership NHS Trust
- George Elliott (LRI Urgent Care Centre)
- CNCS (GP out of hours/Loughborough UCC)
- DHU (NHS 111)
- SSAFA (acute visiting services)

This application also has patient and public backing from the three LLR Healthwatchs 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.

NHS England is currently establishing a wider sub-regional Urgent & Emergency Care Network (UECN). This application is submitted with the explicit backing of both NHSE and the NTDA (we are a non FT economy so currently no direct Monitor role).

Our nominated contact is Toby Sanders, Accountable Officer of West Leicestershire CCG,who chairsourSRG & UCB (Toby.Sanders@westleicestershireccg.nhs.uk, Tel: 01509 567740).

Q2. What is your local vision for implementing the UEC review?

Our vision 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; enhancing recovery and reablement, and; reducing harm through integrated services that exploit innovation and promote care in the right setting at the right time.

Ours 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 organisationalboundaries. It is a vision which recognises the need to work together and ensure local consistency whilst interacting with neighbouring healthcare economies to realisebenefits of at scale, regional services.

Over the last six months our SRG has led a complete our UEC Improvement Plan; our 'Futures Group' (comprising clinicians, patients & managers)has developed our of how we will improve urgent and emergency care to deliver better outcomes for patients and a more efficient and sustainable (clinically and financially) system.

Our vision is informed by the principles of the Keogh review, but also responds to what we know about local health needs and service challenges from:

- Overarching Better Care Together 5 year plan for LLR health and care
- Independent review from Dr Ian Sturgess which highlighted fragmentation across care pathways and clinical variation in care models
- Learning Lessons mortality cases review which identified system issues particularly around care for older people with frailty
- Healthwatchexercise 'A Week at LRI' which gave an insight into patient experience and perceptions of service access and quality.

Care setting	Patient Outcomes refresh of
4 Emergency Acute Care	• Patients are guaranteed immediate response to time critical & life threatening need. • Patients can rely on a mobile response through 999 and have a care decision made in under 4 hours. • Patients will access intensive input to treat & care for episodes of crisis.
3 Urgent Care & Crisis Response	• Patients can access urgent advice, care, treatment or diagnosis 24/7. • Patients will receive consistent and rigorous assessment of the urgency of care need. • Patients can expect a response within 2 hours and completed care within 48/72 hours
2 Enhanced Routine Care	• Patients will receive proactive and targeted care delivered routinely and as part of a package of care; long or short term. • Patients will be cared for in a consistent and planned way. • Access will be same day, tomorrow &planned
1 Primary Care	• Patients will access Primary health care as the first active point of contact in the health and social care system. • Patients will have access to primary health care when needed on the same day, tomorrow or planned in advance.
0 Self- Care & Prevention	• Patients will easily engage with advice, support and information services. • Patients will be able to access these services without a referral. • Patients will have the ability to Choose Well.

This clear, shared and ambitions vision, together with our collective determination to achieve it, has shaped our system Improvement Plan and this Vanguard application.

Q3. What have you already achieved?

18 months ago we were identified as a 'challenged' health system with major financial and operational issuesincluding unacceptably low performance against A&E. Since then we have come together around our Better Care Together and UEC Plan and are proud that UHL is the 3rd most improved Trust nationally for A&E performance (Jan-June 2015 vs. same period 2014).Our achievements are measurable across three levels:

1) **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.

2) **Delivering quantifiable improvements in quality and patient responsiveness:**
   - A&E performance improving to 92% (av. YTD) from av. 89% in 2014/15
   - UHL DTOCrate reduced from 5.5% to 1.5%
   - Highest non-conveyance rate across the EMAS at av. 47%.

3) **Building strong system-level leadership for improvement across organisations**:
   - 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

- Strong clinical leadership and engagement across BCT & UCB programmes
- New provider models including all GP practices in at scale federations/hubs
- New large Alliance Contracts (planned care) involving UHL/LPT/GP providers & CCGs
- 15/16 contracting round completed without external arbitration.

Our clear vision, recent momentum and appetite for further rapid improvement sets us up to be a Vanguard ready to accelerateand share our transformational change journey.

Q4. Where could you get to by April 2016 and by April 2017?

The following five aspects of our Improvement Plan will offer the greatest potential for rapid improvement and replicable learning over the next two years:

1. **Integrated health and care, triage, navigation and hard scheduling**.
Patients tell us they don't know where to get advice and professionals tell us they can't keep up with expanding variety of alternative services and referral routes.

We will create linked servicesacross EMAS, NHS111, OOH and the local Single Point of Access (SPA) services for health and social care that get patients to the most clinically appropriate service, first time. This will reduce handoffs, avoid patients repeating their stories and reduce duplication.

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 • 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	• Re-procured fully integrated NHS111 • Implemented 1st stage of SPA integrated • Connected triage services with real time activity information to inform resource deployment and hard scheduling of referrals

2. **Consistent and networked local community urgent response, in and out of hours**
Patients tell us that they go to A&E because they are not clear what other services are available, how to access them and they don't want to be passed from service to service.

We will create 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 be underpinned by care planning and record sharing.

By April 2016 we will have…	By April 2017 we will have…
• 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	• Re-procured fully integrated OOH 'plus' model • Established care plan sharing platform

3. **LRI urgent care front door ambulatory assessment model**.
Patients and staff tell us the clinical pathways at the LRI A&E/UCC front door create delays, are confusing and too variable.

We will redesign the front door 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 new ED floor layout (open early 2016) will support this.

By April 2016 we will have…	By April 2017 we will have…
• Piloted single assessment service through UHL with Lakeside • Completed new ED floor development • Implemented standardised emergency ambulatory pathways	• Fully integrated new clinical assessment function into long term provider model • Developed local GP and nursing skill mix to provide sustainable workforce • Extended the range of out of hospital services for referral

4. **System-wide contracting for transformation**.
We know that current contracts, payment mechanisms and measuresdo not appropriately or adequately incentivise the required system behaviours.

This year we developed a local 'year of change' contract with UHL for emergency activity. Using our experience of Alliance contracting we want to develop a new urgent and emergency care alliance based model that incentivises providers to work as a network. We will underpin this with new measures of clinical quality and patient experience, expanding our UCB Dashboard to be increasingly whole system and clinical outcome focussed.

By April 2016 we will have…	By April 2017 we will have…
• Reviewed 14/15 'year of change' contract arrangement • Scoped alliance/network contracting model • Identified system clinical quality measures	• Completed shadow year and entered new alliance contract with aligned payment mechanisms • Embedded clinical quality and patient experience measures into contractual framework

5. **Operational resource deployment through predictive demand, capacity and activity modelling**.
Providers and commissioners know we struggle to predict and respond to surges in demand despite our wealth of trend data.

We will work with the national team and locally with IBM and Loughborough University Simul8 model to develop the 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.

By April 2016 we will have…	By April 2017 we will have…
• Completed development and testing of new model • Scoped options for extending this into operational tool	• Daily use of tool based resource deployment (staffing/bed capacity/crews) • Real time activity and capacity information feeding professional and patient facing information

Delivery of improvements and benefits realisation in terms of quality, patient responsiveness and system efficiency (moderating the increase in emergency attendances/admissions) will be governed by our existing UCB with issues requiring collective agreement or resolution escalated to our existing SRG.

Q5. What do you want from the structured support programme?

We believe the improvements we are making locally are replicable and relevant across our UECN and nationally. Being a Vanguard will allow us to adopt enabling levers early to accelerate change and shareour good practiceand learning.

In return we seek support the national bodies in five areas:

1. **Access to experience and learning** from other Vanguards
2. **Early implementer status** - for new NHS111/OOH service, demand/capacity model and new quality measures
3. **Contracting flexibilities and technical support** - to adopt a networked/alliance approach to multi-provider contracting and payment
4. **Sponsorship and expertise from national clinical leaders**–a critical friend in the development of new models
5. **Transformation funding** – to accelerate the pace and scale of delivery.

Leicester, Leicestershire and Rutland: Urgent & Emergency Care System Improvement Plan

2015/16

Contents

FOREWORD

To be completed
Signatures also required from Leicester City Council &Healthwatch to be inserted on final page

This document sets out the 2015/16 improvement plan for Urgent and Emergency Care in the Leicester, Leicestershire and Rutland health and social care economy. It is a reference document for the system over 2015/16 which is supported by the more detailed Urgent and Emergency Care Action Plan and represents the collaborative approach we are taking to improve services for our local population.

The focus of the document is the "Programmes of Change" section comprising chapters 4, 5, 6, 7 and 8. These chapters detail action plans for each of the sub-groups of the Urgent Care Board; Inflow, Flow, Out of Hospital Transfers, Future Group and Communications. The focus areas under each sub-group demonstrate how together we are taking tangible steps to improving urgent and emergency care services.

We look forward to continuing to work more effectively and efficiently with our partners and providers, so that we continue to make a positive difference to the health and wellbeing of our population.

Toby Sanders
Managing Director, West Leicestershire CCG

Tim Sacks
Chief Operating Officer, East Leicestershire & Rutland CCG

Sue Lock
Managing Director, Leicester City CCG

John Adler
Chief Executive, University Hospitals Leicestershire

Richard Henderson
Director of Operations, East Midlands Ambulance Service

Pete Miller
Chief Executive, Leicester Partnership Trust

Helen Briggs
Chief Executive, Rutland County Council

Tony Dailide
Assistant Director, Adult Social Care, Leicestershire County Council

Paul Willets
Director of Governance & Quality, Arriva Transport Solutions

Signature pending committee approval of UEC Improvement Plan

Ruth Lake (tbc)
Leicester City Council

Sarah Hull
Medical Director, Central Nottinghamshire Clinical Services (CNCS)

Signature pending

Healthwatch

Stephen Bateman
Chief Executive Officer, Derbyshire Health United (DHU)

Robert Gorringe
Assistant Director, Strategy & Development SSAFA Care CIC

Introduction & Strategic Context

1. Introduction

Clinical Commissioning Groups (CCGs) were requested by NHS England (NHSE) to submit refreshed operational plans in May 2015 with a specific focus on demonstrating how as a system they were meeting eight high impact interventions for urgent and emergency care. This improvement plan builds on this request from NHSE and demonstrates tangible in year actions to improve the urgent and emergency care system in Leicester, Leicestershire & Rutland (LLR).

This plan brings together a system-wide narrative for 2015/16 urgent and emergency care priorities for improvement and delivery across LLR and provides the strategic framework within which the local system will operate. As such, it is intended to be used as a reference document that is jointly owned across partners within the local health and social care economy. It will help to ensure that the system is progressing jointly agreed priorities and is taking the necessary steps towards the 5 year future model. Ultimately, this plan represents the 'one version of the truth' for the local health economy to help guide and shape local delivery.

The document explains how urgent and emergency care links in to the Better Care Together (BCT) programme but concentrates more broadly on system-wide approaches and principles for 2015/16 Urgent and Emergency Care improvement. This plan will not give detail of specific CCG initiatives as the focus is on system ownership of the improvements required rather than organisational plans.

1.1 *Context*

1.1.1 The LLR health and social care economy is comprised of the 3 Clinical Commissioning Groups (CCGs); Leicester City CCG, East Leicestershire & Rutland CCG and West Leicestershire CCG, together with Leicestershire County Council, Leicester City Council, Rutland County Council, University Hospitals of Leicester NHS Trust (UHL), Leicestershire Partnership NHS Trust (LPT) and East Midlands Ambulance Service (EMAS), Arriva, Central Nottinghamshire Clinical Services (CNCS), Derbyshire Health United (DHU), George Eliot, Healthwatch and SSAFA.

1.1.2 Despite facing significant challenges in meeting key national performance standards during 2014/15 thelocal health economy has a good track record of partnership working together inan 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.

1.2 *Programme Governance*

1.2.1 The programme governance structures in place are shown in the diagrams below (Figures 2 & 3). These describe the governance of the local Urgent and Emergency Care system and shows links with the wider BCT programme.

1.2.2 LLR has in place an Urgent Care Board (UCB) comprising of providers, commissioners and patient representative thatcollectively own the challenges faced and holds the system to account. The Board has strong clinical and patient representation. As per its Terms of Reference, the Board provides direction to the urgent and emergency care programme of work and takes decisions including approval of projects, products, budgets and plans. It advises on and signs off use of non-recurrent funds. The Board meets every other week. It is the forum

whereby all partners are held to mutual account and is itself accountable to the System Resilience Group (SRG).

1.2.3 Reporting into the UCB are 5 sub-groups with the responsibility for delivering their strategic objectives to support system level improvement. The sub-groups are detailed below in Figure 1 and represent the patient's journey. There is Patient and Public Involvement (PPI) representation on the Future Group and this will be rolled out across the other sub-groups. The sub-groups provide updates to the UCB on a 4 weekly rotation.

Figure 1: Sub-Groups of the Urgent Care Board

Sub-Group	Focus
Inflow	Pre-hospital pathways which include; admission avoidance, access to services, community based services to support assessment and treatment closer to home and optimization of ambulatory pathways within the community setting.
Hospital Flow	Processes within A&E and the hospital to streamline and co-ordinatepatient flow, improve leadership and identify blocks in the system.
Out of Hospital Transfers	Stream lining transfer pathways and reducing delays in the processes across all parts of the system and by all partner organisations. It identifies blocks, duplication or variation and takes action to resolve these thereby simplifying the process.
Future Group	Supports the strategic direction of the urgent and emergency care pathway by articulating a common vision and shared system principles to support local delivery. It enhances the partnership working to enable longer term actions to be shaped for delivery.
Communications	Development and co-ordination of communications plans and resources in support of the UCBsub-groups.

1.2.4 The UCB reports into the System Resilience Group (SRG). This group is a national requirement and has strategic oversight of the joint planning arrangements for service delivery of elective and non-elective care. Membership includes senior officers from the local health economy partners together with representatives from NHSE and the NHS Trust Development Authority (TDA).

1.2.5 Urgent Care is also one of eight clinical workstreamsin the local BCTprogramme; a transformation agenda which sets out a vision to improve health and social care services across LLR.

Figure 2: Structure chart of LLR Programme Governance

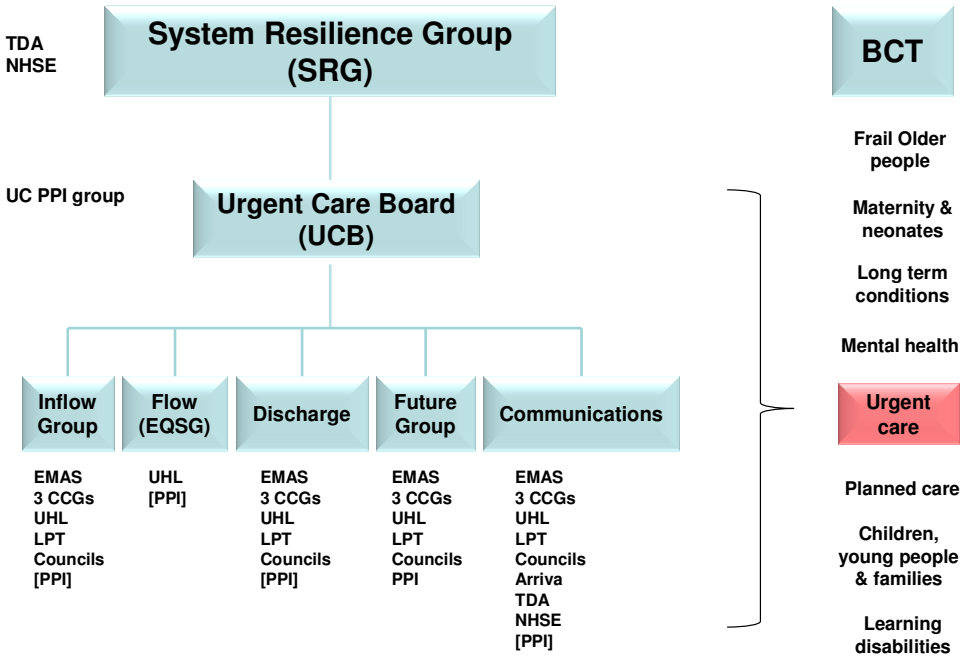
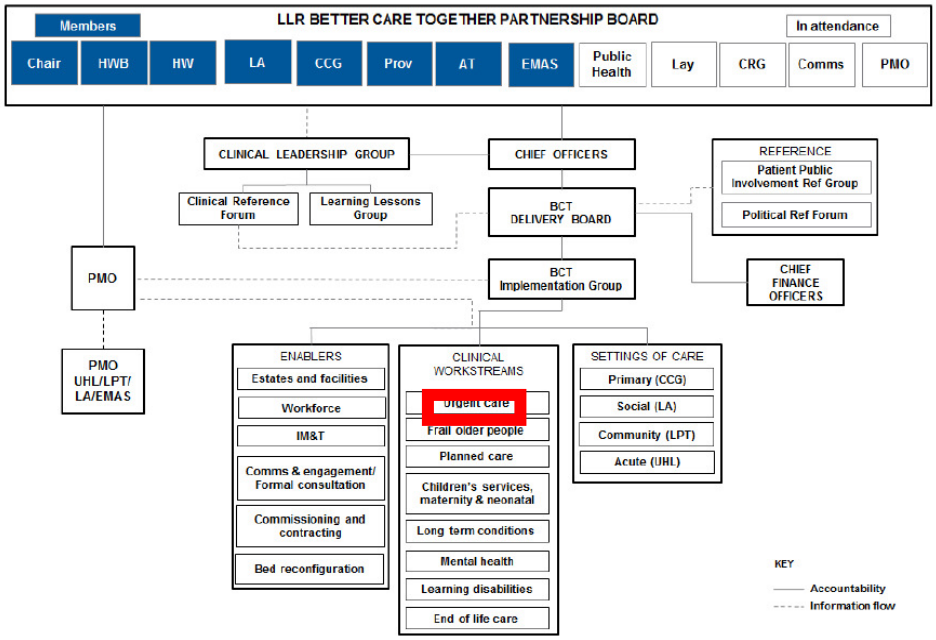


Figure 3: Better Care Together Programme Governance



1.3 *Document Structure*

1.3.1 The overall document sets out the 2015/16 improvement plan for Urgent and Emergency care in LLR. It is divided into a number of sections:

- Sections 1 – 3 describe the current context, the challenges faced and the 5 year strategic direction.
- Sections 4 – 8 are the main body of the report and detail how the sub-groups of the UCB each have clear areas of focus for 2015/16 to drive the 5 year strategy (transformation programme).
- Sections 9 and 10 detail how the success of the urgent and emergency care programme will be measured and sets out the aspirations for delivery within the context of contract targets and the benchmarks for success.
- Section 11 highlights key risks and mitigating actions and how system resilience is ensured.

2. Strategic Direction: LLR's future model of urgent and emergency care

2.1 *National Context*

2.1.1 The NHS is facing significant challenges in delivering effective and efficient healthcare with services and finances experiencing increasing pressure. A population that is living longer, lifestyle factors impacting negatively on health and increasing public expectations have led to increases in the use of health services, with patients often accessing services that are of greater intensity than they need with an over reliance on hospital based services.

2.1.2 This reliance on hospital services has led to increasing numbers accessing A&E departments and minor injury units. In 2013/14 this figure was 21.7mcompared to 16.5m in 2003/04. This significant increase has stretched the ability of the departments to manage this demand effectively.

2.1.3 The national Keogh review of Urgent and Emergency care (November 2013) summarisedthe 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.
- 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.

2.1.4 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.

2.2 *Local Context*

2.2.1 Leicester, Leicestershire and Rutland's 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

[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

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).

2.2.2 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.

2.2.3 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.

2.3 *Future Model of Urgent and Emergency Care in LLR*

2.3.1 The Future Group sub-group has been tasked with designing a model of urgent and emergency care for LLR to be in place by the end of the next 5 years (see Figure 4 below).The main aim of the future model is to ensure that system improvements tackle the issues patients are currently facing. Its specific objectives are to provide patients withequitable and prompt access to services wherever they are in LLR and whichever 'tier' of care setting they enter the system at. It will ensure thatlocal 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 should be supported at every stage.

2.3.2 These objectives were summarised in a clear set of System, Care Setting and Patient level outcomes and principles which are set out in Appendix A. The agreed principles will ensure a systematic and consistent approach to the changes needed to improve the urgent and emergency care system. They are based on evidence drawn from local and national reviews and are contributed to by all partners in the LLR system. These principleshave informed the development of a high level model of urgent and emergency care that will be implemented over the next 5 years.

2.3.3 Section 7 in this document details how this high level model is being developed into a more detailed system scope (Focus Area 3) which will explain what interventions, treatments and services are needed under each care setting.This section also details the 2015/16 focus areas of the wider transformation plan which take us towards the future model of urgent and emergency care.

Figure 4: High level model of urgent and emergency care

0- Self Care	1- Primary Care	2- Enhanced/Routine Care	3- Urgent Care and Crisis Response	4- Emergency and Acute care
Right Care: patient decision aids	General Practice	**Enhanced care planning:**	**24/7 SPA: 999/111/OOH SPA all interoperable with one single assessment**	Acute medical / surgical care
Health Coaching	Comprehensive disease registers	Risk stratified population: Managing the high risk 10-20%	**Clinical triage at single point of access**	Emergency Department: Majors and Minors
First Contact- multi agency support	Primary care nursing and ANP support	Integrated and proactive care planning using standard shared care plans and records	Direct booking to local services	Cardiac arrests
Lifestyle Hub-city	ECG/Spirometry/INR NPT in federated hubs.	EOLC pathways and plans	**Rapid Response services:**	Stroke
Public health schemes you can access yourself	2% at risk patients profiled and managed	Supported residents reviews	-Leicester care alarm & falls response	Trauma
Weight management	7 day access and working between practices	**Enhanced management:**	-Fast Response Vehicle + see & treat ambulance	Neuro
Alcohol and drug misuse	Expert patient programmes	Community health and mental health wraparound services	Acute Visiting Service (West)	Paeds
Smoking Cessation	Dementia care advisors	Case management through virtual ward schemes	Integrated crisis response Service	Major Trauma Unit- out of county
Sexual Health	Optometry services	'Locality' health and social care teams targeting at risk and case managed patients (HSCCs)	CRT (City) Clinical Response Team MH Assertive Outreach	Maternity
Wider community & vol. sector support	Dental surgeries	Key workers	Psychosis Intervention and Early Recovery (PIER)	Neonates
Local Area Coordination/ Local Support Groups	Community Pharmacies	Case workers	**At increased risk group:**	Discharge date and pathway agreed at point of admission
Healthy Cities Programme		Direct booking in to primary care	Pharmacist lead medication reviews	Mental health acute admissions
Customer portal; self assessment and signposting		Falls response team- trusted responders	Palliative care and night nursing	
Carers and Young carers support and training		**Remote monitoring:**	**Urgent care centres**	
Dementia cafes		Tele care	Standard offer across Urgent care centres	
Integrated housing support service		Tele health	Comprehensive assessment (including CGA)	
Falls prevention information			Ambulatory care sensitive conditions pathways with access to MDT: asthma, COPD, Heart Failure, DVT, Cellulitis	
		Step up/down services:	**Frailty hubs/ Older people's unit**	
		Domiciliary care		
		Intensive primary care/ social care interventions immediately following discharge	Observation "beds"	
		Intermediate care beds: social care	Community diagnostics (digital links/ near patient testing)	
		Residential and non-residential reablement services	ECG/X Ray/Ultrasound	
		Intensive Community Support	Pathology/Phlebotomy	
		Community hospital inpatient care (length of stay 0-5 days- increased acuity and throughput)	Intravenous procedures: Diuretics, antibiotics	

IMT: 1 shared primary care system. Standardised and accessible care plans and risk stratified approach to promote continuous care planning. One SPA with clinical assessment at point of contact and local alternatives available for direct booking: eDOS. Customer portal and single point of information. **Workforce**: skill-mix mapping and redesign across sectors. Understand impact of shift in services "to the left" and increase in acuity of patients managed in the community **Premises**: understanding virtual and physical hubs/ footprints. link to City premises review **Other**: Demand/ capacity whole system modelling. Capacity management & early warning system/ emergency planning system.

2.3.4 The LLR local health and social care economy has been working to achieve a significant 'out of hospital shift of activity' from acute settings into more appropriate care settings within the community with more care being offered closer to home. LLR have applied an aspirational reduction of 6% and 7% for A&E attendances and emergency admissions respectively on the 2016/16 contract baselines. These reductions are owned across the system and each CCG has their own apportioned reduction.

2.3.5 This improvement will be captured in the following system-wide indicators which monitor 'out of hospital shift' of activity:

- Reduction in attendances to Leicester's Emergency Department (ED).
- Reduction of emergency admissions at Leicester's Hospitals.
- Consistent achievement of the national 4-hour emergency care standard.

Current Challenges & Performance

3. Current Position and Challenges

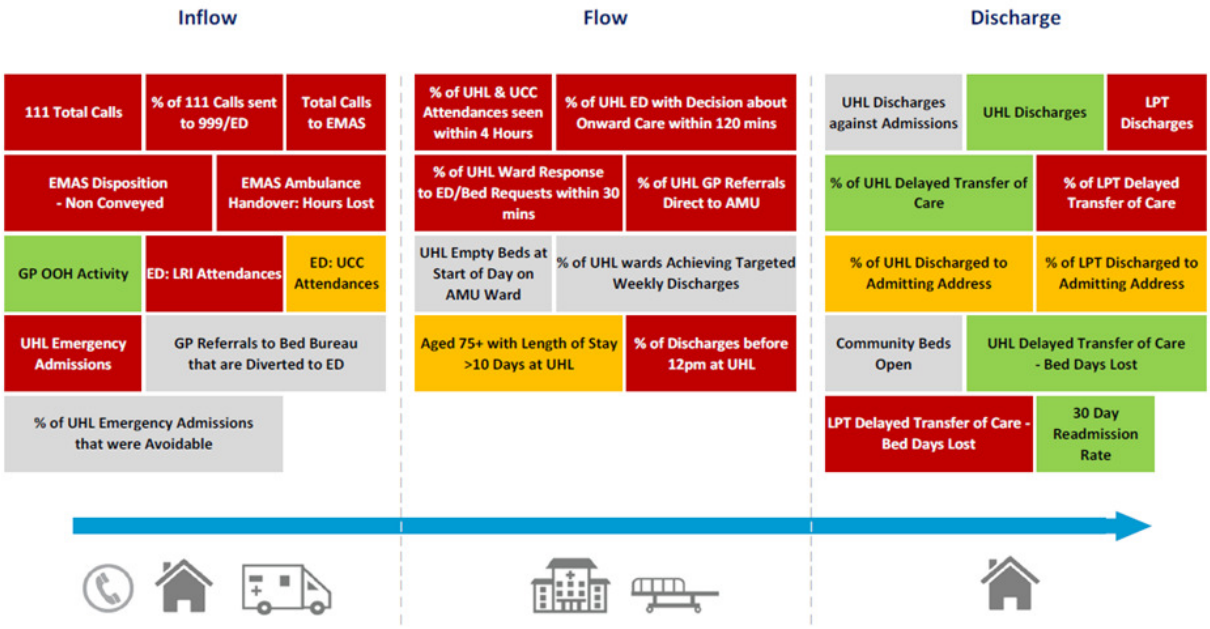
This chapter describes the current performance of the Urgent and Emergency Care system in LLR and includes specific areas of challenge. This section also explains howthe impact of focus areas and actions will be monitored across the urgent and emergency care system to ensure delivery of improvements in performance and services.

3.1 *Urgent Care Dashboard*

3.1.1 The Urgent Care Dashboard comprisesof 30 indicators whichmonitor system performance, split between 3 of the 5sub-groups: Inflow, Flow and Discharge. All the indicators are owned by the sub-groups they align to with the understanding that the overall performance improvement of the system is a shared responsibility owned by the UCB. The dashboard is produced weekly and formally reviewed at each UCB meeting with a key emphasis on variation from plan and trend change.

3.1.2 The dashboard is RAG rated per indicatorsagainst set targets (either from contracts or jointly agreed at UCB) to provide a snapshot of system performance at a glance[2] as per the diagram below:

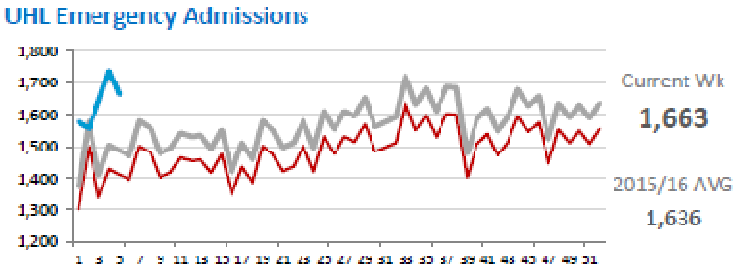
Figure 5: Dashboard snapshot view of system performance



For each indicator there is a graph that reflects the weekly performance against target and against last year and year to date average. This is shown on the next page for UHL emergency admissions:

[2]The grey area identifies those indicators without defined targets.

Figure 6: UHL Emergency Admissions weekly performance 2015/16



Recognising that the UCB Dashboard is system level, each of the 3 sub-groups has identified a further set of metrics to create sub-dashboards to enable more in-depth analysis.

3.2 *Key Challenges*

3.2.1 The health economy is experiencing high demand for urgent and emergency care and system pressures are highlighted and monitored by the following key metrics (Please see Appendix B for each metric's performance graph for 2014/15):

- A&E attendances and waiting times.
- Emergency admissions.
- Ambulance handovers and conveyances.
- Delayed transfers of care (DTOCs).

3.2.2 A&E Performance (Attendances):

At the end of 2014/15, attendance figures for the year were 152,227 which was an increase of 116 patients from2013/14. Whilst the outturn was very similar to 2013/14, activity against the contract plan showed an increase of 11%. This is an area of focus for the Inflow group for 2015/16.

Whilst the forecast activity for Leicester Urgent Care Centre (UCC) in 2014/15 was broadly in line with plan (99,996 forecast vs. actual of 99,087 attendances) the UCC currently triages approximately 30% of the patients they see into the emergency department based on acuity or access to specialist pathways. Work will be undertaken to reduce this figure from 30% in 2015/16.

3.2.3 A&E performance (4 hour target):

Over the last 2 years the system has faced significant challenges in meeting the national A&E 4 hour target with persistent under performance. The report by Dr. Ian Sturgessstressed the importance of this target as a reflection of the whole health and social care system.

During 2014/15 A&Eperformanceat UHL against the 4 hour target was not sustained above 95% however with a performance average of 89.1% this is still an improvement on the 2013/14 average of 88.4%. In 2015/16 the system will aim to meet the 95% target.

3.2.4 Emergency Admissions:

By the end of 2014/15 emergency admissions had increased by 18% against plan and by 6.28% against the 2013/14 outturn.Over the year the figure rose from an initial 1370 admissions per

week in April 2014 to 1663 per week by the end of March 2015. This trend was reflected nationally.

In April 2015 there were higher admission rates than the 2014/15 outturn and actions to address this are being picked up within the Inflow and Flow sub-groups.Increasing admissions rates can only be managed effectively if there is an incremental rise in the number of discharge over the same period. Weekly admission and discharge rates tend to reflect a balanced position but there is significant variation on a daily basis which impacts on flow and overall performance.

3.2.5 Ambulance Handovers:

The national standard for ambulance handover at hospital is 15 minutes. During 2014/15 performance ranged from a monthly average handover time of 20 to 31 minutes. In April 2014 the total hours lost to delayed handover was 802 hours rising to 1322 hours in March 2015. Ambulance turnaround delays continue to be a challenge for EMAS in terms of releasing crews to respond to waiting calls but it is also a challenge for the acute trust in terms of avoiding patients being held on the back of ambulances.

3.2.6 Ambulance Conveyances:

During 2014/15 the ambulance service have focused on increasing the number of patients they'Hear, See and Treat' to prevent inappropriate ambulance conveyance to A&E. There was an increasing trend for non-conveyance, starting the year with rates of 44% and by the end of the year averaging 46%. Overthe Christmas periodnon-conveyance rose to above 50%. The plan for 2015/16 is to achieve and sustain non-conveyance rates above 50%

3.2.7 Delayed Transfers of Care (DTOC):

DTOCs rates had been consistently above the national target of 3.5% or acute patients for the first 9 months of 2014/15,which means more patients were delayed than nationally expected. Significant work was undertaken with both UHL and LPT to ensure consistent application of the national DTOC guidance but more importantly to introduce the daily rigour of chasing DTOC blocks. As a result improvements were made in December 2014 which brought performance below the national target of 3.5%. The current challenge is to sustain improvements over 2015/16 to meet the new national target of 2.5%. Early performance within 2015/16 has been below 2.5%.

The DTOC rates for Community Hospitals within LPT indicate an increase from the beginning of November 2014 with an average rate in April 2015 of 8.8% against an aspirational target of 6.5%. Analysis shows that there are challenges in some rural areas of LLR in relation to domiciliary packages of care (where this is the case bridging packages are offered but at times family chose not to take the interim package),and delays by families in making the choice for discharge location.Improving DTOC rates for mental health beds will require greater focus during 2015/16.

3.2.8 At UHL only 11% of discharges take place before midday which creates discharge pressures late afternoon/early evening. This in turn means beds are not available for patients to come in to and can create a bottleneck in A&E with patients waiting for beds. There has also been no sustainable progress made over the last 12 months to reduce the numbers of patients who are over 75 with a length of stay over 10 days.

3.2.9 Primary care is also experiencing a high demand for their services and this also impacts on urgent and emergency care provision. For many people a visit to their GP is the most common form of contact with the NHS. Nationally each year, 340 million appointments are made with

GPs. 90% of all patient contacts in the NHS are with a GP.Increasingly there is recognition that general practice is over-stretched and under-resourced, and patients are becoming increasingly concerned with timely access.

Analysis by the Nuffield Trust indicates that activity in a sample of general practices increased since 2010. The total number of consultations rose by around 11 per cent and the number of consultations per person per year registered on a practice list also rose – from 7.6 to 8.3 %[3]. This is in line with what we would expect from trends over the previous decade and reflects the sense of GPs across LLR. The rise in the number of patients requiring longer and more in-depth consultations due to complex health needs, time pressures from non-clinical work; and increasing workloads all add to the pressures faced by general practice.

There are mounting concerns nationally and locally that inability to access primary care in a timely way when needed, adds to the pressure on other parts of the system, largely A&E. This imbalance needs to be redressed through an accessible range of services out of hospital that respond to both the planned and unplanned needs of patients.

3.3 *Summary*

3.3.1 Whilst performance targets provide an indicative measure of effectiveness within a defined area, the system needs to understand the challenges and gaps that prevent optimisation of the pathway and care delivery. LLR is experiencing a number of key challenges to service delivery:

- The inability to offer consistent services 7 days a week.
- Lack of consistency across service offers and across geographies.
- Lack of staffingto meet demand.
- Complex and multiple discharge pathways.
- Ineffective integration of services.

The sections below demonstrate how each of the UCB sub-groups is tackling these issues to improve system performance and improve services for patients.

[3] http://www.nuffieldtrust.org.uk/blog/fact-or-fiction-demand-gp-appointments-driving-crisis-general-practice

Programmes of Change

2015/16

The Focus Areas within each sub-group will be delivered through a Programme of Change which is outlined in the following sections (4-8). The agreed actions will be held to account through the Urgent Care Board and each month the sub-group leads will provide detailed feedback on progress and risks to delivery of the plan.

The NHSE 8 High Impact Interventions are introduced within each relevant Programme of Change section. Appendix C contains the full NHSE submission made by the 3 CCGs.

4. Programme of Change: Inflow

4.1.1 Overview

The LLR Inflow sub-group focuses on a whole system approach to demand and capacity management in the out of hospital setting, exploring solutions for more localised and consistent pre-hospital care. The prevention of inappropriate use of secondary care services is a crucial element to decreasing pressure on emergency services.

Locally, patients are continuing to use acute services inappropriately reflecting a mismatch between need, setting and provision of care. Many A&E attendees are admitted for conditions which would not need hospitalisation had earlier proactive management in the community been in place.

The Group meets monthly and the following organisations are represented:

- LLR Urgent Care Team.
- West Leicestershire, East Leicestershire & Rutland and Leicester City CCGs.
- East Midlands Ambulance Service (EMAS).
- University Hospitals of Leicester (UHL).
- Derbyshire Health United (DHU) (provider of NHS 111 services).
- Central Nottinghamshire Clinical Services (CNCS) (providers of OOH services and Loughborough Urgent Care Centre).
- George Eliot Hospital (providers of the Leicester Urgent Care Centre).
- Soldiers, Sailors, Airmen & Families Association (SSAFA) (providers of the Clinical Response Team and the Acute Visiting Service).

4.1.2 Currently there are five system-wide agreed Focus Areas for Inflow set out in this section. A monthly update report is provided to the LLR Urgent Care Board as part of the monitoring and governance process. The Inflow Group has established two sub-groups: partnership working around care homes, and care planning. Both sub-groups provide monthly action plan updates to the Inflow Group.

4.1.3 The focus areas aim to drive the planned reductions in A&E attendances (reduction of 6%) and emergency admissions (reduction of 7%) and drive the planned increase (increase of 4.8%) in utilisation of alternative urgent care services i.e. Urgent Care Centres. There will also be an increase in alternatives to admission by GPs, EMAS and care homes (CCG-specific trajectories to be shared to develop an LLR-wide trajectory).

Figure 7: A&E Attendancesat Leicester Royal Infirmary (LRI) 2015/16 – reduction of 6%

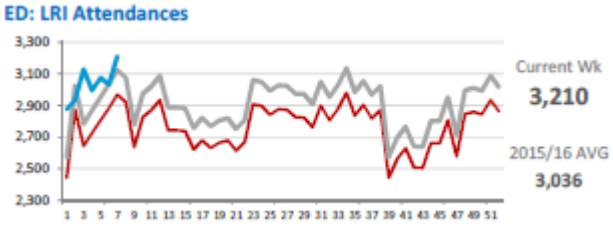


Figure 8: UCC Attendances 2015/16 – increase of 4.8%

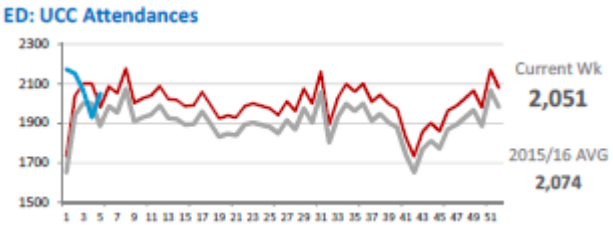
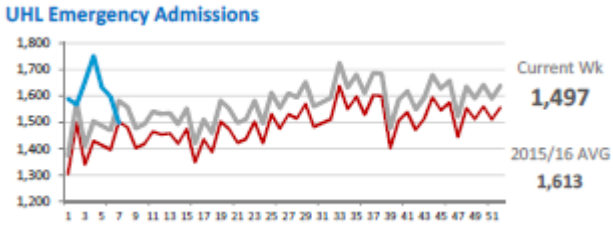


Figure 9: Emergency Admissions at UHL 2015/16 – reduction of 7%



4.2 *Focus Area 1: Alternative to Admission*

Maximising use of alternatives to admission in primary and community care settings

4.2.1 Work to date

Work is focused on optimising all non-acute pathways of care to reduce people presenting at A&E and/or being admitted when appropriate community alternatives exist. Work to date has focused on supporting GPs, EMAS and care homes to use alternatives to admission. There are month on month increases in the use of these alternatives by all of these groups although there is still some way to go.

4.2.2 Impact

- Reduction in planned attendances (6%) and admissions (7%)

4.3 *Focus Area 2: Access to General Practice*

(A) Improving access to General Practice both in hours and out of hours

4.3.1 Work to date

The Inflow sub-group has developed a range of schemes to support the primary care surge during the winter period. The learning that will be gained from these schemes within 2015/16 will inform the planning for winter 2015/16. This will also further develop the 7-day primary care offer and enhance the range of services supporting general practice. The RCGP 'Patient Access to General Practice: Ideas and Challenges' and the 'Wave 1 Prime Ministers Challenge Fund' will be reviewed to inform future work.

High Impact Intervention 1:

No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out of hours services.

In addition to the plans in place as described above, please see Appendix C for the full submission made to NHSE.

(B) Responding to requests for GP home visits earlier in the day

4.3.2 Work to date

There is a need to ensure that patients requesting GP urgent home visits are seen earlier in the day to avoid significant numbers of patients arriving together at hospital during the later afternoon and to increase the number of patients who are discharged on a same-day basis. Work to date has focused on timely triage and appropriate referral onto services targeted at managing patients in their own home e.g. the Leicester City Clinical Response Team or the West Leicestershire Acute Visiting Service. Monthly reviews have evidenced an ongoing increase in the numbers of referrals to these services which enable patients to be managed at home. Focus will be on the consolidation of an in-car visiting service for LLR and work with EMAS to develop a more rapid response to GP requests for ambulances for patient admissions. Inter-agency referrals for patient care to avoid acute interventions will aim to wait no more than sixty

minutes. Targets will be agreed for the reduction in the number of patients being referred to A&E and for the number of patients directly admitted to a hospital ward without A&E input.

4.3.3 Impact:

- Percentage reduction in A&E attendance and Emergency Admissions.
- Increase in alternatives to admission by GPs, EMAS and care homes (CCG-specific trajectories to be shared to develop an LLR-wide trajectory).
- Audits to confirm an average 60 minute response time to GP Urgents by EMAS.
- 80% of patients requiring conveyance to hospital to be on an acute provider site by 13:00 daily.
- Month on month increase in direct admissions to wards rather than being held in A&E awaiting a bed.

4.4 *Focus Area 3: Care Homes support*

Maximise effectiveness and consistency of support to care homes across LLR

4.4.1 Work to date

All CCGs have worked to increase the level of support to care homes both in hours and out of hours. Examples include care homes having the GP back office contact numbers, the Falls Decision Tree with local checklists and the summary of appropriate support services both in and out of hours. Nursing homes also have direct access to the OOH Health Care Professionals telephone advice line although uptake is low at present. Each CCG has dedicated care homes pharmacy support and West Leicestershire has also provided some dedicated care home staff support training. In the City, care homes have direct access to CRT to further support proactive care at home. There is a differential offer across LLR which now needs to be addressed.

4.4.2 Work plan 2015/16

The main aim of this work plan is to consolidate all current work streams and associated task groups into one LLR-wide care homes forum to ensure that by the end of Q3 there will be one approach that maximises all opportunities for care homes support. Month on month increases in direct referrals from care homes to wider support services will be delivered and ensured that, prior to any decision to admit, a senior clinical review has occurred both in hours and out of hours.

4.4.3 Impact

Increase in alternatives to admission by GPs, EMAS and care homes (CCG-specific trajectories to be shared to develop an LLR-wide trajectory).

4.5 *Focus Area 4: Care Planning*

Ensure the delivery of effective care plans and the sharing across relevant agencies

4.5.1 Work to date

Personalised care plans have been completed for the risk stratified top 2%[4] of the population to ensure that all appropriate care is delivered in a 'home first' environment, patients' wishes are adhered to and they are not unnecessarily conveyed to A&E. The audit of care plans indicates inconsistencies in both content and quality and in how they are shared across services to inform the care of patients. This will be addressed by implementing a consistent approach to care planning and an electronic solution to how they are shared. A mechanism for the sharing

[4] These are the 2% of patients who are most at risk from an unplanned hospital admission.

of care plans with all partner agencies will be agreed and rolled out in year. The use of care plans by all relevant organisations will be monitored.

4.5.2 Impact:

- Increase in alternatives to admission by GPs, EMAS and care homes (CCG-specific trajectories to be shared to develop an LLR-wide trajectory). There will be a demonstrable increase in care plan utilisation to inform the best pathway for the patient.

4.6 *Focus Area 5: Clinical Triage*

Maximising clinical triage to aid decision making prior to an A&E or Ambulance disposition being made

4.6.1 Work to date

The opportunities for increasing clinical triage at the various patient-facing points of contact across the LLR health economy have been reviewed i.e. NHS 111, EMAS and OOH. In 2015/16 these enhanced approaches to patient signposting and interventions will be implemented to maximise out of hospital care including the use of 'See and Treat' in local ambulance services. This will require better access to clinical decision support and responsive community services.

4.6.2 Impact

- There will be improved utilisation of all referral pathways across both health and social care services. The EMAS non-conveyance will be a minimum of 50% without suitable associated re-contact rates.

High Impact Intervention 3:

The local Directory of Services supporting NHS 111 and ambulance services should be complete, accurate and continuously updated so that a wider range of agreed dispositions can be made.

In addition to the plans in place as described above, please see Appendix C for the full submission made to NHSE.

High Impact Intervention 4:

SRGs should ensure that the use of See and Treat in local ambulance services is maximised. This will require better access to clinical decision support and responsive community services.

In addition to the plans in place as described above, please see Appendix C for the full submission made to NHSE.

4.6.3 Workplan 2015/16

Figure 10: Overall plan for all focus areas in 2015/16

Focus Area	Q1	Q2	Q3	Q4
Alternative to	Use of real time data to	Implement OOH and	Implement	Evaluate effectiveness

Focus Area	Q1	Q2	Q3	Q4
Admission	increase alternatives to admission by providers. Agree process of EMAS exception reporting: individual practitioner learning of alternatives. Deep dive into UCCs/WICs and mapping of services to develop a consistent patient offer. Reflect where there are barriers to accessing alternatives to admission. EMAS crews pilot Smartphone access to all pathways EMAS business case for smartphones to be submitted to UCB.	UCC appointment bookings by NHS 111. Increased EMAS direct referrals to GPs. Roll out of Community Pharmacy emergency repeat medicine referrals. OOH and NHS 111 access to web-based LLR Directory of Service (DoS).	Adastra for EMAS CAT. Investigate method that enables EMAS crews to access General Practice back office numbers in hours. Introduction of MDoS. Share education, learning and activity of and through all community care pathways.	of Adastra. Evaluate EMAS contacts with GP back office numbers. Evaluate MDoS (to include further recommendations). Share education, learning and activity of and through all community care pathways
Access to General Practice ***Improving access to General Practice both in hours and out of hours***	Review of all LLR GP opening hours to ensure full compliance with GP Contract. Agreement of each CCGs 7-day access model for 2015-16. Evaluate 2014-15 winter surge schemes. Implement CCG practice-based LTC QIPP schemes.	Complete rollout of pilot of GP virtual consultations. Implement UCC reporting to capture patient-reported access issues in general practice. UCCs to implement a uniform approach to promoting appropriate use of general practice via Choose Better materials. Preparation for primary care winter surge plans. Audit OOH dispositions to assess suitability for community services.	Implement primary care winter surge plans. Share education, learning and activity of and through all community care pathways.	Share education, learning and activity of and through all community care pathways.
Improving Access to General Practice ***Responding to***	Clinical audit of GP usage of Bed Bureau at practice level. Analysis of skill mix	Evaluate current in-car response services to inform future service provision.	Evaluate time profiles of GP home visits requiring acute pathways of care.	Evaluate continuity of management of GP visits.

Focus Area	Q1	Q2	Q3	Q4
requests for GP home visits earlier in the day	required for transportation of GP Urgent patients to hospital.	EL&R CCG to pilot an 'in-car' in year solution. Introduction of mobile DoS to crews via smartphone platform. Implement solution for managing GP home visit requests. Formulate guidance to inform consistency in clinical triage at practice level to inform clinical outcomes.		
Care Homes Support	Audit use of GP back office numbers. Re-launch of care homes group to give LLR consistency. Map existing support services to care homes across LLR. Introduction of OOH HCP line for residential homes. Ensure consistent use of RI codes in general practice and link to care homes dashboard. Implement pro-active care homes element of CRT.	Audit use of GP back office numbers/HCP line. Completion of Falls Prevention Strategy. Finalise the LLR Falls Pathway. Standardise communications LLR-wide to care homes. CRT to be enhanced as a pilot to incorporate pro-active care.	Audit use of GP back office numbers/ HCP line. Monitor Falls Dashboard for consistency in non-conveyance activity. Monitor Care Homes Dashboard for ED and Emergency Admissions activity.	Audit use of GP back office numbers/ HCP line. Monitor Falls Dashboard for consistency in non-conveyance activity. Monitor Care Homes Dashboard for ED and Emergency Admissions activity.
Care Planning	Audit of care plans utilisation. Implementation of care plan audit action plan. Devise a measure of EMAS/CRT/AVS/OOH adherence to care plans.	Audit of care plans utilisation. Develop electronic sharing of care plans. Commencement of the vulnerable persons pilot with Police, Fire, Ambulance and Social Care services.	Audit of care plans utilisation. Monitor A&E and emergency admissions activity. Monitor emergency activity specific to the Braunstone area.	Audit of care plans utilisation. Monitor A&E and emergency admissions activity. Monitor emergency activity specific to the Braunstone area.
Clinical Triage	Pilot increased clinical	Evaluate 111 clinical	Introduction of	Evaluate effectiveness

Focus Area	Q1	Q2	Q3	Q4
	triage of NHS 111 calls. Complete EMAS Fallstraining. Complete social care additions to the DoS.	triage pilot and make recommendations to UCB. EMAS to complete Pathfinder training. Develop proposal for EMAS enhanced winter CAT. EMAS support of CRT rapid response capability.	DoS Capacity Management Grids. Monitor EMAS non-conveyance rates.	of DoS Capacity Management Grids. Evaluate effectiveness of Pathfinder and MDoS.

5. Programme of Change: Flow

5.1.1 Overview

For the Flow sub-group of the UCB the focus is on creating and sustaining effective flow through UHL to maximise the numbers of patients seen and treated in a timely manner. There is a focus on internal UHL actions to improve flow throughout the hospital, exploring solutions to process, bed and behavioural delays to treatment.

5.1.2 The sub-group provides a monthly update report to the LLR UCB and meets weekly as the EQSG Board in UHL. Regular membership comprises:

- UHL Chief Executive Officer
- UHL Chief Operating Officer
- Clinical Leads for ED, AMU, Medicine, Geriatric Medicine, Ambulatory Care and CDU
- Senior Site Manager
- Assistant Chief Nurse
- Head of Nursing for Emergency and Specialist Medicine (ESM)
- Lead Nurse for ESM
- Service Managers

The work plan includesallpriority areas of Urgent and Emergency Care at UHL; ED, AMU, Medical Basewards, CDU, Whole Hospital Response and Ambulatory Care.

5.2 *Focus Area 1:Ambulatory Pathways*

Increase internal and external awareness of ambulatory pathways at UHL

5.2.1 Work to date

UHL provides approximately 19 ambulatory pathways for same day emergency care. The utilisation and ease of referral into these services is inconsistent across UHL and up to date information is not readily available to GPs. The report by Dr. Ian Sturgess also highlighted the opportunity to increase the number of ambulatory pathways provided by UHL. This is recognised as the right direction of travel by UHL as it will decrease the numbers of non-elective admissions and improve patient experience. The initial focus has been on ascertaining the current state of the ambulatory pathways at UHL. A pro forma has been sent to all clinical leads asking them to state the opening hours, referral pathway and inclusion and exclusion criteria for patients.

5.2.2 Workplan 2015/16

The plan for 2015/16 is to refresh the ambulatory services repository on both the UHL intranet and across GP services to allow more patients to be referred directly onto these pathways, avoiding A&E and non-elective admissions. To further increase external awareness of ambulatory pathways at UHL an engagement event is planned for acute consultants and GPslate June. The event will also act as an opportunity to discuss how UHL can support GPs to refer into services more effectively.

Three new pathways have been identified for development due to the high volumes of patients presenting with the following conditions: Headaches, First Fits and general Neurological Ambulatory Conditions. The Headache pathway is particularly innovative as UHL is the first Trust to adopt this pathway. A fourth pathway (Ambulatory Conditions presenting at CDU) is in

development. This pathway will reduce overcrowding in the CDU, reducing the need to divert patients and therefore improving 4 hour performance.

As UHL is working to provide a wider range of ambulatory services, ongoing communication between primary and acute physicians will be imperative to ensure they are used and deliver the benefits to the wider emergency care pathway.

5.2.3 Impact

The intended outcome is for an increasing proportion of patients to be treated via ambulatory pathways, decreasing the pressure on ED. This will be demonstrated by:

- Increase in % of UHL and UCC attendances seen within four hours from 91% to the national target of 95%.
- Reduction in admissions (contribution to the 7% reduction in emergency admissions for 2015/16) from the baseline of 75,879 to 70,814 by 2015/16.
- Increase in % of UHL GP referrals direct to AMU from 26% (2014/15 average) to 70% by Q4 2015/16.

5.3 *Focus Area 2: Improve 7 day processes*

5.3.1 Work to date

The number of patients discharged from Emergency Specialist Medicine on Saturdays and Sundays is lower than those discharged on weekdays. Currently the number of discharges at weekends are 59% of the discharges on each weekday. UHL recognises that increasing this proportion to 80% (in line with high impact change expectation) will improve patient experience and reduce length of stay. To date UHL has focused on delivering a programme of work to reduce delays in discharges across the week delivering benefits including:

- The implementation of a standardised, assertive multi-disciplinary team (MDT) board round, 7 days a week for key cohorts of patients on key wards.
- Wards generating a list of next morning discharges with TTOs written the previous day so that there are fewer delays on the day of discharge.
- All patients having an EDD and CCD set at first review on base wards including criteria for nurse delegated discharge.
- Increased pharmacy support to admission areas and base wards.
- Upskilling staff to facilitate simple discharge and the liberation of nursing time to drive discharges.
- The implementation of a robust rota with well supported 7-day consultant-led care.

5.3.2 Work plan 2015/16

The plan for 2015/16 is to continue to drive reductions in discharge delays, with a renewed focus on weekend discharges. UHL has identified that nurse-delegated discharge (NDD) is a key enabler of weekend discharges and has devised an action plan. There is positive engagement with the clinical teams and NDD is currently being piloted. UHL will be focusing on empowering teams to set safe parameters for discharge and discharging patients in an appropriate manner.

UHL will also be making improvementsto increase the visibility of the discharge process, including the implementation of ‘real-time bed state’ and improving the accuracy of recorded discharge time.

The final piece of work focusses on the optimisation of internal processes. 'Discharge 2 Assess' currently accounts for over 60% of internal discharge delays. UHL is rationalising this process and developing a standard operating process(SOP). The aim is to reduce the discharge 2 assess process from 3 days to 24 hours.

5.3.3 Impact

The intended outcome is for there to be consistent flow of patients and timely discharge throughout the week. This will be demonstrated by:

- 50% of weekend discharges being nurse delegated (Q1 a robust baseline to measure this against will be established).
- Weekend discharges at 80% of weekday rate this will support moving to 7 day processes (Q1will establish a robust baseline to measure this against).
- % of UHL wards Achieving Targeted Weekly Discharge.
- 10% reduction (1,200) in patients aged 75+ with Length of Stay >10 Days at UHL by Q4. The baseline is the average from 14/15 of 1,335 hours per week. The group will work with Discharge group to achieve an improvement in the stranded patient metric.

5.4 *Focus Area 3: Understanding variability in Emergency Department performance*

5.4.1 Work to date

There is high variation in UHL's performance against the 4 hour target, even when factors such as attendance, admission and discharge rates are comparable. As an example, given two days in the same week which had almost identical attendance and discharge rates, plus a similar conversion rate, there was a 9% difference in percentage of people seen within 4 hours:

Figure 11: Attendance, admission and discharge rates

Day	Attendances	Admissions	Conversion Rate	Time to Bed Request	Discharges	Time to Bed Allocation	4hr performance
Thursday	366	237	65%	133	270	24	87%
Friday	368	260	71%	140	271	16	96%

The Emergency Quality Steering Group (EQSG) has agreed factors which drive variability including a subset which are within the direct control of UHL. There is a specific opportunity to address individual staff/team differences which can have a large impact on how well the department and the rest of the hospital performs.

5.4.2 Workplan 2015/16

There are two aspects to the way UHL will address this variation:

- Maintain a framework for quickly being able to assess the causes of, and potential solutions to, variability. This is done at monthly Journey Meetings which review ED process delays and identify factors that are external to UHL e.g. patient acuity or availability of community services.
- Drive forward on the established action plan to address known factors affecting variability. The Simulation Tool will be used to plan further mitigating actions e.g. different staffing patterns.

5.4.3 Improving escalation management;both the ED and the wider hospital need to improve how they manage in times of high activity. The ED aim to introduce an hourly check-in across all areas (and linking in the UCC) so that the Doctor in Charge, Nurse in Charge and Duty Manager can more effectively plan what is required to meet current & expected patient need. To improve the Whole Hospital Response on call competencies for all related roles and use self-assessment will continue to be defined to inform an escalation training plan. The first training event will take place in June.

5.4.4 Improving relations between ED and other specialties;the ED relies heavily on support from other specialties, particularly Medicine, certain surgical areas (Orthopaedics/ENT/Max-Fax/Plastics) and ITU. It is important that these areas understand the pressures within the department and agree best ways of working together. A group of ED staff and representatives from the duty management team plan to undertake a series of meetings to promote awareness of 'Exit Block'.

5.4.5 Out of Hours and portering; out of hours arrangements even within the ED are not always consistent with measures in place during the day. The ED will be looking to introduce the use of iPorter 24x7 (having successfully completed a trial of running this 8am – 8pm).

5.4.6 Impact

The intended outcome is for UHL to be able to better understand what has caused recent performance deterioration and take the actions (within our control) to mitigate these reasons from occurring again. This will be demonstrated by:

- Increase in % of UHL and UCC attendances seen within four hours from a 2014/15 Q4 average of 91% to the national target of 95%.

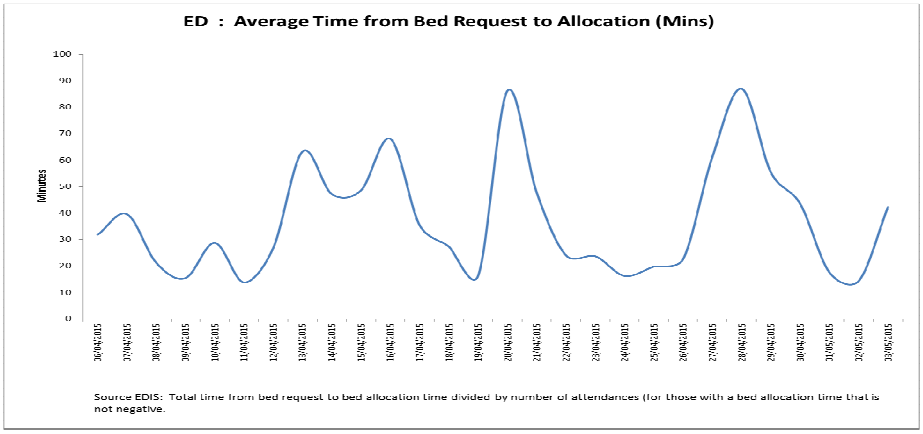
5.5 *Focus Area 4: Improve flow from Emergency Department to Acute Medical Unit*

Reduce time from bed request to bed allocation to improve flow from the Emergency Department to the Acute Medical Unit

5.5.1 Work to date

Consistent flow from the ED to the Acute Medical Unit (AMU) is a key factor in UHL's performance against the four hour target. There is currently a wide degree of variation in the time taken to allocate a patient a bed on the AMU, as demonstrated by the graph below:

Figure 12: Average time from bed request to allocation (mins)

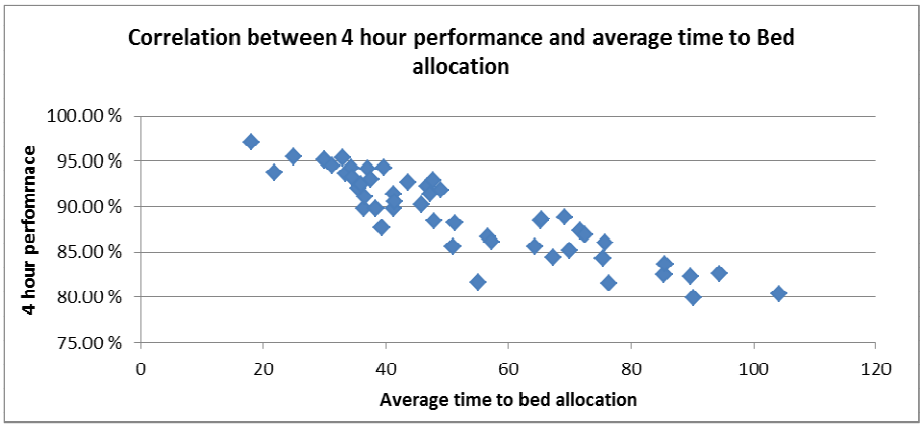


The average time to bed allocation for April was 37 minutes, however the variation in time ranged from 14 to 87 minutes. The impact of this variation is twofold:

- Patients are not being allocated beds on AMU in a timely manner, resulting in breaches of the 4 hour target.
- ED are not able to prepare the patient for transfer as it is unclear when a patient will be allocated a bed, creating further delays between bed allocation and transfer.

5.5.2 The graph below shows that there is a strong correlation between the 4 hour performance and the average time to bed allocation. The Trust is aiming to reduce the average time to bed allocation to 30 minutes and has formulated an action plan to drive consistent and timely allocation.

Figure 13: Correlation between 4 hour performance & average time to bed allocation



5.5.3 Workplan 2015/16

The Trust has identified that one of the key reasons for poor flow to the AMU is that the discharge pattern from AMU does not match the bed request pattern from ED. The Trust is therefore focusing on improving discharge processes on AMU to free AMU beds earlier in the day. This will align the bed capacity on AMU with the referral profile from ED.

5.5.4 To understand the barriers to timely discharge of patients home or to base wards a programme of 'AMU Flow' Workshops has been initiated. The workshops include clinicians, nursing staff, management and therapies staff to ensure that all aspects of the patient journey through AMU is captured. The initial workshop identified some key areas for improvement including the need to:

- Redesign the role of the nurse coordinator to ensure consistent service delivery.
- Reduce variation in discharge rates across senior clinicians to ensure consistent clinical care.
- Design an escalation policy to effectively respond to ED and Medicine pressures.
- Ensure AMU take ownership of improvements needed and take accountability for this KPI by making the time from bed request to bed allocation visible on the AMU.

5.5.5 Impact

The intended outcome is there will be consistent flow of patients from ED to AMU throughout the day. This will be demonstrated by:

- Increase in % of UHL and UCC attendances seen within four hours from 91% to the national target of 95%.
- Increase in % of discharges before 12pm at UHL from the baseline of 10.6% average for 2014/15 to 35% by Q4.
- Increase in % of UHL Ward response to ED/Bed Requests within 30 minutes from 66.7% average for 2014/15 to 90% by Q4.
- UHL empty beds at start of the day on AMU ward. Baseline to be established Q1.

5.6 *Focus Area 5: Ambulance Handovers*

Reduce delays due to ambulance handover delays

5.6.1 Work to date

Rapid clinical assessment is a key element of providing safe and efficient emergency care. The Emergency Department at the LRI has an Assessment Bay (AB) open 24x7 which is designed to ensure that a nurse-led rapid assessment and treatment (RAT) process is undertaken on patients:

- Brought in by ambulance crews.
- Triaged by the Urgent Care Centre.
- Who are referred by GPs when Bed Bureau isclosed.
- Self-present direct to the ED.
- Are stepped down from a Resus red call.

The AB area in the ED is well established with a clear SOP. There are a minimum of 3 and a maximum of 6 teams on at any time. The nurse teams are supported by a Senior Clinician and an ANP as a minimum, who provide senior medical review and early senior decision-making. This team is at times further augmented by a GP.

Protocol dictates that any patients who require rapid treatment have their notes marked with a sticker before transfer to Majors (except those requiring morphine for 10/10 pain and sepsis patients who get immediate fluids). On average from 30/03/15 to 26/04/15, patients were triaged within 17.2 minutes. There is some difficulty establishing a baseline for overall performance as the data from EMAS and from UHL varies, at times significantly.There is a high degree of variation between the EMAS and UHL time recorded for ambulance handovers:

- An Audit showed that on 20/4/15 EMAS stated 37 over 60 min waits and UHL can confirm 27 occurred this shows a 20.5% difference and 1 patient's handover was 16 minutes only .
- In another Audit over 10 days in a 4 week period 56 patients were recorded as above 15 minutes handover and had actually achieved handover within 15 minutes. This on average could mean at least 5.6 patients a day are inaccurate.

Whilst CAD+ coming into effect from June should help to improve data consistency, there is still further work that will be needed by EMAS to ensure they are accurately recording times (as well as agreeing what will happen if the servers at UHL or EMAS go down).

5.6.2 Workplan 2015/16

The AB Working Group identified five areas which are driving inconsistencies in ambulance handover performance:

- Lack of open and reliable data on patient transfers from EMAS to UHL.
- Staff are not always consciously aware of importance of adhering to 15 minute turnaround.

- Individual differences in the way in which people work in the AB.
- The variety of entry streams into the AB (7 in total) makes it harder to co-ordinate flow.
- Staffing numbers and patterns do not always match demand profile.

5.6.3 Impact

The intended outcome is for LRI to consistently meet a 15 minute handover for EMAS crews. It is also the aim that there is greater transparency and stronger relations between the two providers. This will be demonstrated by:

- Increase in % of handovers complete within 15 minutes.
- Reduction in % of handovers taking longer than 30 minutes.

High Impact Intervention 6:

Rapid Assessment and Treat should be in place, to support patients in A&E and Assessment Units to receive safer and more appropriate care as they are reviewed by senior doctors early on.

In addition to the plans in place as described above, please see Appendix C for the full submission made to NHSE.

High Impact Intervention 7:

Consultant led morning ward rounds should take place 7 days a week so that discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.

In addition to the plans in place as described above, please see Appendix C for the full submission made to NHSE.

5.6.4 The overall plan for all focus areas within 2015/16 is summarised in the table below:

Figure 14: Overall plan for all focus areas in 2015/16

Focus Area	Q1	Q2	Q3	Q4
Ambulatory Pathways	Baseline current provision of ambulatory services. Compile directory of ambulatory services and engage with GPs and CCGs.	Roll out Headache and First Fit Pathway.	Engagement event and updated repository of existing pathways in UHL. Roll out Neurology ambulatory care clinic.	Roll out Ambulatory Clinic for CDU.

Focus Area	Q1	Q2	Q3	Q4
Improve 7 day processes	Establish baseline for number of nurse delegated weekend discharges. Establish baseline for number of weekend discharges.	Pilot nurse delegated weekend discharge (NDD). Undertake discharge 2 assess (D2A) diagnostic.	Roll out nurse delegated discharge at weekends. Implement new D2A plan. Embed use of real time bed state. Work with community partners to reduce external delays. Diagnostics on remaining internal discharge delays.	Establish robust junior doctor cover. Ensure support processes e.g. pharmacy and phlebotomy are aligned with weekend discharge. Review impact of actions.
Understanding variability in ED performance	Hold escalation training event – June 12th. Trial keeping Minors open overnight on the weekend. Introduce Situational Awareness updates – in advance of May Bank Holiday.	Hold "ED Road Tour". Review Journey Meetings to see if any changes are required. Test changes to Gold Command. Support escalation training event with a coaching programme.	Look to introduce iPorter across the Trust if proven effective.	Review actions to establish if further engagement and actions are necessary.
Improve flow from ED to AMU	Establish baseline for number of empty beds on AMU at start of day.	Redesign of nurse coordinator role. Embed process for moving patients awaiting discharge out of beds first thing in AM where clinically appropriate (training and SOPs).	New escalation policy for AMU in place and aligned to whole hospital response.	Review impact of escalation policy and discharge rates to inform further actions.

Focus Area	Q1	Q2	Q3	Q4
		Standardise working practices for Junior Doctors.		
Ambulance Handovers	Establish baseline data for handover times.	AB audit team to monitor compliance with SOP. Support with launch of training video. Explore use of twilight shifts. Look to improve fill of bank / agency shifts. Install alarm clocks in each bay to keep staff focused on flow. Establish new protocol for AMU medics to come down to AB when bed bureau on divert.	Establish data sharing with EMAS plus review reliability of CAD+. Assess performance variances between individual team members and agree training plan to address any gaps. On board new (international) staff.	Explore streaming UCC referrals into a dedicated bay or cubicle to ease congestion. Establish training plan to upskill EDU staff to be able to back-fill roles of ED nurses who can then be re-assigned to the AB when on amber/red escalation.

6. Programme of Change: Out of Hospital Transfers

6.1.1 Overview

As a system Leicester, Leicestershire and Rutland health and social care organisations have undertaken detailed work on understanding the issues that impact on delayed discharges of care. Findings from Dr. Ian Sturgess' identified the key principlesrequired when implementing timely discharge to prevent deconditioning and ensuring a home first approach.

The Out of Hospital Transfers work stream will support and facilitate the timely transfer of patients from acute and community settings 7 days a week through an integrated approach to care and transfer using the principle of 'home first'. This would be supported, where appropriate, with the opportunity for reablement and/or assessment within their own home or another suitable homely environment.

The Discharge sub-group meets monthly, reports into the UCB and comprises system-wide representation from all partner organisations.

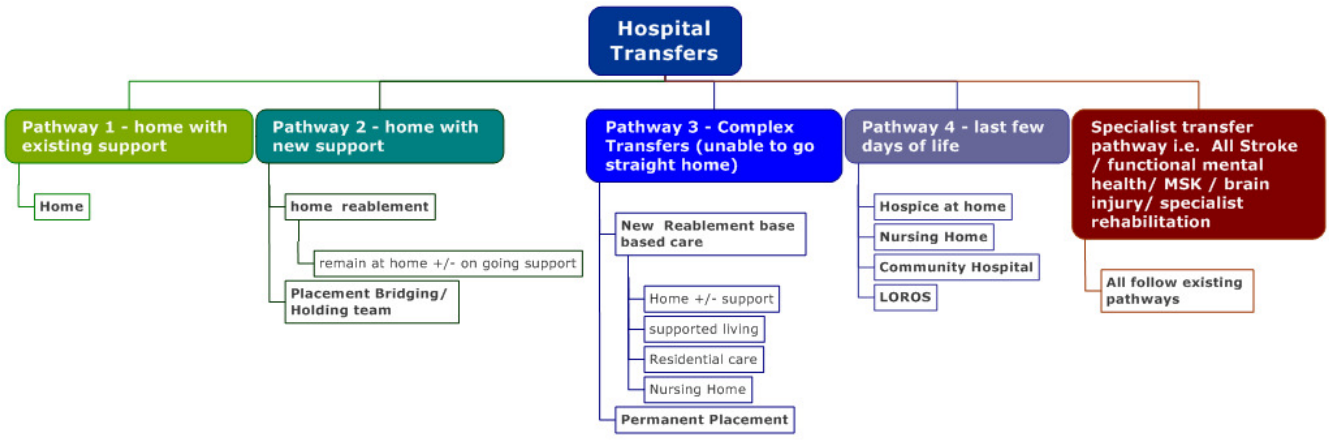
6.2 *Focus Area 1: Transfer to Assess*

Developing a sustainable model to enable patients to reach their full potential following transfer (a transfer to assess approach)

6.2.1 Work to date

The system acknowledges that the current 56 pathways for transfer from hospital do not facilitate enough patients to successfully undertake a period ofreablement or assessment out-of-hospital which will support them to reach their optimum level of self-care.The result is that a significant number of patients are adversely affected by the impact of deconditioning. They may lose their independence triggering the need for eithera long term care package or a permanent placement. Five new transfer pathways have been identified and redesign work iscurrently underway. A number of pilots have been implemented to test two of the five new transfer pathways.

Figure 15: LLR Transfer Pathways



6.2.2 Pathway 3 is a transfer pathway based on patients moving into a residential or nursing placement which is focused on enablement. There is currently one pilot open in the city and one in the county with a second county one due to open in June 2015.

6.2.3 Pathway 2 is a pilot for county patients which enables patients with a positive Continuing Healthcare (CHC) checklist to go home with an enablement package and receive further assessment at home for their long term needs. The early indications from these pilots is that the number of patients requiring long term packages of care or placements are sustainably reduced when compared with the current pathways. Both of these pathways aim to enable the patient to transfer out of hospital at the point that they are medically stable resulting in a reduction in their hospital length of stay.

6.2.4 One of the main factors in delayed discharges has been due to the sourcing of care packages in some parts of the county and family declining interim packages. As a result,County Adult Social Care developed a system to ensure that reviews of all new care packages are undertaken at two weeks. This has resulted in a significant number of packages being reduced or no longer required thus freeing up the capacity.

6.2.5 Work plan 2015/16

Work is being undertaken to commission permanent solutions for the transfer to assess pathways as described above (Pathway 2 and Pathway 3). Pathway 2 is likely to be part of the CCGs future Better Care Fund (BCF) plans and the Better Care Together (BCT) Bed Reconfiguration work. Pathway 3 is likely to be sourced through a procured route.

6.2.6 Impact

The actions being taken aim to:

- Maintain the DTOC rate for UHL at below 2.5%.
- Improve the number of patients remaining at home after 90 days of discharge.
- Reduce the number of Continuing Health Care packages of care through the availability of enablement and discharge to assess pathways.
- Reduce the length of stay in both acute and community hospitals including those aged over 75 with a length of stay over 10 days.

6.3 *Focus Area 2: Patient Transport*

Further improvements to how transport is booked to support earlier on the day discharge and managing capacity in times of surge

6.3.1 Work to date

A more streamlined and effective transport e-booking system has been developed and introduced across UHL and LPT. The following are also in place; late booking is being tracked and learning feedback sent to referrer; the transport site controller is working alongside the acute discharge teams to ensure capacity is matched to demand; schedules are matched to known constraints of the patients destination to reduce rebeds; operational co-ordination on site has been extended to 8.00pm; and work has been undertaken to ensure the right type of vehicle is booked.

6.3.2 Work plan 2015/16

The focus of the work in relation to transport over the next few months will be around the piloting of a TTO car which will enable medicines to follow the patient, and on wards to ensure

that patients are booked and made ready earlier in the day to ensure there is not a surge for transport later in the day.

6.3.3 Impact

The actions being taken aim to:

- Maintain the DTOC rate for UHL at below 2.5%.
- Reduce the number of rebeds that occur.

6.4 *Focus Area 3: Supporting family discharge decision-making*

Undertaking a dialogue with patients and families to raise awareness, responsibilities and expectations in relation to the discharge process

6.4.1 Work to date

Each CMG within UHL has a Delayed Transfer of Care (DTOC) call each day, which identifies patients who are medically stable but not able to go home at that point. This information feeds into a daily 11am multi agency call/meeting held in the Command Centre at the LRI. At the end of the call specific people are tasked to resolve identified issues that are potentially delaying patient's discharges. Anyone with actions has to provide feedback at a follow up call at 4pm each day. Discharges are further supported by a 12.30pm formal DTOC call which again is system wide. The purpose is to discusses and agree actions for the patients across UHL and LPT community hospitals who are on the DTOC list. This includes discussions that are required with patients and families and what support they need to expedite discharge or transfer.

6.4.2 Work plan 2015/16

Develop information for patients and families that explains the patients' journey from admission to their final placement (i.e. home or a care home placement which may involve an interim placement whilst a permanent placement is found). It will also set out reasonable expectations on the timeliness of family decision making. Work with Healthwatch will develop this with patients and families.

6.4.3 Impact

The actions being taken aim to:

- Maintain the DTOC rate for UHL at below 2.5%.
- Decrease the number of delays due to family choice and availability of packages of care.
- Reduce the length of stay in both acute and community hospitals including those aged over 75 with a length of stay over 10 days.

6.5 *Focus Area 4: 7 day care home discharges*

Working with the care home sector to facilitate discharges seven days a week

6.5.1 Work to date

Each CCG has undertaken work locally with the care homes in their localities. The outcome from these various pieces of work has been reviewed and will now feed into a system Care Homes Working Group.

6.5.2 Work plan 2015/16

Work is underway with the care home sector to understand and unblock issues relating to transfers of patients from hospital to care homes. In particular this work focuses assessing and

receiving patients over the weekend, reducing the time for a decision from a care home to accept a patient and how the sector can support with transport and live vacancy information. Improvement work will develop a trusted assessor function.

6.5.3 Impact

The actions being taken aim to:

- Maintain the DTOC rate for UHL at below 2.5%.
- Reduce the number of rebedsthat occur.
- Increase the number of discharges to care homes over the weekend.
- Improve the number of patients remaining at their placement after 90 days of discharge.
- Reduce the length of stay in both acute and community hospitals including those aged over 75 with a length of stay over 10 days.

6.6 *Focus Area 5: Improving the flow through community services*

6.6.1 Work to date

Health and Social care teams already work closely together at UHL to facilitate timely discharge home:

- The County Adult Social Care Team is based at UHL and has dedicated staff on all relevant base wards and the Emergency Department. Direct access to Crisis Response Service (admission avoidance) and HART (reablement) is available via the out of hour's office until 10.00 p.m. every day. All the county community hospital wards have staff assigned to them.
- City social care locality teams have assigned workers on all hospital sites who participate in the morning conference calls and work closely with ward staff to coordinate discharge. In addition, the integrated Crisis Response Service (ICRS) provide a 24/7 support service to all sites to provide bridging packages of care to support discharge.
- Primary Care Coordinators and Acute Care Specialist Nurses work across the Emergency Department, Emergency Decision Unit and the medical assessment wards to facilitate patients transfer to home, community hospital or reablement placement.
- Analysis has shown that many complex discharges often involve issues that are much wider than just health issues such has housing, debt and welfare benefits. As a result a pilot housing enablement scheme has been introduced to UHL. The objective is to identify housing and other non-health and social care issues at the point of hospital admission and to work with partners to eliminate barriers to a timely and appropriate hospital discharge. The pilot is hosted by Blaby District Council, but is covering the whole of Leicester city and Leicestershire county, early indications are very positive.

6.6.2 Work plan 2015/16

Further work will be undertaken to support the flow through community services including a review of the transfer process between UHL and community hospitals to enable early allocation and transfer of patients. In addition, a process of standardisation across all community hospitals will be introduced to ensure transfers are being consistently managed.

Work will also be undertaken to understand any impact from the Better Care Together (BCT) Bed Reconfiguration programme on flow through community services and appropriate measures put in place to ensure that the service can manage the increased number of patients being cared for in community settings. Within this an in-reach service is being developed to support the transfer of suitable patients from base wards to community settings.

6.6.3 Impact

The actions being taken aim to:

- Maintain the DTOC rate for UHL at below 2.5%.
- Improve the number of patients remaining at home after 90 days of discharge.
- Reduce the number of Continuing Health Care packages of care through the availability of enablement and discharge to assess pathways.
- Reduce the length of stay in both acute and community hospitals including those aged over 75 with a length of stay over 10 days.

High Impact Intervention 8:

Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharged. SRGs will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.

In addition to the plans in place as described above, please see Appendix C for the full submission made to NHSE.

6.6.4 The overall plan for the focus areas within 2015/16 is summarised in the table below:

Figure 16: Overall plan for focus areas in 2015/16

Focus Area	Q1	Q2	Q3	Q4
Transfer to Assess	Pathway 2 county outline business case. Outline business case for bed based reablement/assessment. Set up the Extra Care pilot at Oak Court. Agree the Rutland pathway 2 and 3 proposal. Review of county D2A home first pilot and agree the way forward. City complete review of existing services against pathway 2. Development of the MDS for use at the pilot sites.	Pathway 2 county full business case. Evaluate the Catherine Dalley House pilot. Review and refine the NWB pathway. Review and refine the existing D2A placement pathway. Full business case for bed based re-ablement/ assessment. Start to implement the pathway 2 and 3 Rutland plan. Continued	HTLAH county procurement. Put the bed based reablement/ assessment out to procurement. Continue the implementation of pathway 2 and 3 Rutland Plan Complete the initial development of the MDS	Commence the implementation of pathway 2. Implement the bed based reablement/assessment pathway. Complete the pathway 2 and 3 Rutland plan Review the next steps for the MDS

Focus Area	Q1	Q2	Q3	Q4
		development of the MDS across the pilot sites.		
Patient Transport	TTO car scheme is being developed and trial commenced. Ensure TTO's is a key part of the 11am conference call. Bring forward made ready times to earlier in the day.	TTO care scheme to be evaluated. Monitor and review the 11am Conference call Monitor and review the bring forward times	TTO car monitoring Monitor and review the 11am Conference call Monitor and review the bring forward times	TTO car monitoring Monitor and review the 11am Conference call Monitor and review the bring forward times
Supporting family discharge decision-making	Develop a communications plan for the introduction the 'Home First Work Plan, including the implementation of the 'Principles of Good Practice for Transfer from Hospital' for staff, patients and carers. For patients – explaining journey setting out patients role and family engagement.	Implement the 'Home First' communications plan. Launch Pathway 1 including patient information on all the support available. Develop new patient/family information leaflets on transfer/discharge into Pathway 2/3.	Imbed the 'Home First' into regular communication program. Monitor and review the Pathway 1. Introduce new patient/family information leaflets on transfer/discharge into Pathway 2/3.	Review and monitor the effect of the ongoing program. Monitor and review the Pathway 1. Monitor and review new patient/family information leaflets on transfer/discharge into Pathway 2/3.
7 day care home discharges	Scope out the 'Trusted Assessor Role' with the care home association and UHL. Develop the scope and role of the new care home meeting as a conduit for resolving care home transfer problems.	Review the role of the Integrated Discharge Team and how they can support timely care home transfers. Implement the 'Trusted Assessor Role' for care homes. Scope out a 'live' care home bed state. Undertake an audit of transfer experience. Evaluate audit.	Implement the 'Trusted Assessor Role' for care homes. Implement 'live' care home bed state.	Monitor and review 'Trusted Assessor' role Monitor and review the 'live' care homes bed state.
Improving the flow through community services	Revise and refine the referral route and transfer process into the community hospitals from home and acute hospitals.	Undertake a joint review of the Integrated Discharge Team working within UHL in light of the	Progress the agree changes to the Discharge Team Monitor and	Complete the changes to Discharge Team Evaluate the Housing Officer pilot.

Focus Area	Q1	Q2	Q3	Q4
	Further develop the Housing Enablement Officer role. Review the learning from the Melton health and social care initiative. Develop a roll out program for the Melton initiative.	planned changes to the discharge pathways Expand the Housing Enablement Officer role to provide support to LGH, GGH and LPT. Commence roll out plan for the Melton initiative across the community hospitals.	review the Housing Officer pilot. Continue with the roll out of the Melton initiative.	Continue with the roll out of the Melton initiative.

7. Programme of Change: Long Term Strategy

7.1 *Focus Area 1: Future Model of LLR Front Door*

7.1.1 Context

In July 2013 a single front door was established between the Urgent Care Centre (UCC) and the Emergency Department (ED). This enabled all ambulatory patients to be routed and triaged through the UCC.

As part of the urgent and emergency care review last year, Dr. Ian Sturgess identified that the changes made to patient flows and pathways through the Leicester UCC to improve performance had not been effective. He identified that delays had been created for some patients and pathways not optimisedin line with national best practice. On average 30% of patients per day are currently triaged into ED from the UCC. A better solution is required that improves the quality of care provided.

7.1.2 Work to date

A new working group designed to resolve clinical governance issues was created. This group, comprising of UHL and UCC clinical staff, has developed some shared protocols and has started to streamline some of the processes and blocks in the pathways for patients who would benefit from a more rapid transfer into the ED department.

7.1.3 Work plan 2015/16

Thisyear the single front door will be developed further to optimise pathways to avoid where possible patient transfers to A&E and to develop non-admitted pathways for patients who require more time for diagnosis and treatment decisions but who do not require admission.

In order to do this the top priority in this area is to develop a clinical specification that solves the problems of clinical flow through the emergency department in its totality. This will be informed by areas of good practice and engagement of clinical leads from partnerorganisations.Based on this, priority areas for development and implementation will be identified both as an immediate action and as preparation for the new ED build.

7.2 *Focus Area 2: Future Model of Urgent Care Centres*

7.2.1 Context

There are a number of UCCs within LLR that have developed independently of each other thus resulting in different levels of services offered to patients. This has been due to a combination of factors such as local access issues to primary care, distances from ED departments and historical settings for minor injury units (MIU's).

The variation in service provision across the UCCs causes confusion and some difficulty for patients in accessing the right services when needed. Variation also cause issues for other providers as it results in a lack of clarity over which service are appropriate at given times e.g. 999 providers conveyancing patients.This variety also adds a further layer of complexity when planning appropriate access levels to services, OOH's and 7 days services since the presence of so many variants skews demand profiles.

7.2.2 Work to date

The Urgent Care Future Group undertook a mapping exercise of urgent care activity 'hotspots' and found that there was a discrepancy between where people needed services provided and

where services were available. This indicates a misalignment between supply and demand locally.

Further work undertaken by the Inflow sub-groupdemonstrated that there was significant variance in the service offers specifically in the areas of diagnostics, opening hours, available staffing and the skill mix and competencies of staff.

Based on these findings, exact requirements of all UCCs will be specified to deliver as a system. This will include specifying locations, hours of provision, and level of risk delivered to in order to manage presenting urgent care needs alongside 7 day and OOH services.

7.2.3 Work plan 2015/16

Whilst the Future Group will be developing an overall system scope for urgent and emergency care in LLR (see Focus Area 3 below) there are three specific areas where individual service specifications will be developed in 2015/16 to address this challenge. These areas are 111, OOH and Urgent Care Centre service provision.

There will be a read across between the specifics of these 3 key services and will ensure that the detail of OOH and Urgent Care Centres are developed by the group with this in mind.

High Impact Intervention 2:

Calls to the ambulance 999 service and NHS 11 should undergo clinical triage before an ambulance or A&E disposition is made. A common clinical advice hub between NHS 111, ambulance services and out-of-hours GPs should be considered.

In addition to the plans in place as described above, please see Appendix C for the full submission made to NHSE.

7.3 *Focus Area 3: Longer Term Strategic View of Urgent and Emergency Care*

Developing a system scope for urgent and emergency care and how this will be contracted

7.3.1 Overview

LLR is trying to improve integration by moving to commissioning one comprehensive urgent and emergency care service rather than piecemeal services. This requires a focus on outcomes, treatments and on patient need irrespective of geography or provider. In order to achieve this alternative ways of contracting for urgent and emergency care services will be considered and put in place contractual architectures that support the longer term strategy and Better Care Together programme. Underpinning this ambition is the collaborative work with and support of Providers that are progressing this transformation.

7.3.2 Work to date

The Future Group has agreed a clear set of principles and outcomes for the future urgent and emergency care system, specific care settings and patients (see Appendix A). These are designed to be the framework within which the more detailed system scope will be developed and commissioned.

This year a different approach was taken to the development of local contracts across urgent and emergency care pathways which led to fundamentally different thinking from Chief

Officers in LLR during the 2015/16 contracting round. The outcome has been significantly different contracting arrangements with some of the key urgent care providers. The aim is to align drivers and incentives in the system to deliver the right care for people in the right place first time. The contract changes cover most of the pathway for urgent care. Examples of the changes made that were collaboratively agreed across system partners ranged from:

- A 'semi' block contract for non-elective activity with the main acute provider that incentivises the reduction of activity for both providers and commissioners
- Moving away from a block contract with other providers if the drivers were right; i.e. working with the 999 provider on a cost and volume basis rather than the usual block arrangement.
- Including winter funding in contracts so better planning can be undertaken and enough activity has been ensured to meet the forecast demand in the system and bought it in a way that builds a platform for change.

7.3.3 Local Providers are also working together alongside commissioners in various forums such as the Urgent Care Board and its sub-groups of Inflow, Out of hospital transfers and Future Group. However, it is recognised that a separate provider led forum is needed to drive transformational redesign. The aim of this group will be to open communication channels and promote co-operative working across the urgent and emergency care provider landscape.

7.3.4 Work plan 2015/16

To achieve this longer term strategic view, the Future Group will focus on delivering the following:

- Design a system wide scope (high level specification) for an urgent and emergency care service. This will build on the high level model in Section 2 of this improvement plan. The system scope will be developed by clinical working groups. A process has been signed off for a series of workshops to develop the content of the system scope over the next 3 months.The Future Group will lead the development of the system scope, defining interventions and treatments needed per "settings" of care, as defined by the 'doors' between them.
- A sub-group will be established to consider contracting forms for 2016/17 and beyond; this group will comprise both commissioners and provider leads. This sub-group aims to ensure that contract structures will support the system changes progressed through BCT, will deliver new models of care that support the 5 year forward view and will realise the Keogh outcomes that contextualise the changes required. It is proposed that the outcome of this focus area is options paper to be considered by the System Resilience Group (SRG). This focus area will tie in with work around Vanguard applications which LLR may consider in 2015/16.
- Facilitate the establishment of a local Urgent and Emergency Care Provider Network in response to the release of the NHS Five Year Forward View and the Dalton Review. This network will be responsible for looking at innovative models of care, responding to Vanguard bids and UECN guidance throughout the year. They will bring updates to the Future Group on a 6 weekly basis. Membership will include a role such as a Director of Transformation and a representative from the BCT programme to ensure links into the wider transformation work and are developed in line with local pace and scale of change.

7.4 *Focus Area 4: Information Management &Technology*

7.4.1 Overview

The urgent care workstream is focused on integrating services and providers around patients and enabling patients to better navigate the system and manage their own care where appropriate. This means it has a high level of IM&T need.

7.4.2 Work to date

There have been a number of pieces of work to datefrom all the sub groups of the UCB that engage with IM&T.

- **Inflow:**The Care planning group has been working to improve information quality and flow of information across services whilst the implementation of the MIG – Medical Interoperability Gateway - will enable sharing of GP Primary Care data with secondary care and the ability to share health data in Social Care environments.
- **Flow:** There is a project being set up to stream data to show real time wait times within ED and the UCCs. The live Surge and Capacity escalation receives information twice a day from partner organisations to inform on organisational and system pressures and direct appropriate responses.
- **Out of Hospital Transfer**: The Minimum Data Set (MDS) team have been working with Nerve Centre to implement the MDS tool in handover software to enable sharing of common discharge assessments across partners. T There is further work to be undertaken to enable the triggers to be incorporated into the tool and weighting to be applied to inform the system resilience position.

7.4.3 Work plan 2015/16

The identified leads will support delivery of the schemes currently in place and more closely link to the IM&T BCT enabling workstream. In particular they will:

- Advise the BCT IM&T group on information sharing requirements from the Urgent and Emergency Care System Scope (and upcoming procurements), ensuring alignment with future urgent and emergency care model.
- Set the scope for demand and capacity analysis to include parameters for data capture, scope and scale of the data sets required, data quality and data reliability; this piece of work will start to inform a better understanding of system variation and the triggers.
- Review the existing capacity modelling tools available in the system to develop an understanding of variation and then inform local response once warning signs are triggered. This will include the participation in the National work on ED capacity being undertaken by KPMG for NHSE.
- Establish a tool to enable forecasting to inform capacity, response, expected points of escalation and resilience. This will align the forecasting tool to the surge and capacity plan.
- Explore the opportunities to use on-line/app based GP consultation via speech and/or video.

7.4.4 The overall plan for the focus areas within 2015/16 is summarised in the table below:

Figure 17: Overall plan for focus areas in 2015/16

Focus Area	Q1	Q2	Q3	Q4
Future Model of LLR Front Door	Complete clinical specification for single front door. Report to the UCB by the end of June. Identify priorities for development.	Agree redesigned service model and identify provider delivery arrangements	Implement changes on a pilot basis to test and refine service model	Utilise the clinical specification to develop the contract specification for re-procurement for the single front door.
Future Model of UCCs	Hot spots of activity mapping; April Table top review of UC centres: May Create local UCC contract log: June.	Review finding of the OOH's service specification development and undertake a gap analysis for UCC specification: July. Commence service specification development: August. Take early draft of specification to Collaborative Commissioning Board (CCB): September.	Decision to extend UCC contract by 1 year or start procurement: Oct.	
Longer Term Strategic View of Urgent & Emergency Care	Agree clinical leads per Care Setting area and agree core attendance list per care setting. Align workshops/ meetings with existing BCT dates. Review service level gap analysis being completed by Inflow sub-group. Establish membership, governance and outputs for provider group and network:It is proposed the following membership is set up: - 111 Service (DHU)	Series of workshops per care setting running concurrently. Feedback to working group to collate in to draft system scope. Review and agree response/ approach to Establishing Urgent & Emergency Care Networks Advice (released for review by June 2015). Build informal networks and contacts between counterparts at the providers, to build trust and communication. Review and implement guidance and toolkits on UEC Networks. Agree strategic direction	System scope taken to Future Group- comments received. System scope taken to UCB for sign off and used in OOH procurement. Use footprint tool to refine geographical boundary and composition of their Urgent and Emergency Care Networks. Align provider network work with review of new contractual models.	System scope taken round Boards, PPI events, BCT Programme for inclusion in all future redesign. Feed into contracting round with outcomes of desktop review and signed off initiatives.

Focus Area	Q1	Q2	Q3	Q4
	- 999 Ambulance Service (EMAS) - Accident & Emergency Department (UHL) - LPT Urgent and Unscheduled Care services (LPT) - GP Out-of-Hours (CNCS) - Urgent Care Centres (George Eliot, CNCS, Northern Doctors) Sign off Memorandum of Understanding between providers and share with UCB for provider network. Agreement to review innovative contracting models. Agree sub group leads. Identify commissioner and provider membership.	of commissioning one integrated urgent care service (5 year's time). Scope contractual models to undergo desktop analysis which could deliver the overall strategic aim.	Develop paper for UCB detailing contractual alternatives. Send paper to SRG for sign up to direction of travel. Identify opportunities for 2016/17 contracting round to move towards innovative models if appropriate.	
Information Management & Technology	Pilot MDS at Brookside Court. Participate in the National Project on Emergency activity and supply.	Commence System roll out of the MDS and the MIG. Take any learning from the KPMG work to inform plan. Commence data review and scope the data sets required. Commence review of capacity modelling/management tools available.	Analyse the data variation and cause Agree forecasting model, key data requirements and pilot.	Align the forecasting model, the surge and capacity tool and escalation triggers for individual organisations and system wide.

8. Programme of Change: Communications

8.1.1 Overview

In January 2015, the UCB asked for ideas on how communications could support the pressures that were being experienced across the LLR health community and particularly in reference to the Emergency Department's 4-hour target.

A communications sub-group of the UCB has been set up consisting of senior communications representatives from across the health and social care community to co-ordinate communication plans and resources.

8.1.2 The group have collectively delivered a wide range of communications activities ranging from promoting existing campaigns such as 'Feeling under the weather?', to relaunching the 'Choose Better' campaign across LLR and a number of new campaigns specific to CCG areas such as 'Keep Well' in Leicester City, a health bus in West Leicestershire and a campaign promoting new urgent care services in East Leicestershire and Rutland.

8.2 *Focus area 1: Dedicated communications resource*

A dedicated Communications Manager to provide system-wide communications support to the LLR urgent and emergency care agenda

8.2.1 Work to date

Communications activity to date has been coordinated and delivered by the existing communications team within Leicester City CCG, supported by communications teams across the LLR health and social care system to varying extents.

There is a strong commitment from partners to drive communications in relation to urgent and emergency care but it is apparent that most do not have the resource or capacity with which to do this in a sustained manner and to the level required.

Projects such as Better Care Together, CCGs' Better Care Funds and other local priorities are causing teams to feel too thinly stretched.

Funding has been identified for a dedicated individual to be responsible for promoting matters related to the urgent and emergency care agenda across Leicester, Leicestershire and Rutland, initially for a period of six months at band 7/8a. The recruitment process has commenced for the position.

8.3 *Focus area 2: Communication and engagement strategies to support UCB sub-groups*

Ensure that the interventions and actions identified by the four other sub-groups are supported with any required communications and engagement activities using free and owned channels.

8.3.1 Work to date

A great deal of activity has been implemented by the Communications sub-group since January, to have an impact on emergency department attendances and hospital admissions. Focus has been on outward facing media and marketing activity linked to Choose Well and winter.

More detail about this can be found in a separate report provided to the LLR UCB on 28th May 2015.

8.3.2 Work plan 2015/16

To work with and/or participate in the working groups to identify focused actions through which communications activity can inform and/or engage staff and patients and the public to deliver the wider system change planned by each of the sub-groups.

Actions for this focus area are dependent on the appointment of a dedicated communications resource detailed above. Timing of actions will be aligned to delivery in each sub-group

8.4 *Focus Area 3: Reactive Communications*

Pre-prepare a toolkit of reactive communications that can be implemented quickly using free and owned channels and implement them as necessary in response to particular pressures in the urgent and emergency care system.

8.4.1 Work to date

Requests for communications to alleviate particular system pressures have been dealt with on an individual basis to date.

8.4.2 Work plan 2015/16

Actions for this focus area are dependent on the appointment of a dedicated communications resource detailed above. Timing of actions will be aligned to delivery in each sub-group

8.5 *Focus Area 4: Seasonal Messaging*

Produce a 12-month plan of proactive communications aligned to seasonal topics/pressures that can be implemented using free and owned channels. The plan should be consistently coordinated across all partner organisations and facilitate collaboration and upscaling of existing plans where appropriate to avoid duplication and maximize use of resources.

8.5.1 Work to date

To date seasonal messaging has focussed on the 'Choose Better' campaign that was implemented LLR wide, promoting existing campaigns such as 'Feeling under the weather?' and individual organisations' campaigns such as 'Keep Well' in Leicester City and a New Year health bus in West Leicestershire.More detail about this can be found in a separate report provided to the LLR UCB on 28th May 2015.

8.5.2 Work plan 15/16

Agree priorities for the next 9 months and align national campaigns for local delivery. Through the Communications group, co-ordinate campaigns designed to deliver the most impact within the available resourcing.

Actions for this focus area are dependent on the appointment of a dedicated communications resource detailed above. Timing of actions will be aligned to delivery in each sub-group

8.6 *Focus Area 5: Social Marketing Strategy*

Produce a proposal for a social marketing campaign(s) based on insight about patient attitudes and behaviours and using behavioural (social marketing) theory to improve patient use of services across the urgent and emergency care system and prevent patients needing such services in the first place.

8.6.1 Work to date

Avoidable attendance data for Leicester's Hospitals has been reviewed alongside previous East Midland's insight into patient behaviour and attitudes.

Three target audiences have been recommended for a campaign from this review:

- Young people
- Parents of 0-2s
- Older people

Additional insight is being collected from patient experience visits being carried out at the Leicester Urgent Care Centre and A&E in June 2015 that can be used to inform future plans.

8.6.2 Work plan 2015/16

Proposal is based on funding being available with which to undertake research/insight work and support the delivery of any proposed social marketing campaign.

Actions for this focus area are dependent on the appointment of a dedicated communications resource detailed above. Timing of actions will be aligned to delivery in each sub-group

8.6.3 The overall plan for the focus areas within 2015/16 is summarised in the table below:

Figure 18: Overall plan for focus areas in 2015/16

Focus Area	Q1	Q2	Q3	Q4
Dedicated Communications resource	Identify funds for a dedicated communications resource. Begin recruitment to the position. Agree job specification and scope of role. Agree reporting/hosting arrangements. Appoint the Communications Manager	Communications Manager to commence work and begin working on the remaining areas of focus identified for communications. Chair communications group.	Review the appointment and decide on whether to extend the period. Chair communications group.	Review the appointment and plan how urgent & emergency care communications will continue to be resourced. Chair communications group.
Communication and engagement strategies to support UCB sub-groups		Dedicated Communications Manager to meet with key individuals for each sub-group to get a full understanding of their plans and identify what	Delivery of action plan and communications/ engagement support, aligned to progress in each sub-group.	Delivery of action plan and communications/enga gement support, aligned to progress in each sub-group.

Focus Area	Q1	Q2	Q3	Q4
		communications and engagement support will be required. Develop action plan for each workstream – focusing on implementation, delivery and evaluation. Delivery of action plan and communications/ engagement support, aligned to progress in each sub-group.		
Reactive communications		Liaise with sub-groups to identify issues/themes that are likely to need responding to throughout the year. Create suite of resources and key messages, including aspects that can be adapted to suit individual organisations. Obtain approval of messages by communications and sub-group leads. Agree spokespeople for each topic. Share all materials with communications leads and agree distribution mechanisms/processes.	Implement communications from resources toolkit as required.	Implement communications from resources toolkit as required.
Seasonal	Delivery of Choose	Develop a plan of	Develop	Develop resources for

Focus Area	Q1	Q2	Q3	Q4
Messaging	Better campaign across LLR. Opportunities for promoting the key messages of the Choose Better campaign through the media, social media and other free and owned channels will continue to be sought. Evaluation of Leicester City Keep Well campaign and consideration of a potential wider reach for winter 2015/16.	seasonal campaigns that can be delivered and coordinated across LLR, with an emphasis on evidenced based campaigns. Develop resources for each campaign and distribute in line with plan above. Develop plans for re-launching Keep Well campaign across LLR depending on results of evaluation and funding available.	resources for each campaign and distribute in line with plan. Implement Keep Well campaign (if applicable).	each campaign and distribute in line with plan.
Social Marketing Strategy	Collect patient experience information and generate report.	Identify gaps in patient insight. Collect additional insight using free and owned channels. Develop proposal for a social marketing campaign(s) based on insight and behaviour change theory. Obtain approval of proposal and secure funding.	Implement social marketing campaign(s) if approved.	Implement social marketing campaign(s) if approved.

Measuring Success

9. Measuring Success

9.1.1 The LLR local health and social care economy has been working to achieve a significant 'out of hospital shift of activity' from acute settings into more appropriate care settings within the community with more care being offered closer to home. This will lead to anassociated reduction in activity including A&E attendances and emergency admissions.

9.1.2 In order to quantify this, the Heads of Agreement for the contract has applied an aspirational reduction of 6% and 7% to the 2015/16 contract for A&E attendances and emergency admissions respectively.These reductions represent the total quantum of reductions proposed by schemes submitted by CCGs from QIPP, BCT and BCF. The % reductions have been apportioned across the 3 CCGs to ensure both system and organisational ownership of the total reductions required.

9.1.3 The tables and graphs below show the figures for the full year phased over a monthly trajectory. Updates on actual activity against baseline and aspirational baseline will be reported to UCB at every meeting.

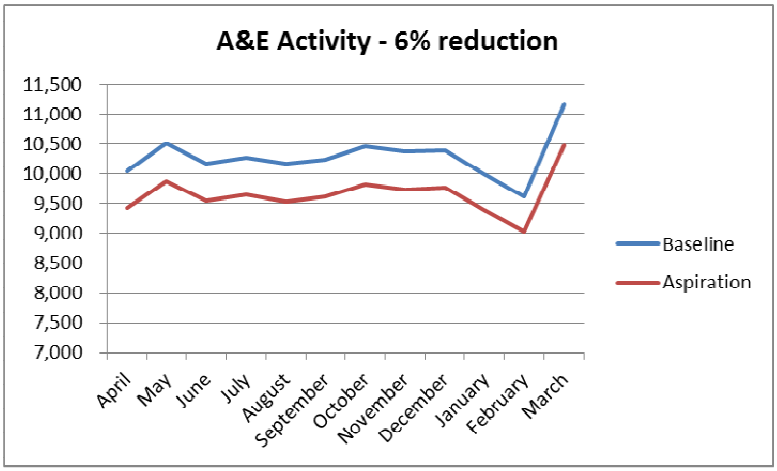
9.1.4 A&E Activity- 6% Reduction in 2015/16

In 2015/16 the system has a target of 6% reduction in A&E attendances against the agreed contract (excluding UCC step down referrals and Eye Casualty activity). This is a reduction of 7,524 attendances in year.

Figure 19: Total 6% reduction in A&E activity – 2015/16

A&E	Activity
2015/16 Contract	123,375
Reduction	7,524
2015/16 Aspiration	115,851

Figure 20: Target 6% reduction in A&E activity 2015/16 - Monthly



9.1.5 Emergency Admissions- 7% reduction in 2015/16

In 2015/16 the system has a target of 7% reduction in emergency admissions against contract. This is a reduction of 5,065admissions in year.

Figure 21: Total 7% reduction in emergency admissions activity 2015/16

Emergency	Activity
2015/16 Contract	75,879
Reduction	5,065
2015/16 Aspiration	70,814

Figure 22: Target 7% reduction in Emergency Admissions activity 2015/16 - Monthly

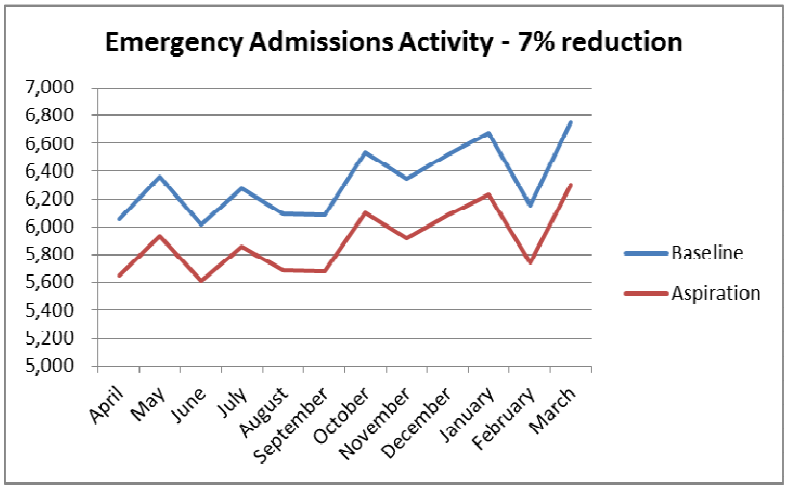
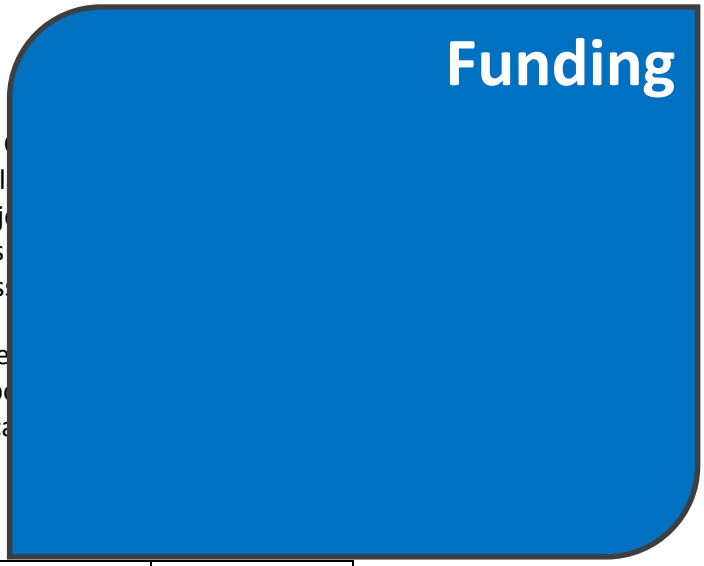


Figure 23: CCG split of activity apportioned

	A&E Total 2015/16	Emergency Admissions
ELR Baseline	29,488	21,474
Reduction	1,798	1,433
ELR Aspiration	27,690	20,041
City Baseline	68,666	32,093
Reduction	4,188	2,142
City Aspiration	64,478	29,951
WL Baseline	25,221	22,311
Reduction	1,538	1,489
WL Aspiration	23,683	20,822

10. Funding



10.1 *Winter Monies*

10.1.1 Additional funding for the Emergency
Winter Funding and has often arrived l
This has led to reactive actions and proj
had not been pre-determined. This has
that have generated recurrent cost pres

10.1.2 In 2015/16 the winter allocations have
enabled winter resources to be incorp
provider organisations. The winter alloc

Figure 24: Winter allocations 2015/16

Winter funding within contracts	UHL	£4,800,000
	LPT	£1,177,000
	EMAS	£487,675

10.1.3 An allocation of £2m has been identified for UCB allocation and the current commitments and proposals are outlined in the table in Appendix D. This shows a current commitment of £778k for schemes with further proposals to be considered over the next month. Each of the schemes is aligned to one of the 3 key sub-groups(Inflow, Flow and Discharge) to enable outputs and impact to be closely monitored.

The benefit of early allocations is that many of the schemes can delivered during 2015/16 so that processes are embedded for the winter period. Greater efficiencies can be gained as there is the potential for less reliance on locum staffing as workforce requirements can be planned in advance.

10.2 *MRET and Re-admissions*

10.2.1 The table below presents a detailed breakdown of the schemes identified where this money is currently re-invested. The schemes have been identified by CCGs, often in partnership with providers and local authorities through the Better Care Funds, and address reducing emergency admissions and avoiding readmissions. Most of these investments have been recurrently built into provider contract funding by CCGs and predecessor PCTs over a number of years. CCGs have committed to work with partners to undertake a review of the impact and value for money of these schemes during 2015/16. This work will be led through the Urgent Care Board with any final decisions taken by the three CCGs through their Commissioning Collaborative Board. Any decision to disinvest from particular schemes will need to be implemented in line with current contractual commitments, particularly in terms of notice periods, in order to enable providers to manage the transitional operational and financial impact.

Figure 25: 2015/16 MRET & Readmissions Investment - LLR CCG's

				15/16 MRET & Readmissions Investment			
Scheme Description	**Acute/Community Provider**	**NHS/Non NHS**	**Provider Name**	**East**	**West**	**City**	**TOTAL**
				£	**£**	**£**	**£**
Proactive Care	Community	NHS	LPT	563,000	540,000		**1,103,000**
Intensive Community Support	Community	NHS	LPT	835,000	966,000	874,000	**2,675,000**
Care Home Nursing Support	Community	NHS	LPT	75,000	85,000	90,000	**250,000**
Mental Health Triage Car	Community	NHS	LPT	75,000	85,000	90,000	**250,000**
End of Life (Pilot Extension)	Community	Non NHS	GP's	642,000	369,000		**1,011,000**
CVD & Rapid Access	Acute	NHS	UHL/LPT/GP's		516,000		**516,000**
Urgent Care Bed Co-ordinators	Community	NHS	LPT	-	-		**-**
Pulmonary Rehab Funding	Community	NHS	LPT	116,650	95,000		**211,650**
GEH Urgent Care Centre	Community	NHS	GEH	1,160,000	834,800		**1,994,800**
Memory clinic	Community	NHS	LPT	76,300	76,000	61,000	**213,300**
Loughborough UCC	Community	NON NHS	Private provider		248,000		**248,000**
Step Down Beds - CHC & Non Weight Bearing	Community	NON NHS	Nursing Homes - Various	140,295	489,000	90,000	**719,295**
Strengthening RIT - LPT CHS (BCF)	Community	NHS	LPT			389,216	**389,216**
Enhanced Night Nursing	Community	NHS	LPT			90,000	**90,000**
COPD Telehealth	Community	NHS & Non NHS	LPT & Private providers			80,000	**80,000**
Alcohol	Community	Non NHS	Private provider			70,000	**70,000**
3T Cardiology	Community	Non NHS	GP's			28,000	**28,000**
Transforming End of Life and Care Plans	Community	Non NHS	GP's			24,000	**24,000**
Parkinsons Nurse	Acute	NHS	UHL	28,000			**28,000**
Safe minimum data set (BCF)	Acute	NHS	UHL	-			**-**
IM&T projects EPR & EDRM	Acute	NHS	UHL	-			**-**
Empath	Acute	NHS	UHL	-			**-**
PMO	Acute	NHS	UHL	-			**-**
MND Nurse	Community	NON NHS	LOROS	-			**-**
Community Equipment	Community	NON NHS	LA	179,000	100,000	250,000	**529,000**
Social care assessment	Community	NON NHS	LA				**-**
Quality in care homes	Community	NON NHS	LA	134,000	135,000	128,000	**397,000**
Dementia Nursing Care	Community	NHS	LPT	84,401			**84,401**
Mental Health Discharge (BCF)	Community	NHS	LPT	112,101	148,599	60,644	**321,344**
Assertive in reach (BCF)	Community	NHS	LPT	184,000	208,000	220,000	**612,000**
Frail elderly (BCF)	Community	NHS	LPT	159,000	380,000		**539,000**

Figure 25: 2015/16 MRET & Readmissions Investment - LLR CCG's

				15/16 MRET & Readmissions Investment			
Scheme Description	**Acute/Community Provider**	**NHS/Non NHS**	**Provider Name**	**East**	**West**	**City**	**TOTAL**
				£	**£**	**£**	**£**
Falls (BCF)	Community	NHS	LPT	12,900			**12,900**
Single point of access (BCF)	Community	NHS	LPT	206,000	240,000		**446,000**
Integrated Health & Care Crisis Response (ICRS) (BCF)	Community	NHS	LPT	513,000	600,000		**1,113,000**
Frail older persons advice and liaison service (FOPALS)	Community	NHS	LPT	49,349	57,651		**107,000**
7 day primary care service (BCF)	Community	NON NHS	GP's	362,500	241,159		**603,659**
Ambulatory Care admission avoidance GP team (BCF)	Community	NON NHS	GP's			1,365,000	**1,365,000**
Stroke Rehab	Community	NHS	TBC		100,000	100,000	**200,000**
Step Down Additional Therapy Services	Community	NHS	LPT	209,000	300,000	150,000	**659,000**
Primary Care Support >75's	Primary Care	NHS	GP's	482,000	188,000	1,589,000	**2,259,000**
Mental Health Triage Nurses	Community	NHS	LPT	114,000	147,571	190,621	**452,192**
Primary Care Urgent Response	Primary Care	NHS	GP's		10,000		**10,000**
Hinckley Review	Community	NON NHS	Various				**-**
Diabetes	Acute / Primary Care	NHS	UHL, GP's	96,000	70,000	63,000	**229,000**
Atrial Fibrilliation				80,250			**80,250**
Chronic Kidney Disease Nurse	Community	NHS	UHL		35,000	40,000	**75,000**
Acute Visiting Service	Community	NON NHS	SAFFA		532,928		**532,928**
Dementia	Community	NHS / Non NHS	Alzheimers Society	18,000	50,000	61,000	**129,000**
Rapid Access Heart Failure	Primary Care	Non NHS	GP's			150,000	**150,000**
Care Homes Pharmacist	Primary Care	Non NHS	GP's			59,145	**59,145**
Care Homes Dietician	Community	Non NHS	Various			90,000	**90,000**
Care Homes Practice	Primary Care	Non NHS	GP's			354,000	**354,000**
Mental Health Facilitators	Community	NHS	LPT			279,000	**279,000**
Planned Care (BCF)	Community	NHS	LPT			382,000	**382,000**
Unscheduled Care (BCF)	Community	NHS	LPT			1,475,000	**1,475,000**
TOTAL				**6,706,746**	**7,847,708**	**8,892,626**	**23,447,080**
Investment required				**3,970,498**	**4,027,851**	**3,435,637**	**11,433,986**
Surplus investment				**2,736,248**	**3,819,857**	**5,456,989**	**12,013,094**

Risks & Resilience

11. Risks and Resilience

There are risks within the urgent and emergency care systemwhich are monitored by the UCB by way of regular update and a Clinical Quality dashboard. Risks covered are broadly; Patient Safety, Patient Experience, Clinical Risks and the capacity and resilience of the system to respond to surges in pressure. The current pressure on urgent and emergency care has required a reactive response and LLR recognises the need for sustainability in the longer term and monitors clinical risk and overall system resilience.

11.1 *Risk to Services*

11.1.1 Oversight and scrutiny of a range of quality metrics is used to ensure mitigation of clinical risk; risk is managed proactively and transparently by the UCB through the Quality and Safety dashboard and through the Risk Register. Ensuring safe, effective care with a positive experience for the populations of LLR is a high priority for commissioners and local providers. It is well recognised that those patients who have long waits in A&E departments have poorer outcomes such as increased length of stay and higher mortality rates than those treated promptly.

11.1.2 A Quality and Safety dashboard has been developed alongside the Risk Register that provides a monthly snapshot or temperature check of a range of quality indicators which will indicate harm. The purpose of the dashboard is to provide a context to the consequence or impact of events or actions. This does not take away from existing quality contracting mechanisms which are in place to respond in a more real time way to elevated levels of risk within the system.

11.1.3 The Risk Register has been developed following all partner discussions which focused on the highest risk which have the potential to impact on patient safety. This is updated by providers and reviewed monthly at UCB prior to submission to the LLR System Resilience Group (SRG). It is noticeable that the most significant risks are associated with the below areas (section 11.3).

11.2 *System Resilience &Capacity Planning*

11.2.1 The local health economy Surge and Capacity Plan acknowledges predictable peaks in demand (for example over the Christmas and New Year period) and plans for variation in demand throughout the year. The commitment is to ensure that there are adequate ‘system wide’ resilience plans in place, to respond to operational difficulties in parts of the system, occurring in isolation or as a building pressure across the economy.

11.2.2 The LLR Surge and Capacity Management Plan identifies the steps that are undertaken across LLR health and social care economy to ensure appropriate arrangements are in place to provide high quality and responsive services during periods of surge and/or pressure. The plan defines for each stage of escalation those triggers which reflect the capacity pressures within each organisation and identifies the actions to mitigate the risks. The agreed triggers and corresponding escalation policy are based on 4 levels of escalation from normal working to extreme pressure at Level 4. Escalation reaching level 4 would prompt an internal major incident for that organisation:

Figure 26: Escalation levels

Level 1	Green	Normal Working
Level 2	Yellow	Moderate Pressure
Level 3	Amber	Severe Pressure
Level 4	Red	Extreme Pressure

11.2.3 For each level all partners within health and social care have defined actions cards which include the escalation triggers and the action required by the organisation and the response required form external partners. Escalation levels are reported twice daily through a web portal to enable system wide communication of pressure and mutual aid response.

11.3 *Risks to delivering the Urgent Care Improvement Plan*

11.3.1 The following risks have been identified in relation to delivery of the urgent and emergency care programme of work as presented in the table below:

Figure 27: Risks to delivery and Mitigating Actions

Risks to delivery	Mitigation
This is a whole system plan and relies on the relationships between partner organisations for delivery. There is a risk that organisational priorities will compete with priorities in delivering this plan.	The UCB will play a key role in holding organisations to account for delivery of the plan and supporting mutual accountability between organisations.
There is a risk that the actions in the plan will not have the desired impact.	Robust performance arrangements linked to KPIs are being put in place to be monitored at sub-group and UCB level.
Key to success of the plan is clinical leadership and senior clinical staff will need to be actively involved in both delivery and monitoring. There is a risk that they will not be fully engaged.	Clinical Leaders are key members of the Urgent Care Board (and Operational Sub-Groups). Ensure there is sufficient clinical involvement in service redesign, disseminate and embed new pathways.
There is a risk that sufficient staff cannot be recruited or retained to fulfil the needs of the new operating models	BCT Workforce leads to develop a system workforce capacity plan for years 1-5 across clinical workstreams (including urgent care). Work with provider organisations via UCB and sub-groups to understand workforce implications.
7 day working whilst desirable for sustainable delivery it is not financial achievable across all partners	Work with partners to increase weekend capacity where avoidable within current plans or through available non recurrent funding.
Disconnect between BCT programmes and UCB	Increase engagement with the BCT leads and workstreams to avoid duplication and disconnect.
Risk of services being commissioned in isolation to the strategic direction either in terms of CCG initiatives or service re-procurements	For all partners to be informed by the UC strategic plan to inform commissioning decisions. To ensure clinical leads within the urgent and emergency care programme engage in contract re-procurements or contract specifications ahead of tender or contract discussions.
Lack of capacity and timely provision of data and information to support workstream actions/schemes	Scope the need for additional data analytics support.

East Leicestershire and Rutland Clinical Commissioning Group
Leicester City Clinical Commissioning Group
Leicestershire Partnership NHS Trust
University Hospitals of Leicester NHS Trust
West Leicestershire Clinical Commissioning Group
East Midlands Ambulance Service

Appendices

12. Appendix A: System Principles, Care Setting and Patient Outcomes

Figure 1: System Principles

System Principles: What principles will the Urgent and Emergency Care system be commissioned against?

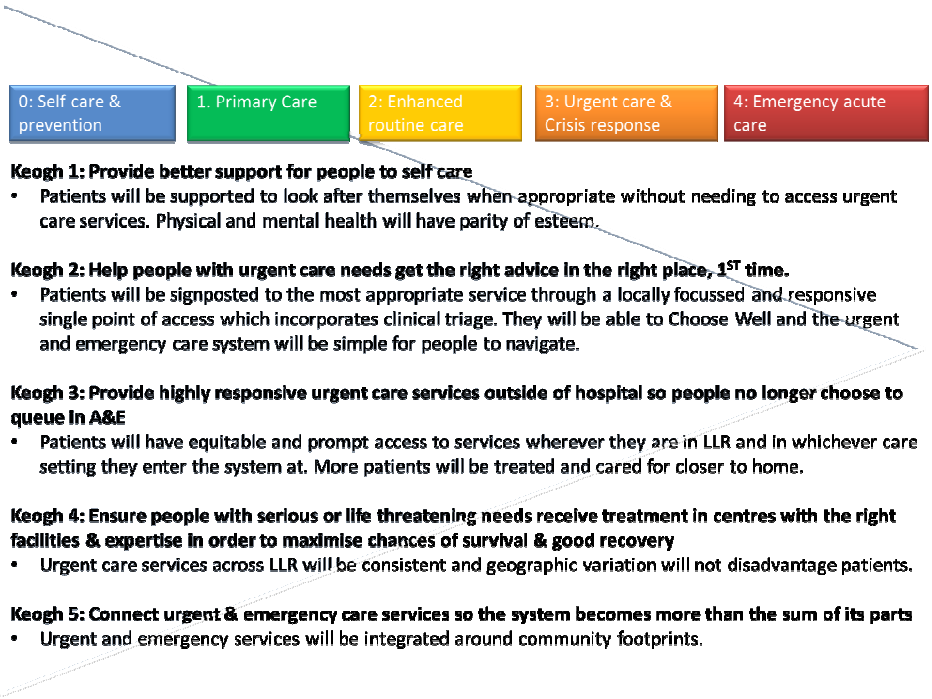


Figure 2: System Outcomes

System Outcomes: What outcomes do we commit to delivering as a system?

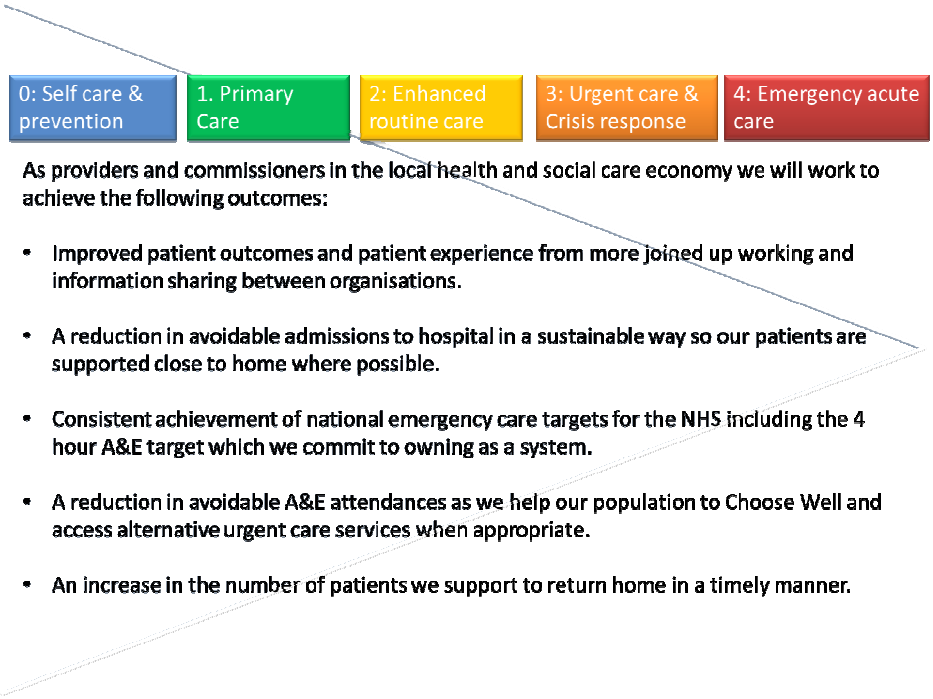


Figure 3: Care Setting Principles

Care Setting Principles: What standards will we hold services to under each care setting of the urgent and emergency care system against?

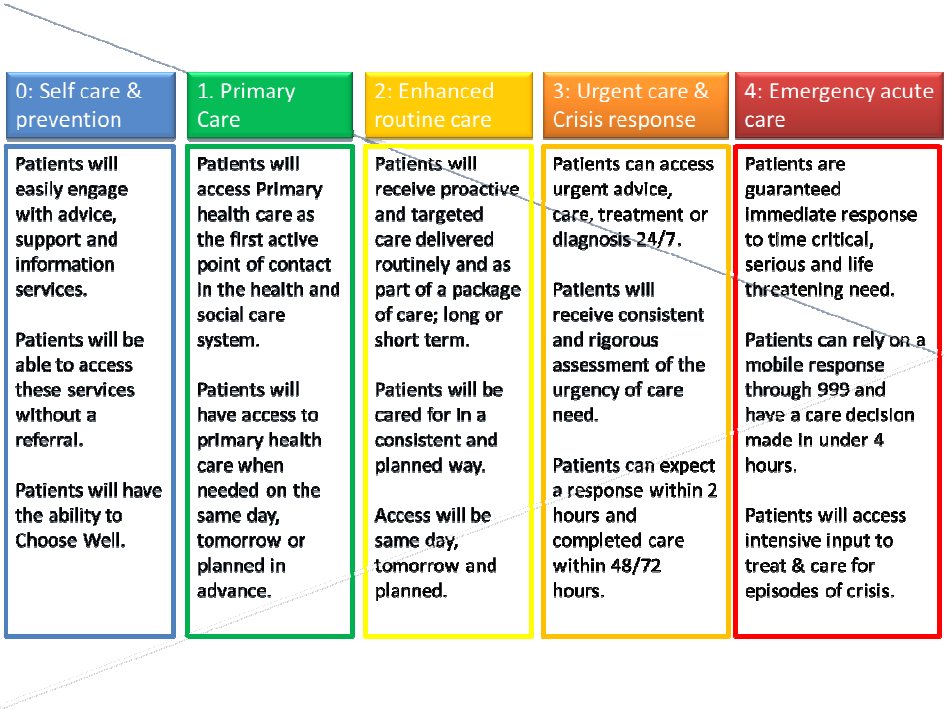


Figure 4: Care Setting Patient Outcomes

Care Setting Patient Outcomes: What can patients expect from each care setting of the urgent and emergency care system?

0: Self care & prevention	1. Primary Care	2: Enhanced routine care	3: Urgent care & Crisis response	4: Emergency acute care
I am able to look after my physical and mental well being day to day. I am able to access self-care advice when needed. I know where to get guidance on the resources I can use from the health and social care system. I will be able to access patient education courses. I am linked in to the wider voluntary and community support networks in my area. I know who to call if I want more information	I can get a Primary Care appointment on the same day. My GP knows what care I have been receiving elsewhere. I am referred promptly to other services when needed. I feel supported to manage my own condition. My mental health needs are given equal priority.	I am involved in my care and understand my condition. I have a named care worker and a care plan shared across partner agencies. I am supported at home and in the community. I am helped to navigate the system. I can talk with my GP about my care plan. I know who to call if I am worried. I can access short or long term care depending on my needs. I am assessed once and have regular check ups.	I can access the same level of treatment at any UCC within LLR. I can access crisis response services within 2 hours day or night. I can speak to a clinician about my urgent care needs within 2 hours. I have rapid access to community services when needed. I understand alternative options to the Emergency Department. I am seen by trained and competent staff.	I will be seen promptly if I need to attend A&E. I will have access to senior clinical advice when needed. My onward care decisions will be made quickly. If admission is necessary, I will be transferred to a ward in a timely fashion. I will have comprehensive discharge planning in place upon admission. I will not be in hospital for longer than is necessary. I will be discharged before 12pm on day of discharge and have no delays. I will be returned home as the first and preferred option.

13. Appendix B: Performance Graphs

Figure 1: A&E Performance (All Attendances)

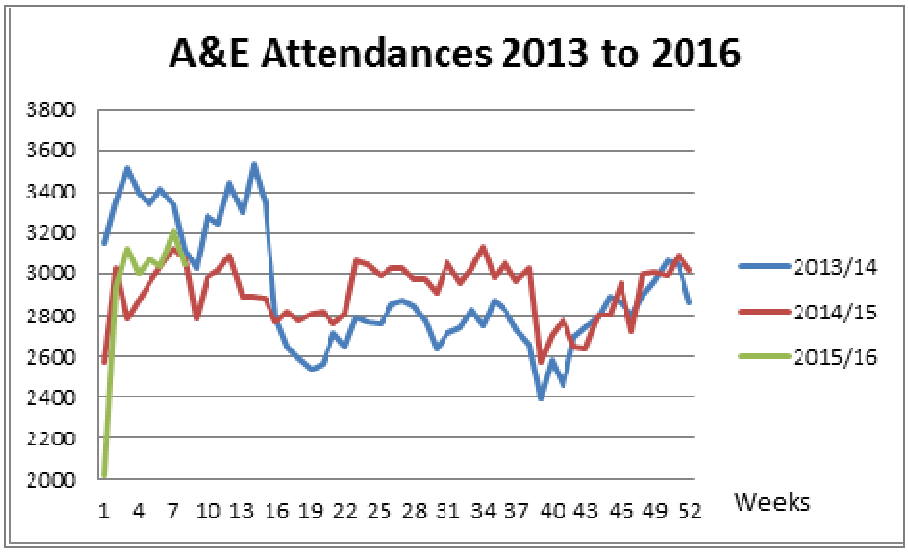
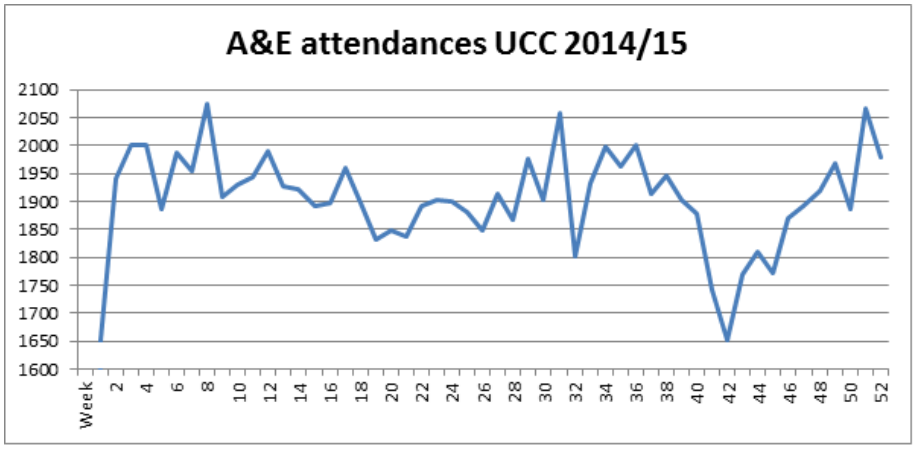


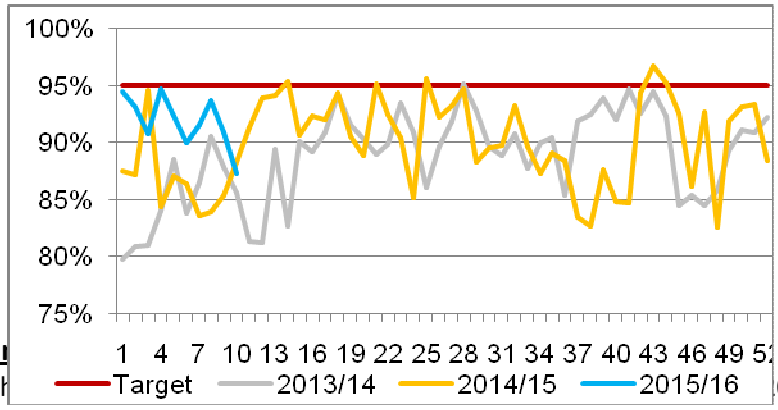
Figure 2: A&E Performance (UCC Attendances)



A&E performance (4 hour target):

As the data below shows, A&E performance against the 4 hour target was not sustained above 95% during 2014/15:

Figure 3: UHL LRI and UCC - All Activity - for patients waiting under 4 hours



E

Th 015-16 activity in blue; the red line indicates the 2015/16 target:

Figure 4: UHL Emergency Admissions

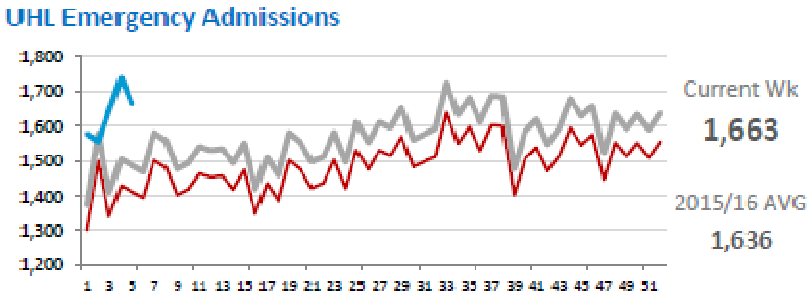
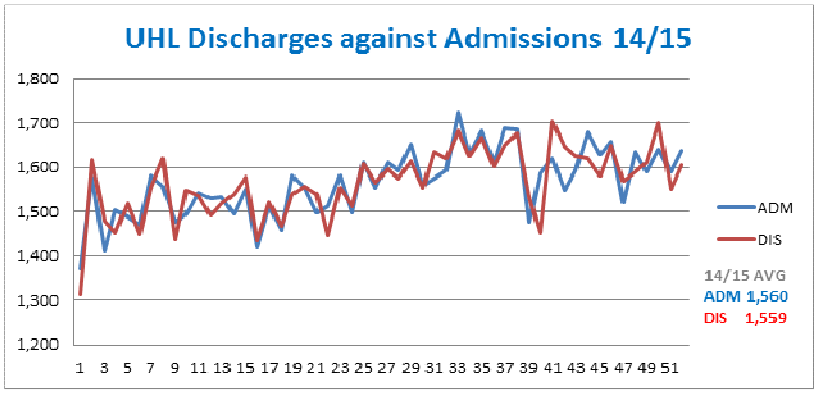
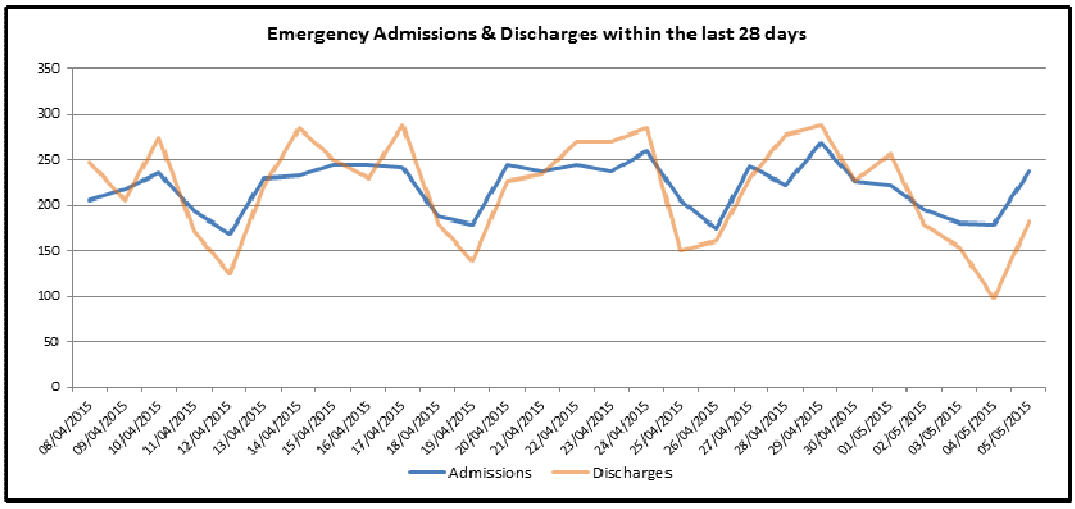


Figure 5: UHL Discharges against Admissions 2014/15



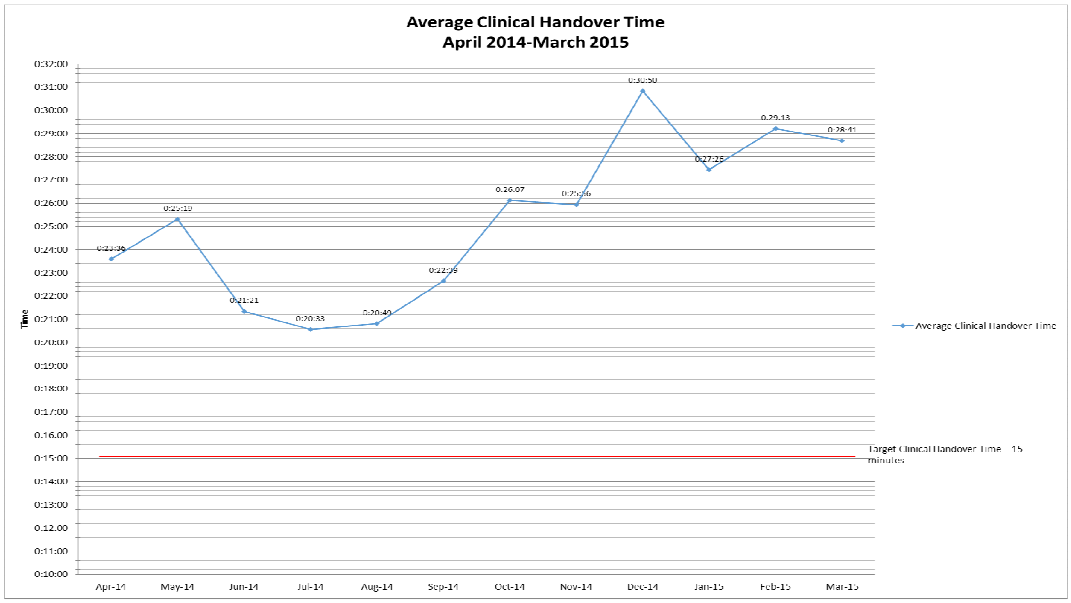
This shows significant variation which poses challenge to seven day and weekend working. The graph below shows a daily rate over a 4 week period and shows a consistent pattern with an Admission v Discharge gap each Saturday, Sunday and Monday which is countered by increasing discharges later in the week:

Figure 6: Emergency admissions and discharges within last 28 days



Ambulance Handovers:

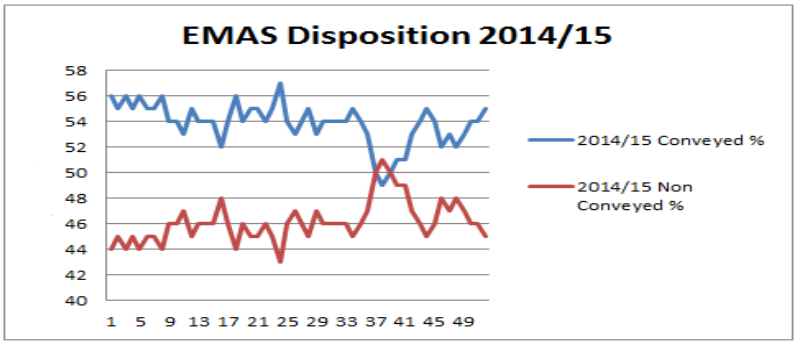
Figure 7: Average monthly handover times for 2014/15



Ambulance Conveyances:

The graph below shows that there is an increasing trend for non-conveyance, starting the year with rates of 44% and by the end of the year averaging 46%:

Figure 8: EMAS dispositions 2014/15



Delayed Transfers of Care (DTOC):

Figure 9: DTOC rates at UHL 2014/15

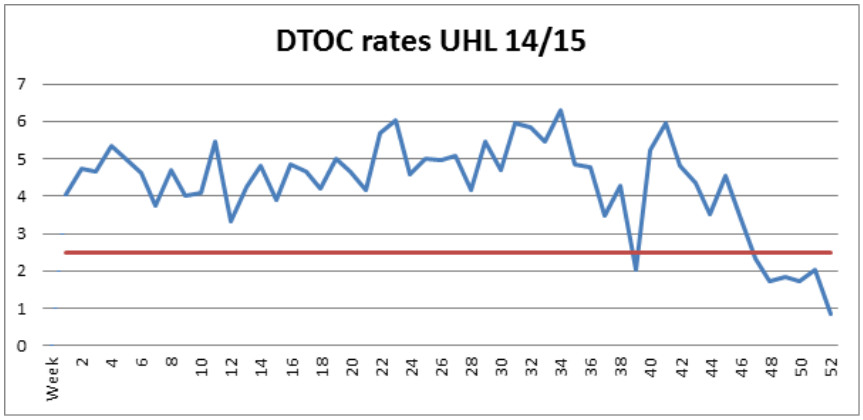


Figure 10: % of UHL DTOC per quarter

% of UHL DTOC	Q1ytd	Q2	Q3	Q4
Baseline	4.46	4.81	4.79	3.26
Target	2.5	2.5	2.5	2.5
Actual	1.2			
Variance	1.3			

The graph below shows DTOC rates for Community Hospitals within LPT, which indicate an increase from the beginning of November 2014: average rate in April 15 was 8.8% against an aspirational target of 6.5%:

Figure 11: DTOC rates for community hospitals (LPT) 2014/15

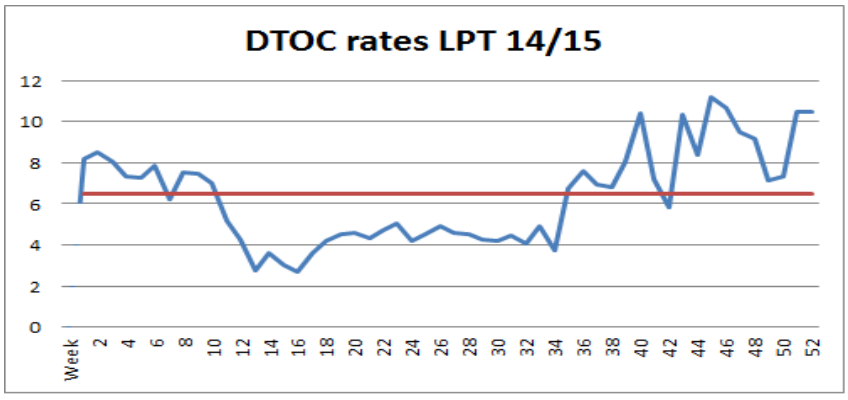


Figure 12: % of LPT DTOC per quarter

% of LPT DTOC	Q1ytd	Q2	Q3	Q4
Baseline	6.75	4.15	5.46	9.08
Target	4.0	4.0	4.0	4.0
Actual	9.5			
Variance	5.5			

The graph below shows that there has been no sustainable progress made over the last 12 months to reduce the numbers of patients with extended lengths of stay:

Figure 13: Patient aged >75years with Length of Stay >10 days at UHL

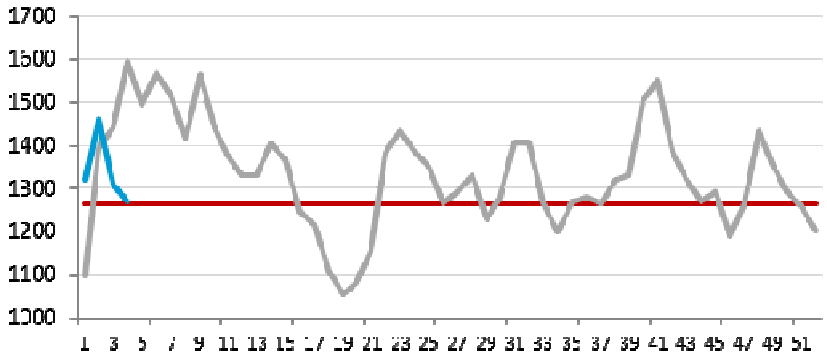


Figure 14: Over 75 with length of stay >10 days UHL

Aged 75+ with a length of stay >10days at UHL	Q1	Q2	Q3	Q4
Baseline	191	191	191	191
Projected activity reduction	181	181	181	181
Actual	187			
Variance	-6			

Figure 15: % discharged before midday

% discharged before 12 midday	Q1ytd	Q2	Q3	Q4
Baseline	10.6	10.6	10.6	10.6
Target	11%	18%	25%	30%
Actual	10.3			
Variance	-12.1			

Figure 16: Total number of re-beds

Total number of re-beds (Arriva aborts)	Q1ytd	Q2	Q3	Q4
Baseline	0	0	0	0

Target	8	6	3	0
Actual	8.4			
Variance	-8.4			

Figure 17: 90 day readmission rate

90 day readmission rate	Q1	Q2	Q3	Q4
Baseline	3111	3111	3111	3111
Projected activity reduction	2800	2800	2800	2800
Actual	2728			
Variance	72			

14. Appendix C: 8 High Impact Interventions NHSE submission

Operational Resilience Planning for Urgent and Emergency Care

High Impact Interventions

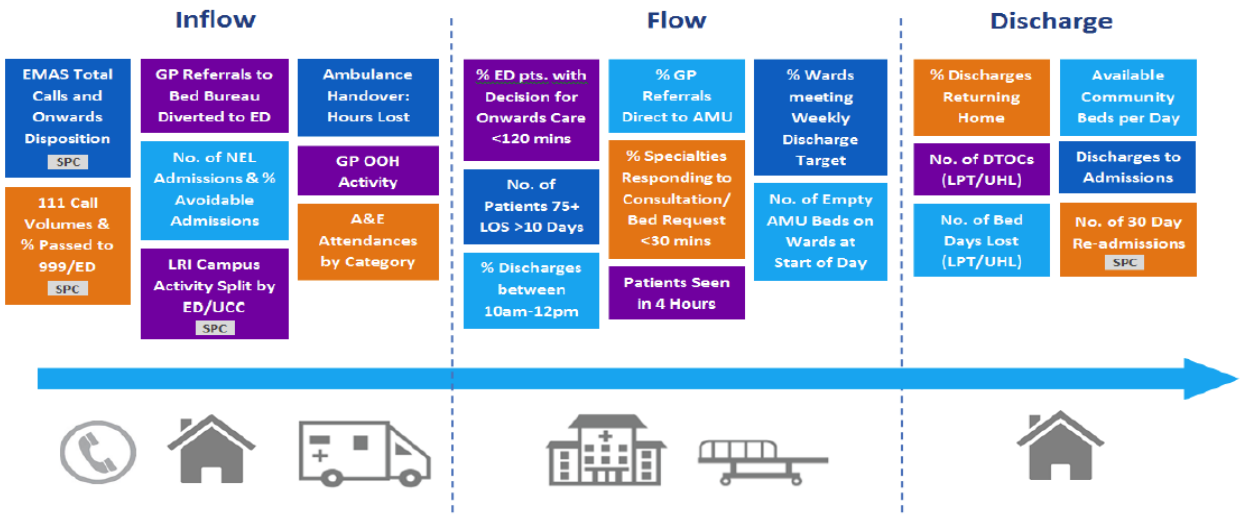
In support of implementation of the Urgent and Emergency Care Review, NHS England has identified eight interventions that every SRG is expected to address and include in final operational plan submissions. We have developed one Leicester, Leicestershire & Rutland (LLR) wide system narrative to show how we are meeting the eight interventions and this will be included as an Appendix to the CCG submissions.

The Urgent Care Board is also developing the LLR Urgent Care System Improvement Plan 2015/16 that will set out our strategic direction and work programme needed over 2015/16 within the wider context of our 5 year journey to the proposed future model of Urgent Care. This will also include the plans in place to address the implementation of the eight high impact interventions. This will take a system-wide view and will relate to the programmes of work being undertaken by the following sub-groups of the Urgent Care Board; Inflow, Flow, Discharge and Longer Term Strategy.

The eight high impact interventions are mapped to the following UCB sub-groups:

Sub-Group	Interventions
Inflow	**1,3,4,5**
Flow	**6,7**
Discharge	**8**
Longer Term Strategy	**2**

The Urgent Care Dashboard displays the system-level KPIs:



Intervention 1: Inflow Sub-Group

No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out of hours services.

CURRENT POSITION:

PROPOSED LEVEL: PARTIAL

Improving access to General Practice

General practice access varies across Leicester, Leicestershire & Rutland (LLR). There are a range of initiatives to support patients both in hours and out of hours currently in place:

- We are currently awaiting the NHSE Area Team evaluation of the previous LES. In 2014/15 56 undertook the DES. This has been reissued in 2015/16 and we are awaiting details of the uptake.
- A pilot of virtual consultations have recently commenced in West Leicestershire. They are very much in their infancy but lessons learned will be shared across CCGs.
- West Leicestershire, East Leicestershire & Rutland have piloted 7-day locality on-call initiatives, part funded by the BCF.
- Personalised care plans have been completed for the risk stratified top 2% of the population to ensure that all appropriate care is delivered in a 'home first' environment, patients' wishes are adhered to and patients are not unnecessarily conveyed to A&E.

Services to support General Practice

- ECP 'In car' services in the form of the Clinical Response Team (Leicester City) and the Acute Visiting Service (AVS) (West Leicestershire) provides 7 day support for two of the three CCGs but at present there is nothing similar in East Leicestershire & Rutland.
- Loughborough's Older Persons Unit has seen an increase in referrals but is still not fully optimised. There is ongoing work with the GPs too increase utilisation.

The relationship between General Practice and Care Homes

- Care homes have all been provided with the GP 'back office' numbers to support in hours access to a senior clinical review in a timely manner prior to a decision to admit to hospital being made. Knowledge and use of these phone numbers is variable at present.
- The CCGs have dedicated care home pharmacy resources; patients can be immediately referred to their GP by the pharmacists for anticipatory support.
- Care homes have all been provided with posters detailing each LLR CCG's service options in hours and out of hours.
- Care homes experience difficulties in registering new patients in some GP surgeries on Friday afternoons (and no registrations possible at weekends), occasionally giving no option other than A&E if an unplanned intervention is required.

Utilisation of Urgent Care Centre (UCC) and Walk In Centres (WIC)

LLR now has six UCCs and one WIC. However, the patient offer is variable at present:

- Urgent Care Centres and Walk In Centres are in the process of having their services aligned to provide consistency of approach, remove public confusion of the (previous) variety of services available at each location and facilitate easier access to a GP when the registered GP is not a suitable option.
- The Single Front Door to UHL, via the Urgent Care Centre, negates all walk in access to A&E; it assesses all patients presenting and those who are appropriate for non-acute care are identified, triaged and treated either within the Urgent Care Centre by a GP/ENP or signposted to an appropriate alternative care pathway.
- There is ongoing work with EMAS to encourage the use of alternative support services to avoid

conveyance to A&E, including referral back to General Practice.

Access to Out of Hours services

The OOH across LLR is provided by Central Nottinghamshire Clinical Services (CNCS). There have been some concerns around the level of workforce and this is being addressed contractually.

The OOH service can refer either to their appointment—based clinics, to the UCCs, to Bed Bureau and to the in-car services. They also have direct access to the community nursing and social care services.

WHAT FURTHER PLANS ARE IN PLACE TO STRENGTHEN THIS POSITION/Include where these are located :

Each CCG is developing 7-day access – Leicester City through the Prime Minsters Challenge Fund, East Leicester & Rutland via the roll out of their hub-based service, West Leicestershire through the evaluation of current pilot schemes to inform service model (Q1-2 2015/16):

- A review of all LLR GP opening hours will be conducted to ensure full compliance with the GP Contract (Q1 2015/16).
- Leicester City CCG has been awarded Prime Minister's Challenge Funding to implement hub-based access to primary care over the weekends (Q1-2 2015/16).
- Leicester City CCG is enhancing its Clinical Response Team to include pro-active care (Q1 2015/16).
- East Leicestershire & Rutland will roll out its hub-based service for 7-day support for complex patients (Q1 2015/16).
- East Leicestershire & Rutland will develop a model to deliver similar benefits to the CRT & AVS (Q1 2015/16).
- The LLR Care Homes Group (Inflow sub-group) is being re-launched to target the top 5 areas of focus and facilitate consistency of offer to all care homes (Q1 2015/16).
- A mechanism for the electronic sharing of care plans with all partner agencies will be agreed (Q2 2015/16).
- CNCS Out of Hours is working with its commissioners to implement wider access to the OOH Health Care Professionals telephone line to incorporate residential homes (as well as the existing access for nursing homes) (Q1 2015/16).
- Derbyshire Health United is working in partnership with CNCS OOH for a pilot to utilise an appropriately experienced GP to support strengthened triage of 111 calls. This has been extended from Easter 2015 to include the two May bank holidays, for full evaluation at the beginning of June 2015 (Q1 2015/16).
- A review of the previous 'Bounceback' scheme will be conducted at the May 2015 Demand Group meeting (Q1 2015/16).
- EMAS will complete their Pathfinder training, Falls training, roll out the Mobile DoS to all staff and look to introduce smartphones to support all available alternatives to admission (Q1-2 2015/16).
- The RCGP Patient access to general practice: ideas and challenges from the front line document will be reviewed to ensure that LLR has considered all of the recommendations (Q1 2015/16).

ANTICIPATED IMPACT CURRENT POSITION & PLANS WILL HAVE:

- Reduction in A&E attendances.
- Reduction in Emergency Admissions.
- Increase in use of alternatives to admission by GPs, EMAS and care homes.

Intervention 2: Longer Term Strategy Sub-Group

Calls to the ambulance 999 service and NHS 111 should undergo clinical triage before an ambulance or A&E disposition is made. A common clinical advice hub between NHS 111, ambulance services and out-of-hours GPs should be considered.

CURRENT POSITION:

PROPOSED LEVEL: PARTIALLY

There is a local CAT scheme in place that takes EMAS clinical triage and links it to our local SPA and 111. It can warm transfer 999 calls back into our local services. This introduces clinical triage which is linked to the local SPA DoS and has supported local dispositions to service other than ambulance dispatch i.e. the EFU in Loughborough, local UC centres and local community services around the issue of falls. This has raised confidence in shared working environments and shown LLR can work across boundaries.

Over Easter LLR introduced GP triage into 111 with an aim of reducing Ambulance dispatch from calls escalating to 999 and reducing number of calls with an outcome of A&E disposition.

LLR is working towards a common clinical advice hub between NHS 111, 999 and OOHs as well as ultimately looking to integrate SPA and social care's Customer Service Centres social care to have one signposting and triage service for the health and social care system. This will be achieved through a staged process; looking to integrate 111 and 999 and link in OOHs. Our local short to medium term plans will maximise interim benefits of combined clinical triage as we work to establish this.

We are required to have new services procured for 111 and OOH's services by April 2016. These procurements are in differing states of readiness and currently have slightly differing strategic drivers. An Urgent Care Future Working Group has been established to resolve this issue and to develop a longer term plan where these two programmes of work can converge into a single offer. The current plan is to develop the two services in parallel in the short to medium term with a clearly published plan for vertical integration of 111/999 and OOH's clinical triage components with our local SPA offer as the local models of care that meet the 5 year forward view challenge develop.

111 procurement:

- Strategic options for increasing the clinical triage capability of 111 (including the areas of ambulance or A&E disposition) have been reviewed by all 3 CCG's and a shared approach agreed.
- The initial short/medium term direction is to maximise the clinical triage capability between 111/999.
- This strategic approach has been discussed through LLR's collaborative commissioning group and ratified by LLR's CCG boards.
- In parallel with this activity the strategic approach has been shared with the regional CCG congress and a process for a single regional procurement to be completed by April 2016 has been developed.
- This process which includes an option to develop individual procurement lots to cover local variance across the region will be ratified as an approach in May Congress. With all regional CCG boards having had an opportunity to review the options and agree the approach by April 2015.
- Local groups to develop a shared specification across CCG's which ensures that clinical triage benefits between 111/999 services have been initiated. The specification is due to be completed by the end of June.
- The Collaborative Commissioning Board for LLR has begun to mobilise the resources from the 3 CCG's that will be required to get to a successful procurement.
- Arden Gem CSU are working with all CCG's across the region to support the procurement timeline.

OOH's procurement:

There is a greater local complexity in this area that is compounded by local deliberations around what 7 day service will contribute to closing the OOH's gap, and what local models of care will look like (and what they would leave in the OOH's period). It should be noted that community health services that contribute to the avoidance of admission for urgent care causes work for a longer period than core primary medical care services and this is a challenge that the locally developing primary medical care federations are working through.

Given the time pressures of having an effective procurement for the OOH's service by April 2016, the Urgent Care Futures Group have been assigned the task of resolving the following issues during June:

- The Duration of the next OOH procurement contract
- What the core deliverables of the OOH service will be at a strategic level
- How these deliverables will interface with our local SPA services at a strategic level
- How the handover from in hours primary medical care services will maximise at risk patient benefits for the OOH's period.

During July the same group will develop the outline specification for OOH's service and engage both Collaborative commissioning bodies and CCG boards in their findings, with the aim of going out to procurement for the solutions by September 2015.

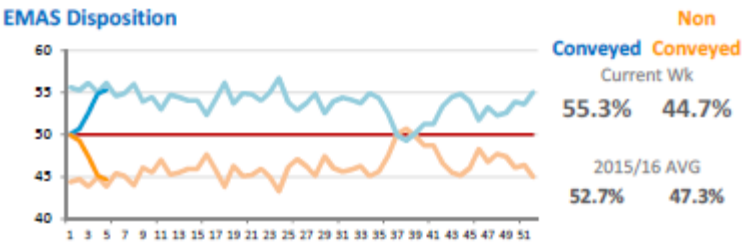
WHAT FURTHER PLANS ARE IN PLACE TO STRENGTHEN THIS POSITION/Include where these are located :

What is clear from the current deliberations is the strategic view that optimising same day access to primary medical care and optimising clinical triage between our GP's and our local SPA services will reduce the amount of care that is left to the OOH's period. Current plans focus on the within year procurements of 111 and OOHs whilst the longer term plans are being progressed through the Urgent Care Future Working Group.

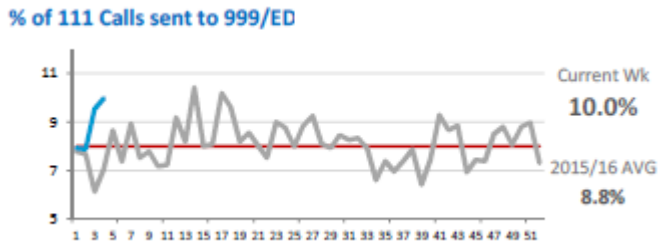
ANTICIPATED IMPACT CURRENT POSITION & PLANS WILL HAVE:

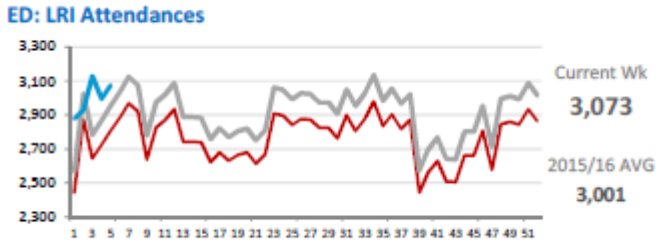
EMAS non-conveyance:

- Improve hear, see and treat ratios for the population



Reduce attendances at ED:





Intervention 3: Inflow Sub-Group

The local Directory of Services supporting NHS 111 and ambulance services should be complete, accurate and continuously updated so that a wider range of agreed dispositions can be made.

CURRENT POSITION:

PROPOSED LEVEL: FULL

The key areas of work around the local DoS focus on implementation of the DoS, widening of the services to cover all urgent care, mobile DoS, capacity management, and integrating health & social care:

Clinical profiling

- NHS 111 Pathways clinical profiling carried out of all clinical releases against the release documentation provided by the regional lead as issued by NHS Pathways clinicians.
- All non-emergency and urgent care services profiled via a strict validation process.
- Validation with the provider and the commissioner or contract lead, clinical lead for NHS 111 LLR.
- Testing - pathways scenario testing, ranking strategy refresh and sign-off currently to release 9.
- Next phase – clinical profile release 10 due to take place from July – September 2015 (plan in place, documentation available), again following the validation process as above.
- All non-emergency, urgent care heavy foot fall services are contained within the DoS.

Clarity

- LLR DoS Lead runs sample triage pathways in pathwaysweb dos, to check for any queries which our providers, commissioners or contract leads both operational and clinical, may have.
- Comparisons of services are run (LLR DoS Lead) within DoS to check if there are any gaps in service; if this is a commissioning issue; if there is one particular service taking all the referrals for a particular pathway and other services require addressing to alleviate pressure.

Referrals

- Weekly reports are run to show utilisation levels for each available pathway and rankings adjusted as needed.

WHAT FURTHER PLANS ARE IN PLACE TO STRENGTHEN THIS POSITION/Include where these are located :

- Current pilot of 50 pharmacies taking Emergency Repeat Meds referrals, clinically profiled to the LLR D.O.S. and referral rates monitored. ITK enablement to a pharmacy hub considered going forward for onward referral to appropriate pharmacy and for an audit trail (Q1 2015/16).
- New commissioning of the Northern Doctors Urgent Care Services for an extended period of 5-9pm weekdays, enhanced hours at weekends and bank holidays, ie: 09am-19.00hrs/08am-20.00hrs (Q1 2015/16).
- Leicester City CCG – ICRS/CRT – profiling of service to the LLR DoS to trigger appropriate referrals.

Plan to take forward the following:

- Introduction of capacity management grids for UCN (Q3 2015/16).
- GP OOH's appointment booking (Q2 2015/16).
- NDUCC's appointment booking (Q2 2015/16).
- SPA – ITK enablement (Q2 2015/16).

ANTICIPATED IMPACT CURRENT POSITION & PLANS WILL HAVE:

This contributes to the targets reflected in Intervention One:

- Alleviate ED pressure, LRI UCC pressure, where appropriate, supporting management of capacity.
- Alleviate repeat prescription referrals for GP OOH's, where appropriate.
- Enable all NHS 111 call handlers to have a SPoC/SPA for Mental Health Crisis.
- Integrating Health and Social Care – SPA/3rd sector.
- Alleviating pressure on NHS 111 call handlers by providing appointment booking.

Intervention 4: Inflow Sub-Group

SRGs should ensure that the use of See and Treat in local ambulance services is maximised. This will require better access to clinical decision support and responsive community services.

CURRENT POSITION:

PROPOSED LEVEL: PARTIAL

There have been a number of initiatives, training programmes, integration of systems and pathway improvements which have aided the availability and access for frontline clinicians, improved and enhanced clinical assessment skills and streamlined decision making tools relating to patient referral outcomes:

- Paramedic Pathfinder training - identification of patient acuity and clinical intervention level using an evidenced based clinical decision making tool.
- Pre Hospital & Assessment Disposition (PHAD) training for all paramedics – enhanced level of assessment training programme for all paramedics providing a clinical platform to make a a full and comprehensive patient assessment using additional skills.
- Falls Training – dedicated falls training to further enhance the clinical decision making process, based on a holistic review of the patient and the circumstances of the fall.
- Enhanced Clinical Assessment Team - referral and support service based within the Emergency Operation Centre dedicated for both LLLR/Non LLR EMAS clinicians to confirm and identify local and approximate Alternative Care Pathway for patients meeting a See & Treat outcome.
- Dedicated Single Point of Access contact number for all EMAS clinicians to avoid delays on scene and a seamless patient transition in the unscheduled care pathway.
- Access to rapid response community services – CRT, AVS, ICRS etc. across LLR.

However, further work is required to maximise awareness of and embed all available pathways across all EMAS front line staff.

WHAT FURTHER PLANS ARE IN PLACE TO STRENGTHEN THIS POSITION/Include where these are located :

- Develop a proposal for an Enhanced Winter Clinical Assessment Team - referral and support service based within the Emergency Operation Centre dedicated for both LLLR/Non LLR EMAS clinicians to

confirm and identify local and approximate Alternative Care Pathway for patients meeting a See & Treat outcome (Q2 2015/16).

- Introduction of Mobile DoS to clinicians on an individual basis using a smartphone platform (Q2 2015/16).
- Virtual/live access to supporting pathway information internal and external (Q2 2015/16).
- Continued Falls, PHAD and Paramedic Pathfinder training 2015/16 (Q1 2015/16).
- Increased use of alternatives to admission via SPA for EMAS staff (ongoing).
- Active membership of partner groups to ensure direct engagement with new initiatives and review of current ones (ongoing).

ANTICIPATED IMPACT CURRENT POSITION & PLANS WILL HAVE:

This contributes to the targets reflected in Intervention 1:

- Utilisation of all referral pathways is improving with the evidenced increases noted across the country for both health and social care services.
- LLR non-conveyance for April at 47.51% (subject to validation).
- 4% above the Trust metric and highest percentage across all Divisions.

Intervention 5: Inflow Sub-Group

Around 20-30% of ambulance calls are due to falls in the elderly, many of which occur in care homes. Each care home should have arrangements with primary care, pharmacy and falls services for prevention and response training, to support management falls without conveyance to hospital where appropriate.

CURRENT POSITION:

PROPOSED LEVEL: PARTIAL

There is an established LLR multi agency Falls Group which meets monthly to review the Falls activity dashboard and for the implementation of the Falls Prevention Strategy:

- EMAS currently have a 48.47% (validated) non-conveyance rate for Falls patients against a Trust performance of 47.8%.
- EMAS bespoke Falls training for all front line staff commenced in October 2014.
- EMAS have a dedicated telephone line into LLR SPA to facilitate requests for community support to avoid conveyance to hospital.
- EMAS FRAT (Falls Risk Assessment Tool) scoring is aligned to community nursing tools to ensure all agencies have the same understanding of the status of the patient.
- EMAS are able to make secondary crew referrals to CRT and AVS across 7 days.
- EMAS staff provide ad hoc advice and education to care home staff as a part of their interventions.
- The Falls Decision Tree has been reviewed to incorporate the NICE guidelines updates and was reissued to all LLR care homes in early 2015.
- The Leicester City RAG rated Falls Management Guide was updated and reissued to all Leicester City care homes in early 2015.
- The Leicestershire County Falls Checklist was updated and reissued to all Leicestershire County care homes in early 2015.
- The West Leicestershire Check for Change document was updated and reissued to all West Leicestershire care homes in early 2015.
- All LLR care homes have the GP 'back office' contact numbers for requesting senior clinical decision making prior to requesting an ambulance.
- All LLR care homes have the LLR in hours and out of hours service posters.

- LLR nursing homes have direct access to the OOH Health Care Professionals telephone support line.
- LLR CCGs care homes pharmacy support provides for medicines reviews to reduce the incidence of residents' falls from polypharmacy issues.
- West Leicestershire have provided dedicated care homes staff training via community nursing to upskill staff in appropriate patient management.

WHAT FURTHER PLANS ARE IN PLACE TO STRENGTHEN THIS POSITION/Include where these are located :

There are a number of further plans in place:

- Completion of the implementation of the Falls Prevention Strategy (Q2 2015/16).
- Development of one uniform LLLR Falls Management Pathway across acute and community care (Q2 2015/16).
- EMAS Falls training will be completed in June 2015 (Q1 2015/16).
- Devise a mechanism for increased utilisation of the direct communication between EMAS and GP practices (Q2 2015/16).
- Extend access to the OOH Health Care Professionals telephone support line to residential homes (Q1 2015/16).

ANTICIPATED IMPACT CURRENT POSITION & PLANS WILL HAVE:

This contributes to the targets reflected in Intervention 1:

- EMAS are aiming for a (maximum) 75% non-conveyance rate for Falls patients upon completion of the staff training.
- Increased use of the GP back office numbers to request appropriate non-acute support.

Intervention 6: Flow Sub-Group

Rapid Assessment and Treat should be in place, to support patients in A&E and Assessment Units to receive safer and more appropriate care as they are reviewed by senior doctors early on.

CURRENT POSITION:

PROPOSED LEVEL: PARTIALLY

Rapid assessment and treatment is fully in place for ED to ensure safe and appropriate care. LRI Emergency Department has an Assessment Bay open 24x7 which is designed to ensure that a nurse-led RAT process is undertaken on patients:

- brought in by ambulance crews;
- triaged to Majors by the Urgent Care Centre;
- who are referred by GPs when Bed Bureau are closed;
- on occasion self present direct to the ED;
- are stepped down from a Resus red call.

This area in the ED is well established with a clear Standard Operating Procedure (SOP). There are a minimum of 3 and a maximum of 6 teams on at any time. The nurse teams are supported by a Senior Clinician and an ANP as minimum, who provide senior medical review and early senior decision-making. This team is at times further augmented by a GP.

On average from 30/03 to 26/04, patients were triaged within 17.2 minutes. Any patients which require rapid treatment have their notes marked with a sticker before transfer to Majors (except those requiring morphine

for 10/10 pain and sepsis patients who get immediate fluids). Intervention is partially in place for the Acute Medical Unit

From 9pm to 8am patients are reviewed by SpR. The majority of the time this is within 6 hours. From 8am - 9pm patients are seen by a Consultant through a rolling ward round, this is usually within 6 hours. There is an issue with data capture which is being mitigated through an electronic solution.

WHAT FURTHER PLANS ARE IN PLACE TO STRENGTHEN THIS POSITION/Include where these are located :

ED

The Assessment Bay management team are aware that this is an area of significant importance. To further improve performance of the Emergency Department's RAT protocol they have devised an action plan which aims to:

- Review staffing arrangements(e.g. breaks) to align to demand.
- Audit adherence to SOPs & address gaps.
- Roll out a training video.
- Consider more transformational changes such as changing protocols for UCC patients and those who are bed bureau diverts.

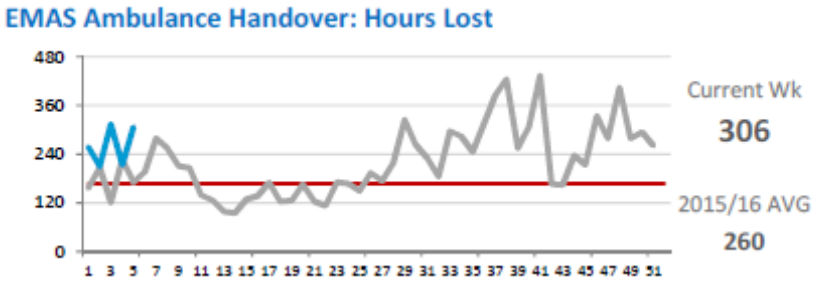
AMU

- The main area of investment required is a robust electronic method of capturing the time to review.

ANTICIPATED IMPACT CURRENT POSITION & PLANS WILL HAVE:

An improved and consistent Rapid Assessment process in A&E and Assessment units will support patients to receive safe care by accessing senior clinical decision makers early. This early assessment will improve flow through the hospital, improve the patient journey and have an impact on the following system level indicators:

- Improvement in percentage of UHL and UCC attendances seen within four hours to meet the 95% target consistently.
- Reduction in NEL admissions.
- Reduction in Hours lost due to delayed EMAS: UHL handovers (see below):



Intervention 7: Flow Sub-Group

Consultant led morning ward rounds should take place 7 days a week so that discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.

CURRENT POSITION:

PROPOSED LEVEL: PARTIALLY

Senior review of patients is occurring 7 days a week across the Trust focussing on acutely unwell patients, new patients and potential discharges. Weekend consultant rotas have been updated to provide 7-day care where possible. Monthly audits show that this is happening regularly. Weekend discharge rate is currently at 59% of weekday rate.

There has been variable impact on the discharge rate as delays are more often being attributed to other causes such as the discharge to assess process, which is also being tackled.
Nurse-led discharge is being trialled with a view to supporting weekend discharges.

Delays to expected discharges are flagged up daily at the conference calls and escalated when issues need unblocking. Community hospitals provide a full 7 day service including admission. The social service providers are working hard to provide a comprehensive service over 7 days but it is limited and variable. Ensuring availability of packages of care consistently is a focus area picked up by the Discharge sub-group.

WHAT FURTHER PLANS ARE IN PLACE TO STRENGTHEN THIS POSITION/Include where these are located :

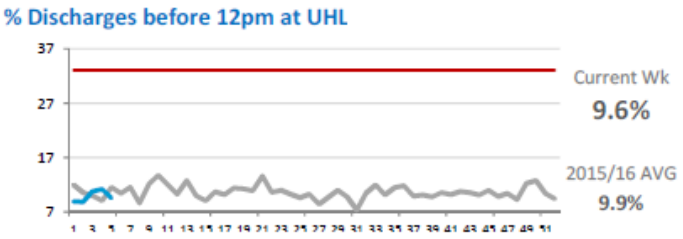
Flow as a sub group has prioritised "Improvement of 7 day working processes" as a focus area in 15/16 and is developing clear actions to progress this including:

- Nurse-led discharge is being trialled with a view to supporting weekend discharges to reduce length of stay.
- Review of Acute Medical rota to ensure consistent 7 day early morning Consultant cover to facilitate morning discharges.

ANTICIPATED IMPACT CURRENT POSITION & PLANS WILL HAVE:

Extra funding provided has been used to support the setting up of workstreams that have set KPI's around which hare reported internally. Moreover, System level indicators reported at UCB monitor the impact on discharges and admissions that improved 7 day working processes will have.

- **Increasing discharges between 8 and 12** - Target of 35% discharges to occur before midday. Currently the system is at 10%:



- **Increasing weekend discharge rate**: Target of weekend discharges being min. 80% of weekday discharges. Currently the system is at 59%.
- **Reducing bed occupancy**
- **Decreasing length of stay**
- **Decreasing delayed discharges**
- **Improved 4 hour performance** (focus on Mondays)

The workstreams feed into a weekly meeting lead by the chief executive to hold individuals accountable to performance and provide support when needed.

Intervention 8: Discharge Sub-Group

Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharged. SRGs will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.

CURRENT POSITION:

PROPOSED LEVEL: FULL

As a system Leicester, Leicestershire and Rutland health and social care organisations have undertaken detailed work on understanding the issues that impact on delayed transfer of care. The outputs of which have formed both the Transfer and Flow workstreams of the LLR Urgent Care Plan. Actions taken to date include:

- A daily system wide delayed transfer conference call where reasons for delay are identified for each patient, actions agreed and followed up.
- Improvements in the way that transport is booked.
- On site presence of social care teams including duty and rapid response teams.
- Piloting of a number of transfer to assess pathways which have resulted in patients going into enablement environments rather than determining long term care needs while still in hospital.
- Improving the availability of domiciliary care by ensuring reviews of are undertaken in a timely manner.
- Ward improvements including training of ward staff on discharge processes; discharge date set at the point of admission; improving TTOs to ensure prompt ordering and improvements to the way that GP letters are prepared.
- Deploying primary care co-ordinators who support discharges into community settings from the Emergency Department; Assessment Wards and Base Wards.
- Introduction of housing support workers to facilitate discharges for those patients experiencing housing or other related issues.
- Increase social care navigators in the emergency department to support admission avoidance.

DTOC rates for the local acute trust are detailed below. This shows that there has been some improvement in the rates in 2014/15 with the last six weeks being below the target of 2.5%. Performance below the target has been maintained to date in 2015/16. However more work is required to really embed the actions to ensure further improvement and sustainability.

WHAT FURTHER PLANS ARE IN PLACE TO STRENGTHEN THIS POSITION/Include where these are located :

In addition to continuing to embed the actions already undertaken further actions are being taken to support the sustained reduction in delayed discharges. These are:

- Developing a sustainable model to enable patients to reach their full potential following transfer (a discharge to assess approach).
- Further improvements to how transport is booked to support earlier on the day discharge and managing capacity in times of surge.
- Continue to ensure that exploration of a patients informal and community support is considered prior to Local Authority service provision and that domiciliary support is utilised appropriately in promoting a patient's independence. This in turn will reduce demand and ensure sufficient domiciliary care capacity particularly in rural areas where this is currently a challenge.
- Undertaking a dialogue with patients and families to enable a better understanding of the transfer process, respective responsibilities and impact of remaining in hospital has on the patient.
- Working with the care home sector to facilitate transfers seven days a week.
- Improving the flow through community services including improving the referral process; early allocation of patient being transferred from acute to community beds; dedicated co-ordinator; and follow up of patients discharged from ED back home by community staff.
- Ensure there is sufficient capacity with the Primary Care Co-Ordinator service to support the transfer of patients in a timely manner.

ANTICIPATED IMPACT CURRENT POSITION & PLANS WILL HAVE:

The actions being taken aim to maintain the DTOC level below the 2.5% target. In addition there are a number of other indicators that the actions will impact on by the end of 2015/16, including:

- Reduction in the number of rebeds.
- Increase in the number of discharges to care homes over the weekend.
- Improvement in the number of patients remaining at home after 90 days of discharge.
- Reduction in the number of Continuing Health Care packages of care through the availability of enablement and discharge to assess pathways.
- Decrease in the number of delays due to family choice and availability of packages of care.
- Reduction in the length of stay in both acute and community hospitals including those aged over 75 with a length of stay over 10 days.
- Increase in the number of patients aged of 75 who return home.

15. Appendix D: Winter Monies Funding Table

Scheme No.	Scheme Name	Organisation	New	Revised Proposals			Total
				Costs incurred	Committed	Proposed	
Inflow	Winter Communications	LC CCG on behalf of all partners			£50,000	£200,000	
Flow	UCC Transfer Nurses	GE		£30,000	£134,000		
Flow	LPT surge support October to March	LPT	Yes			£150,000	
Flow	Additional PCC cover for Glenfield	LPT		£0	£0	£131,000	
Discharge	Additional transport to support surge and TTO car	Arriva		£58,000		£290,000	
Discharge	NRS equipment delivery October to March	NRS		£37,000			
Inflow	ED, UCC's waiting times - web based		YES			£20,000	
Discharge	Care home capacity report		YES			£5,000	
	EY Consultancy		YES	£150,000			
	CHS to suport UHL D2A	UHL		£20,000		£40,000	
	D2A assessor - band 7	UHL			£50,000		
Flow	7 day cover for social workers	Leicester City Council			£184,000		
Inflow	Supporting primary care surge	Leicester City CCG				£100,000	
Inflow	Supporting primary care surge	West Leicestershire CCG				£100,000	
Inflow	Supporting primary care surge	East Leicestershire and Rutland CCG				£100,000	
Discharge	Non Weight Bearing Pathway	Leicestershire County Council			£65,000	£62,000	
Flow	7 day cover for social workers	Leicestershire County Council				£143,000	
Flow	7 day cover for social workers	Rutland County Council				£14,000	
TOTAL				£295,000	£483,000	£1,355,000	£2,133,000