UHL Emergency Performance

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

Executive Summary

Context

We remain under acute operational pressure caused by a combination of increased demand and sub-optimal processes internally and across the system.

A refocus on high impact actions via the new AE Delivery Board and AE implementation group aims to decrease attendance, reduce admissions and improve processes, thus improving 4 hour performance.

We will be implementing Red to Green methodology across the medical base wards at LRI on Monday 12 December and we are very optimistic about the impact it will have on discharges, flow, quality of care, patient and staff experience and ED performance. A more detailed verbal update on R2G will be provided at the trust board.

Questions

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

Conclusion

The RAP has been agreed by LLR, NHSE and NHSI as a credible plan to deliver change and progress is being made on delivering the actions via the AE implementation group externally and EQSG internally. ECIP have launched Cohort two (Midlands and East Region) of their Emergency Care Improvement Programme which we are part of and will therefore receive additional support. UHL continued to focus on internal actions and working with LPT, EMAS and CCGs to ensure we see reductions in attendance and improved discharge processes. It is acknowledged that there is a great deal of work to be done as we head into a challenging time of year with expected increase in attendances and admissions.

Our key risks remain:

1. The growing imbalance between demand and capacity
1. Variable clinical engagement
2. The challenges in transforming a service when we are also trying to focus on the ‘here and now’

Input Sought

The Board is invited to consider the issues and support the approach set out in the report.

For Reference

Edit as appropriate:

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

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

2.This matter relates to the following governance initiatives:

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

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

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

5.Scheduled date for the next paper on this topic: 5 January 2017

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

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

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

Four hour performance

2016/17 YTD

- We are seeing an average of 652 patients everyday through ED at the Leicester Royal Infirmary
- 16/17 performance YTD is 79.5% and October's performance was 78.3%
- 15/16 performance YTD was 91.3% and October 2015 was 88.9%
- YTD attendance 7% up on the same period last year – Nb - the increased use of GPAU makes a like for like comparison more difficult now
- YTD total admissions are similar to last year's levels – NB - – the increased use of GPAU makes a like for like comparison more difficult now

November 2016

- Month to date - November 1 to 16 is 74.4%
- Week ending 20/11/16 – we saw 693 patients on average every day, including a **new 24 hour high of 776 patients on Tuesday 15 November 2016**

ED occupancy

High attendance and variable outflow from the department has resulted in high ED occupancy. In the first 16 days of November, there have been 15 days when ED occupancy has exceeded 100 patients. As in September and October, there have been a number of days when we have been on critical incident in relation to poor ward capacity and high ED occupancy and inflow. Moreover, an internal major incident was called on 16 November following five days of increased emergency pressures, which saw over 140 patients in the department at some points.

Discharges

Adult emergency admissions and discharges are slightly lower, month to date, than November 2015. This will partially be linked to the impact of GPAU. (If fewer patients are admitted, there are fewer patients to discharge). As forecast in our demand and capacity plan, outlying increased from an average of eight beds per day in August to 21 beds per day in September and peaked at 31 patients in October. We have continued outlying throughout November which is impacting on Ca and RTT performance.

Sustainability and Transformation Fund (STF)

October's STF was not achieved and the start of November has been challenging, putting November's delivery at risk:

	STF Trajectory 4hr Performance	**Actual 4hr Performance**	STF Achieved?
Apr-16	78%	**81%**	Achieved
May-16	78%	**80%**	Achieved
Jun-16	79%	**81%**	Achieved
Jul-16	79%	**77%**	Not Achieved
Aug-16	80%	**80%**	Achieved
Sep-16	85%	**80%**	Not Achieved
Oct-16	85%	**78%**	Not Achieved
Nov-16*	85%	**74%**	Not Achieved
Dec-16	85%		
Jan-17	89%		
Feb-17	89%		
Mar-17	91.2%		

Nov-16* - 1st Nov to 16th Nov

A&E Delivery Board (LLR)

The A&E Delivery Board continues to meet fortnightly and the latest Recovery Action Plan (RAP) is attached showing progress against the 5 key interventions:

1. Improved streaming at the front door
2. Increased use of NHS 111
3. Increased ambulance divert away from ED
4. Improved flow
5. Improved discharge

The A&E implementation group continues to meet monthly to progress the RAP actions and ensure confirm and challenge against actions and deliverables is in place across the health economy.

Members of the A&E Delivery Board including the UHL CEO and COO attended a meeting with Dale Bywater and Jeff Worrall from NHSI on Tuesday 22 November 2016 to review the actions that are being taken to improve emergency care performance. The paper reviewed in the meeting and the actions agreed are attached to this document. It is likely these meetings will be fortnightly.

Progress on seven key UHL actions in the RAP for November

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

1. Reduction in patients breaching by ten minutes

Month	ED Type 1 Attendance	All ED Type 1 Breaches	Breaches between 241 and 250 Minutes	% of Total
Jun-16	12455	3613	145	4%
Jul-16	12624	4450	160	4%
Aug-16	12367	3716	153	4%
Sep-16	12963	3818	140	4%
Oct-16	12939	4333	126	3%

By focusing on roles and responsibilities in the team and ensuring everyone understands what they are responsible for delivering, we have achieved a marginal improvement in performance. The team continue to focus on this goal in order to maintain this improvement.

2. Reduction in non-admitted / out of hours breaches

October has seen a small reduction in out of hours breaches and an overnight diagnostic has resulted in the set-up of a task and finish group looking at options for improvement in medical cover overnight to enable further improvements. This piece of work will be completed by the end of November and then options presented to the Emergency Care Programme Leadership team.

Despite high levels of activity, we are now consistently seeing compliant performance in the UCC because of the actions we have taken to improve the front door flow.

Day	Arrival Date	%<4Hrs
Monday	14/11/2016	95.81%
Tuesday	15/11/2016	94.57%
Wednesday	16/11/2016	97.22%
Thursday	17/11/2016	100.00%
Friday	18/11/2016	98.58%
Saturday	19/11/2016	99.53%
Sunday	20/11/2016	93.78%
Cumulative	*Mon-Sun*	**96.92%**
Last 7 Days	*recent data*	**96.92%**
Current Month	*November*	**96.90%**
Year to Date	**all data**	**93.58%**

3. Implementation of rapid assessment and early decision to move to ambulatory

This action has been delayed due to a period of leave in the senior nursing team. This will be implemented in the later part of November and will therefore be reported on next month.

4. Move GPAU to yellow zone and utilisation of the space GPAU leaves behind

GPAU moved from its current location on ward 16 (level 5 Balmoral) to the yellow zone space in the Emergency Department on Monday 7 November. In its new location, GPAU does not only see the patients that it usually does, it also takes appropriate ambulatory patients from the Urgent Care Centre and Emergency Department, including those patients that arrive by ambulance. This should help us to decongest the Emergency Department, and help to treat patients in the right place, first time. The aim is to treat all GP referrals as ambulatory until proven otherwise, and also in-reach to majors to offer an alternative pathway to admission on AMU for suitable patients.

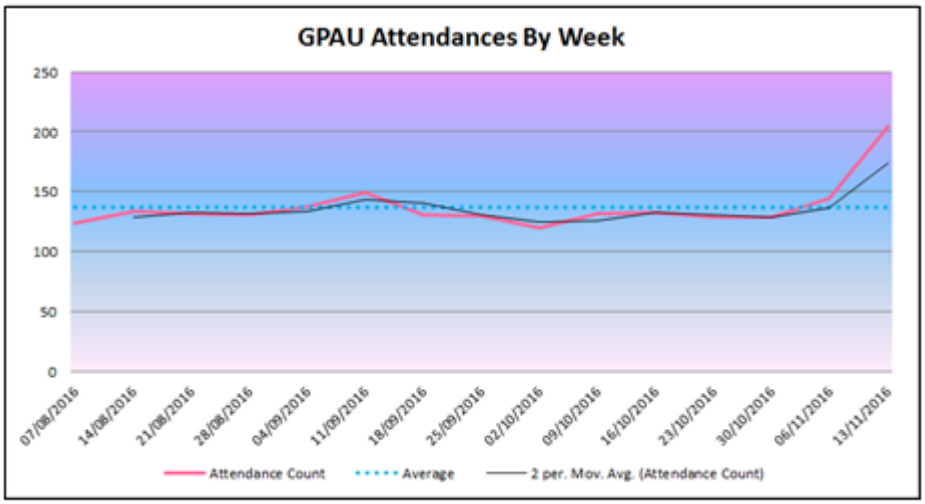
GPAU will continue to be staffed by the acute medical team, working closely with the ED team. The referral process to GPAU will not change. The GPAU model is the one that we will use when the new Emergency Floor opens in March. Relocating GPAU to ED now gives us the next 19 weeks (until the new Emergency Floor opens), to test and refine the way we work and ensure we get it right for patients.

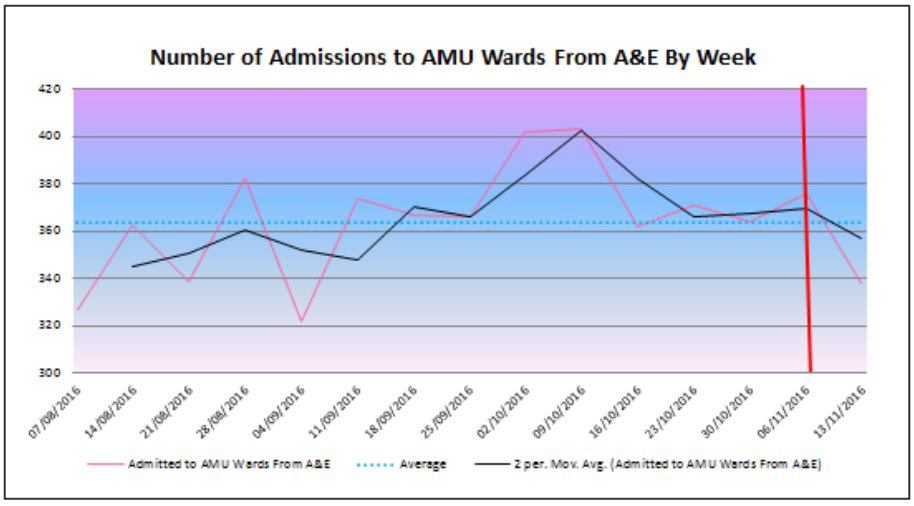
What type of patients will be seen in GPAU?

- Patients referred in from their GP via the Bed Bureau for medical admission
- Ambulatory medical patients who come to ED via ambulance
- Patients from the Urgent Care Centre who are DPS 3 and thought to require a medical admission/opinion.

The vacated space is being used as a rapid flow area, to support earlier flow from ED to AMU.

The increase in the volume of patients attending GPAU is detailed below.





5. Ambulance handovers

October's position was an improvement on September's, however remains extremely poor. November has seen a difficult start to the month. From 14 November, service managers have moved back to support this function to ensuring it is as efficient as possible. The next step is to decide how to address the out of hours deterioration in handover; a plan will be worked up and feedback in January 2017.

Handover data (CAD+) is detailed below:

	Under 15 Mins Delays %	% Delay Over 15 mins (CAD+)	% Delay Over 20 mins (CAD+)	% Delay Over 30 mins (CAD+)	% Delay Over 45 mins (CAD+)	% Delay Over 60 mins (CAD+)	% Delay Over 120 mins (CAD+)
Dec-15	35.1%	64.9%	53.5%	37.2%	23.7%	15.6%	3.3%
Jan-16	57.4%	42.6%	35.4%	24.9%	16.3%	12.0%	3.3%
Feb-16	60.3%	39.7%	31.5%	22.4%	14.8%	9.8%	2.2%
Mar-16	56.0%	44.0%	35.3%	23.7%	15.6%	10.7%	2.7%
Apr-16	58.9%	41.1%	29.5%	17.1%	9.6%	6.0%	0.9%
May-16	57.3%	42.7%	30.4%	17.6%	9.1%	5.6%	0.8%
Jun-16	59.9%	40.1%	28.7%	16.1%	9.2%	5.7%	0.5%
Jul-16	50.7%	49.3%	38.0%	23.7%	14.1%	8.9%	1.5%
Aug-16	53.8%	46.2%	34.5%	20.6%	11.1%	6.6%	0.8%
Sep-16	51.2%	48.8%	37.8%	24.3%	15.0%	9.5%	1.4%
Oct-16	47.5%	52.5%	41.8%	27.6%	14.5%	9.2%	1.2%
Nov-16	43.2%	56.8%	48.0%	34.0%	21.8%	15.2%	2.8%

6. Opening additional medical capacity at the LRI on ward seven

Opening additional medical capacity by using ward 7 (28 beds) at the LRI is a key part of our winter plan, however we have been unable to open the whole ward as planned on 1 November 2016 because of the underlying nurse vacancies.

During the first half of November, ward 7 has consistently had 4 bays opened; 2 bays (fully bedded) have been used for next day discharge patients and 2 bays (each with 3 beds/3 recliners) have been used as the discharge lounge (discharge lounge is currently shut for refurbishment). From 14 November, a third bay is being opened and the team continue to focus on recruitment to enable further staged opening of the ward.

The date for moving the discharge lounge back to the newly refurbished area (available from the 28 November) is under discussion so we ensure maximum bed capacity with staff available.

7. SAFER bundle and Red to Green

In November we have been working on the plan to roll out Red to Green and the SAFER bundle. Red to Green will be implemented across the 13 medical base wards at the LRI on Monday 12 December 2016.

The main aim of red to green is to reduce overall bed occupancy and improve patient flow. More details are attached as an appendix but briefly; imagine a week without back-ups in A&E, with no blockages to admission, no ward outliers, no escalation, no delays in TTAs, with everyone working together to solve problems **as soon as they occur**. Imagine the benefits to patient care that would be delivered. Well that is exactly what we will be doing with the initiative called Red to Green. We have struggled with continuing operational pressures that have seen our hospitals in and out of critical incident status and bed escalation for many months. We need a step-change in the way we deliver services if we are to deliver a safe and quality service that improves the patient's experience whilst in hospital (that we aspire to), at the level of efficiency which our commissioners and the general public demand of us. We need to break the cycle of repeated escalation measures and end the continuing disruption to normal clinical business, which disadvantages patients and frustrates clinical staff. Therefore, we have committed ourselves to a significant intervention called Red to Green Week that aims to change behaviour and identify where we can work better. The model has been designed by the Emergency Care Improvement Programme (ECIP). Several other Trusts have already used the process with excellent results.

Work streams

At EQSG on 9 November 2016, progress on the base wards and the Paediatric work streams were discussed. Key updates are in the attached.

Clinical Decisions Unit (CDU)

The CDU team continue to progress their RAP actions as detailed in the attached. Key achievements in November include:

- The low risk ambulatory service in CDU was re-started on the 1.11.16 (four days a week) with GPs seeing ambulatory patients at the front door of CDU. This will extend to five days as soon as GP resource is provided. This service will continue to end of the financial year.
- The CMG is confident the additional beds on Ward 23 will open as planned in December.

ED Front Door/Urgent Care Centre (UCC)

The ED Front Door/UCC has consistently reached above 95% performance since January 2016, with October reaching 98.8%.

On the 1 November, UHL submitted a paper to the CCG which sets out how UHL wishes to approach the integrated Front Door following the opening of the new Emergency Floor, and thus the nature of the procurement that we would like to undertake in conjunction with CCGs. The CCG are considering the paper and will decide if we can proceed with the procurement as suggested by UHL.

Internal Major Incident

On Wednesday 16 November 2016, we called an internal major incident after five days of significant emergency pressures leading to overcrowding in both our ED and the CDU. The situation had become very serious, not only in performance but also in safety terms and we were seeing incidents and having serious concerns raised by front line staff. We appreciate that IMIs are technically not part of the escalation process now but we needed to do something to uprate our response and that of the wider system.

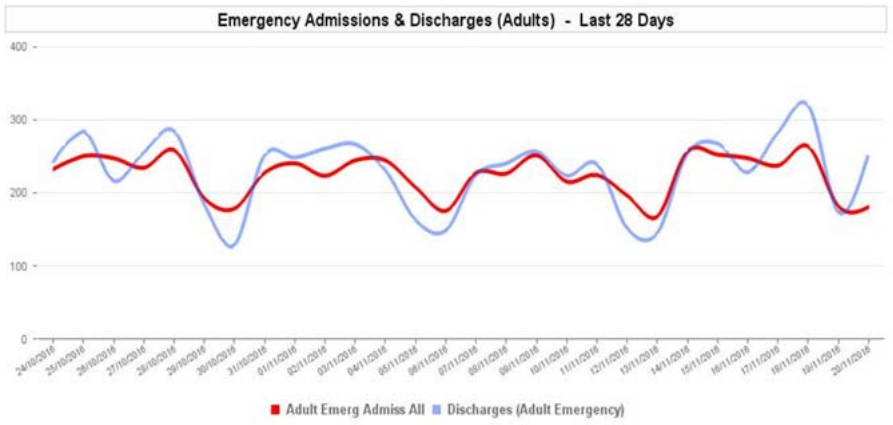
The focus was of course on improving flow and supporting ED and CDU, but we also went beyond that to ensure that every ward round and board round too place with clear measures in place to expedite discharge by requiring every CMG to produce a report detailing all patients who cannot be discharged and why. These lists were critically examined by a central team in order to provide challenge. In addition, delay themes were identified which needed to be tackled corporately and actions were put in place to resolve them. The response could be described as an accelerated approach to Red/Green.

We are also experiencing worse external delays than usual. Much of this is driven by severe teething problems with the new County Help to Live at Home Pathway (noting that the overall approach has been endorsed by all partners. This issue was the subject of a very robust discussion at the Accident and Emergency Delivery Board last week and a set of additional actions were agreed, including prioritisation of available resources for UHL over LPT (due to the greater numerical impact) and on-site review of stranded patients by senior ASC staff tomorrow with our team.

On Monday 21 November 2016, we held a review meeting to understand what worked well when we were on the IMI and to confirm actions which:

- Will be implemented immediately
- Become business as usual
- Will be put in place just before we reach an IMI again.

One of the key benefits from the IMI was the increase in discharges, as detailed below:



Overall in November

We have continued to make progress against the RAP actions against a backdrop of a continued increase in attendances and many days on a critical incident and part of w/e 20/11/16 on a internal major indecent. In order to manage the competing elective, emergency and cancer demands, we have implemented a weekly winter planning meeting with all CMGs with the aim of proactively managing the hospital take and flow to ensure we are doing all we can to enable safe and effective care for our patients.

Seven key UHL actions in the RAP for December

During December and January, we are releasing our senior clinical team from meetings and non-critical administrative work to be based on the shop floor to provide coaching and support to our clinical teams who are in co-coordinating roles, such as majors coordinator, doctor in charge, and nurse in charge, to ensure a consistent approach and reduce variability.

The seven key actions in December are (noting many of them are continuing the themes from November):

1. Reduction in patients breaching by ten minutes

The team have a target of no more than 1% of their patients breaching by 10 minutes. November's position to date is 3%, however as described above, the Trust was on a critical incident between 6-14 November, subsequently calling an internal major incident on 15 November.

Daily validation of all patients breaching by 10 minutes is undertaken, but the challenge remains around overcrowding in the department and the ability to efficiently process all patients.

To support the reduction of overcrowding, rapid flow to AMU started on 14 November, which enables the team to move 5 patients by 10am each morning. Pro-active management of the cohorting areas continues, with support from EMAS, with a clear plan that the team follow. As detailed above, the continued use of GPAU should support the reduction in this cohort of patients.

2. Reduction in non-admitted/out of hours breaches

The new model for GPAU has started to support the reduction in non-admitted breaches based on recent data. This will continue to be review and refined by the clinical team to ensure fully embedded and sustainable processes.

3. Implementation of rapid assessment and early decision to move to ambulatory

The work that the senior clinical team is doing in December and January as described above, will include focus on the rapid assessment process.

4. Continuation of GPAU based in the yellow zone and utilisation of the space GPAU leaves behind

As described above, a rapid flow area (formerly the GPAU space) has been utilised since Monday 14 November, to provide early transfer from ED of patients who require a ward based bed.

5. Ambulance handovers

The team will continue to ensure handovers are as efficient as they can be.

6. Opening additional medical capacity at the LRI on ward seven

Continued focus on recruitment to enable further staged opening of the ward.

7. SAFER (Senior review, All patients will have an expected discharge date, Flow, Early discharge, Review A systematic MDT review of stranded patients) bundle and Red to Green

This is the key action, as described above and in the attached for December.

Risks

As discussed previously the key risks remain:

1. The growing imbalance between demand and capacity

The RAP highlights key actions to address this with timeframes when we should see a change in demand. The opening of ward 7 is critical to reducing the beds gap at the LRI to circa -40 beds this winter. Previously, the problem with activity had been the volume of admissions. More recently, with the successful changes to GPAU, we have partially resolved some of the challenges with high levels of admissions. The pressing issue now is the volume of patients attending ED. This risk remains.

2. Variable clinical engagement

ECIP returned on 26 October 2017 and are providing 1-2 days a week of support to the Emergency Care Pathway. Currently the ECIP support does not include Medical input however the ECIP team are endeavouring to find this for us. Matt Metcalfe, Deputy Medical Director, is also working closely with Ian Lawrence to support the clinical engagement programme in ED. This risk remains.

3. The challenges in transforming a service when we are also trying to focus on the 'here and now'

Additional resource is required to deliver some of the key actions. We have identified the four priorities for the remainder of this year and we are now working on plans to support them appropriately. This risk remains.

Conclusion

The RAP has been agreed by LLR, NHS England and NHS Improvement as a credible plan to deliver change and progress is being made on delivering the actions via the A&E implementation group externally and EQSG internally. ECIP have launched Cohort two (Midlands and East Region) of their Emergency Care Improvement Programme which we are part of and will therefore receive additional support.

UHL continue to focus on internal actions and working with LPT, EMAS and CCGs to ensure we see reductions in attendance and improved discharge processes. It is acknowledged that there is a great deal of work to be done as we head into a challenging time of year with expected increase in attendances and admissions.

Recommendations

- Note the contents of the report
- Note the latest high impact RAP (attached)
- Note the continuing concerns about 4 hour delays and ambulance handovers in particular and the actions in the RAP to reflect the improvements that can be made within UHL to improve performance.
- Note the continued pressure on clinical staff with increasing demand and overcrowding

Leicester, Leicestershire and Rutland Urgent Care Network
System Overview & Recovery Action Plan
Version: 10
Last updated: 17th November 2016 **By who:** Tim Slater
Approval date: **By who:**

Programme Structure

Workstream	Sub-workstream	SRO	Medical Lead	Link to National Actions	Link to SAFER bundle	SRO Update	Link to LLR Risk Register
Minimise presentations at LRI campus		Rachana Vyas	Dick Hurwood	2 (111)		4/11/16 S Smith	CL1, CL2
Improve ambulance response and interface		Mark Gregory		3 (Ambulance)		7/11/16 M Gregory	CL2
Improve the LRI front door	Streaming and Assessment	Lisa Gowan	Ursula Montgomery, Ffion Davies	1 (Streaming)		14/11/16 R Pepper	
	Ambulatory care	Lisa Gowan	Vivek Pillai, Lee Walker	1 (Ambulatory care)		14/11/16 R Pepper	
Improve ED flow	Adults	Julie Taylor	Vivek Pillai	4 (Flow)		14/11/16 R Pepper	
	Children	Julie Taylor	Sam Jones	4 (Flow)		14/11/16 R Pepper	
Improve Ward Flow	Assessment units	Julie Taylor	Lee Walker	4 (Flow)	**S F E**	14/11/16 R Pepper	
	Base wards	Gill Staton	Rachel Marsh	4 (Flow)	**S A F E**	14/11/16 R Pepper	
Improve CDU Flow		Sue Mason	Caroline Baxter	4 (Flow)		14/11/16 R Pepper	
Improve discharge processes		Tamsin Hooton		5 (Discharge)	**R**	4/11/16 C O'Donohue	CL3
Overall lead for UHL-led workstreams		Sam Leak	Ian Lawrence				

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

Urgent Care - High Level Dashboard *GEM logo*

Updated: *Date*

Key Intervention Area				
1. Streaming in A&E	2. NHS 111 Calls	3. Ambulance Response Programme	4. Improving Patient Flow	5. Discharge
1	1	1	1	1
2	2	2	2	2
3	3	3	3	3
Only use if a requirement for 4th metric				
Only use if a requirement for 5th metric				
Patient Safety Incidents: *Number of PSIs in the reporting period*	**Commentary:** *GEM and Urgent Care Team to provide high level narrative*			**Significant Change:** *To highlight any metric that has changed significantly (SPC)*

Insert new format here - split by 5 key intervention areas

If all these measures are within the HL Dashboard or System Metrics, do we need a sperate tab/report?

EMERGENCY DEPARTMENT METRICS DASHBOARD

Monthly updates

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

Key Intervention Number	National Guidance reference / detail	Action Detail	Lead Organisation	Accountable Officer	Action number	Planned activity	Expected outcome/Impact	Key milestones	Delivery date	Contribution to ED recovery	Links to Dashboard	Update (All perf. Figures are dated)	Metric			RAG rating
													Baseline (month 5)	Target	Current position	
Key Intervention Area 1: Streaming in A&E ***(Remodel the front door to better manage patient flow - to ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service).***																
1	1.2	Increase the streaming/ treating and redirection of patients from ED front door.	UHL	Lisa Gowan (Ffion Davies)	**8**	1. Model streaming service integrating Lakeside with primary care team & UHL. 2. Develop staffing model to allow increased streaming. 3. Develop clinical model to enable increased treat and redirect.	1. Reduction in late referrals to ED 2. Increase in the number of patients streamed. 3. Increase in the volume of patients treated/redirected.	1. Paper to JA confirming the service integration plans 23/9/16. 2. Continuation of the streaming service 1/11/16 3. Remodelling of the streaming service 1/12/16 4. Monthly review of the service - on-going 5. Opening of new service 1/4/17	Continuation of service 1/11/16	1. Decrease attendance in ED 2. Ensuring referrals from UCC to ED occur in a timely fashion 3. Reduction in non-admitted breaches in UCC & ED	Treat and redirect	1. Contract with Lakeside extended from November 2016 to 1st April 2017 2. Integrated model of care agreed 3.New integrated workforce model implemented from 10/10 4. Paper outlining the clinical model for procurement from April 2017 being drafted for discussion. 5. Regular KPI monitoring meetings with Lakeside in place from 1.11.16.	44% (% pts treated and redirected)	55%	44%	**5**
1	1.2	**Impact monitoring action:** increase the streaming/treating and redirection of patients from ED front door	UHL	Lisa Gowan (Ffion Davies)	**8a**	1. Ongoing monitoring of new model of care and impact on performance metrics	1. Reduction in late referrals to ED 2. Increase in the number of patients streamed. 3. Increase in the volume of patients treated/redirected.	1. Fortnightly review of the service - on-going, to inform opening of new service, 1.4.17	Continuation of effective service 1.4.17	1. Decrease attendance in ED 2. Ensuring referrals from UCC to ED occur in a timely fashion 3. Reduction in non-admitted breaches in UCC & ED	Treat and redirect	1. First of fortnightly review meetings with Lakeside commenced; metrics for the new clinical model of care agreed. 2. Nurse in Charge role started 1.11.16 to have overview of department 3. Interviews for additional GPs and ECPs to take place in December 4. In-reach ENP for see and treat to begin 3.12.16	44% (% pts treated and redirected)	55%	Awaiting November full month data	**1**
1	1.4	Maximise use of ambulatory pathways to avoid ED attendance	UHL	Lisa Gowan (Ursula Montgomery/ Ffion Davies)	**11**	1. ED on the day review of utilisation of ambulatory pathways planned. 2. Develop action plan to address any gaps 3. Implement change 4. Reaudit 5. Embed a process for continual education and up skilling of all ED staff in available ambulatory pathways and how to access them.	1. Increase number of patients accessing ambulatory pathways	1. ED on the day review of utilisation of ambulatory pathways planned 28/9/16 2. Develop action plan to address any gaps 14/10/16 3. Implement change 4/11/16 4. Reaudit 25/11/16 5. Embed a process for continual education and up skilling of all ED staff in available ambulatory pathways and how to access them 7/12/16	Complete by 07/12/2016	1. Decreased ED attendances 2. Decreased non-admitted breaches	ED attendance	1. Audit of yellow zone scheduled for 28/9/16 not completed as plan due to staffing issues (further date to be arranged). 2. ECIP ambulatory audit took place on 25.10 2. Action plan now being developed based audit findings.	Baseline to be established in the 'on the day' review	20%	TBC	**4**
1	NA	Review short stay capacity & demand and determine if we are going to increase the short stay capacity and reduce base ward capacity	UHL	Lisa Gowan (Lee Walker)	**13**	1. Review literature on how many AMU beds are required to match demand and capacity 2. Visit other Trusts to compare the size of their AMU capacity to ours 3. Determine if we are going to increase our short stay capacity or not	1. Improvement in flow from ED 2. Improvement in patient experience 3. More efficient way of working, leading we hope to a reduction in LOS	1. Review literature on how many AMU beds are required to match demand and capacity - 9/9/16 2. Visit HEFT to compare the size of their AMU capacity to ours - 2/9/16 3. Determine if we are going to increase our short stay capacity or not - 28/9/16	Agree on whether we will increase AMU capacity or not ~~28/9/16~~ 30.11.16	1. Improvement in flow from ED resulting in a reduction in non admitted breaches	Admitted breaches	1. ECIP suggested we are 28 to 50 beds short. 2. Contact being made with HEFT to discuss their capacity and clarify numbers. 3. Agreed to move GPAU to yellow zone 7.11.16 until March 2017; vacated capacity to be used as four additional AMU beds (opening dependent on safe staffing). This will provide insight into future short stay capacity requirements. 4. Nursing and medical staffing pressures and space potentially restrict further increase in bed numbers. 5. Fire, health and safety and infection control reviews of vacated space to be carried out to determine number of bed spaces available: UPDATE: 3 bed spaces available in vacated area. 6. GPAU capacity extended from 6 to 9 spaces. 7. Ward 7 open as transitional ward/discharge area. 8. No other space to add additional beds currently.	106 short stay beds	134	106	**5**
1	NA	Develop ED internal professional standards	UHL	Lisa Gowan (Vivek Pillai)	**18**	Implement Rapid assessment: 1. On the day observation to identify areas of improvement 2. Develop improvement plan 3. Implement improvement plan Patients to be seen by senior decision maker in 90mins & have decision made within 180 mins: 1. Two hourly huddles implemented with senior nurse, doctor and manager; from 1 September there will be a focus on time to be seen by doctor. 2. Implement process to ensure appropriate use of escalation areas 3. Revise SOP for Majors 4. Rapid cycle test new medical model	1. Reduction in non-admitted breaches. 2. Reduced number of patients on ambulances	Implement rapid assessment: 1.Observation and plan - complete 31 Oct 2016 2. Implementation - complete 30 Nov 2016 Patients seen within 90mins/decision within 180mins: 1. Huddles began 1/9/16. 2. Implement process to ensure appropriate use of escalation areas - in place 3. Revise SOP for Majors - 30 October 4. Rapid cycle test new medical model - 30 October	All actions to be complete by ~~30 October 2016~~ 28.11.16	1. Reduction in non-admitted breaches. 2. Reduced number of patients on ambulances 3. Reduce number of 10 minute breaches	non admitted breaches 10 minute breaches	1. Huddles now in place (not consistently). 'Perfect huddle' action learning tool being created to use with teams. 2. Ensuring appropriate use of escalation in place (not consistently) 3. SOP revised and being reviewed by senior team prior to circulation. 4. Single queue working to begin w/c 28.11.16 (as part of roles and responsibilities area of work). 5. Leeds and Ipswich professional standards circulated and discussed with ED consultant body 19.10.16. UHL proposed standards, along with updated watershed policy, to be discussed at Clinical Directors meeting 26.10.16. 6. Doctor in Charge role card updated and circulated to ED team for discussion and roll-out during 28.11 start of single queue working. 7. Daily validation and review of all 10 minute breaches by service managers and 'did not wait' breaches. Expansion of role of ED trackers to ensure decisions are made in timely manner. 8. Internal escalation process updated, to support timely ambulance handover 9. Intensive coaching programme to commence 28.11; increased leadership presence on the shopfloor, alongside senior nursing teams. Implementation plan and comms to team to begin w.c 14.11.	48% (% patients with decision made within 180mins)	95%	54%	**2**
Key Intervention Area 2: No. of 111 calls transferred to Clinicians ***(Minimise presentations from primary and community care to LRI ED assessment services)***																

2	2.2 2.5 2.6 2.7 3.3	All phone based access points only direct patients to ED when clinically necessary	West CCG	Rachna Vyas	**1**	1. Introduce alternative pathways for specific clinical cohorts of NHS111/EMAS patients who initially have an ED disposition 2. Introduce alternative pathways for a specific clinical cohort of G2 patients who initially have an ED disposition	Decrease in ED dispositions of 5% Increased deflection to CRT/AVS or community based hubs from both EMAS CAT desk & 111 by > 5 per day Increase in pathway 0 patients being diverted to base visit rather than ED by 5 per day	1. Test 2: revised pathways for 'ED dispositions' 2. Test 1: Revised H&T pathways for G1-4 calls note: EMAS now dispatch by disposition	1. Pathway live (PDSA) 2. Pathway live (PDSA)	Reduction in Non-admitted breaches in minors/UCC Reduction in admitted breaches	ED attendance Ambulance conveyance	NHS 111 > hub pathway live Sept 2016. Numbers show positive impact but clinical audit required to determine appropriateness. 3 test bed trials undertaken - concluded a mixed model of GPs, ANPs & Nurse Advisors according to staff availability. Pathway to go live 16/11/2016. NHS111 G4 enhanced triage before dispatching vehicle - live from launch of CN Hub on 26/10/2016 NHS111 G2 enhanced triage - DHU proposal for presentation to LLR commissioners Nov 2016 for regional approach from Jan 2017. National IT Solutions working on IM&T fix to allow DHU system to divert G2s by individual county UCC Lo additional enhanced ambulatory care pathways updated on MDoS. GP guide in line with CN Hub will be live from 14 Nov 2016. CTR has forwarded pathways descriptor to Diane Eden to arrange comms to DHU. North & South Charnwood federations evaluating Southward model of patient telephone access to hubs. To be discussed at Charnwood Test Bed mtg 09 Nov 2016. EMAS referrals directly to LC CRT and WL AVS remain static at up to 8/week but with a high percentage of inappropriate referrals. Education regarding appropriateness is ongoing	Increase in module 0 patients conveyed to ED: Baseline requested	Decrease module 0 patient ED attendances by 5 per day	Awaiting Baseline	**2**
2	2.2 2.5 2.6 2.7 3.3	All phone based access points only direct patients to ED when clinically necessary	West CCG	Rachna Vyas	**1b**	Launch of Clinical Navigation Hub (phased implementation with initial restricted offer)	Decrease in ED dispositions of 5% Increase in pathway 0 patients being diverted to base visit rather than ED by 5 per day	1. DoS updated 2. Pathways agreed 3. Staff identified 4. Launch of hub	DoS update underway - for completion 21st Oct CN Hub launch 23 Oct 2016 - note: * phased approach * OOH only until 01/04/2017	Reduction in Non-admitted breaches in minors/UCC Reduction in admitted breaches	ED attendance Ambulance conveyance	Services for update on DoS identified across all commissioners Implementation of CN Hub: 26/10/2016: G4 / Dental / MH Richmond Fellowship live. Also Pharmcy calls at peak times for medication enquiries and toxic ingestion 16/11/2016: ED dispositions (agreed cohort) to go live	ED dispositions: 8%	3%	Current rate:	**3**
2	1.1	Ensure GP's have direct access to a Consultant for clinical discussions prior to acute referral	UHL	Rachna Vyas	**2**	1. Secure funding for pilot extension 2. Implement roll out plan to Paeds and geriatrics 3. Re-launch service to all GP's 4. Evaluate CC activity to agree BAU from 01 Apr 2017	Increase in avoided EAs in specific specialities (from 66% to c.70%) Increase in utilisation rates in Primary care from 74% to 95%	1. Agree to continue CC 2. Roll out to Paeds & Geriatrics 3. Re-launch at PLT using clinical case studies (City) 4. Ensure connectivity with community services	1. Complete 2. Paeds live Oct 2016 / Geriatrics delay but due Nov 2016 3. 21st Sept 2016 4. Dec 2016	Reduction in admitted breaches	ED attendance Emergency admissions Ambulance conveyance	1. Funding secured for pilot to 31 Mar 2017 2. Comms for CC outstanding 3. Case studies for PLT outstanding 4. Will be undertaken by Vanguard WS1 SLS mtg with Julie Dixon 07/11 to update on all o/s actions inc. o/s case studies	Increase in utilisation rates in Primary care Baseline 74%	95%	74%	**2**
2	2.1	Instigate direct feedback loop re patients who were referred to acute care via BB but could have accessed other services (interdependency with action 67)	ELR CCG	Rachna Vyas	**3**	1. Audit sample of case notes 2. Implement direct and indirect feedback 3. Audit other patient pathways listed in national guidance, starting with EMAS & then 111 4. Investigate trial of GP role in Bed Bureau to challenge admissions	As per results of audit	1. Audit GP urgent calls to assess appropriateness 2. Feedback to Primary care at PLT's in Oct/Nov 3. Plan EMAS GP urgents line audit for LLR	1. Complete 2. Nov 2016 3. Oct 2016	Reduction in non-admitted breaches	ED attendance Emergency admissions Ambulance conveyance	1. Audit complete - SLS to circulate to Inflow Group 2. Slots booked at both Sep 2016 and Nov 2016 PLT 3. Audit planning started 4. PV to advise SLS to specific dates for Dr H in Nov or Dec 2016	NA	NA	NA	**3**
2	4.6 1.8	CCG led schemes to manage acute demand	City CCG	Rachna Vyas	**4**	1. Maximise utilisation of Hubs 2. Ensure all acute access services have embedded pathways to use most appropriate/lowest acuity care setting available including GP urgent referrals	Reduction in the number of City patients referred to UCC/ED by 111 by 5% Increase in utilisation rate at each City hub from c75% to 85% by September Reduction in avoidable admissions from LLR care homes by 10% of 15/16 outturn Reduction in conveyed module 0 patients to ED by EMAS by 5% Reduction in deep emergency admissions to commissioned plan	1. Increase use of City Primary care Hubs - Re-launch hubs with focus on reception staff in practices 2. Implement new 111 ED disposition trial to safely treat pts in the hub rather than at ED minors or UCC 3. Open up ANP slots for 111 booked pts, diverting from UCC Re-launch service with practices to ensure appropriate flow from GP to hubs, rather than GP to UCC. Will include increased presence on social media and revised answerphone messages 4. Commission additional resource to Clinical Response Team, specifically for care homes. 5. NHS111 direct appt booking to UCC Le GP consults still to be switched back on	1. Complete by Sept 1st but part of rolling engagement plan with all practice staff 2. Pathway in place as of Sept 15th for GP and ANP 3. Complete 4. Complete 5. Nov 2016	Reduction in Non-admitted breaches in minors/UCC Reduction in admitted breaches	ED attendance Emergency admissions Ambulance conveyance	1. In progress. Model agreed and being communicated to all patients 2. 1st test cycle complete. Data analysis begun 3. Complete - live from mid- Aug - auditing whether appts could have been filled with self-care patients 4. Complete - car live on Aug 16th 5. Gaurav Mehta liaising with Lisa Gowan (UHL)	ED attendances to commissioned plan M4 Baseline: +10% vs plan Emergency admissions to commissioned plan M4 Baseline: +2% vs plan	ED attends: Plan NEL: To plan	ED attends: M5: +9% (Variance +2467) NEL: M5: 0.00% (Variance +30)	**3**

2		CCG led schemes to manage acute demand	ELR CCG	Rachna Vyas	**5**	1. Maximise utilisation of UCC's 2. Ensure patients are aware of service provision via NHS NOW app 3. Review of Urgent Care patient flow across ELR CCG to inform re-design of integrated urgent care offer	Reduction in the number of ELR patients referred to UCC/ED by 111 by 5%	. 1. Maximise the use of the ELR Urgent Care Centres in the four sites providing a seven day evening and weekend service. Oadby profile re-checked on DOS to ensure maximum diversion from 111 2. Focus use of NHS NOW App and continued promotion of service	1. Complete 2. Ongoing rollout programme 3. Clinical leads mtg to review data and proposed model 15/11/2016	Reduction in attendances at ED and Non-admitted breaches in minors/UCC	(SLAM data) ED attendance Emergency admissions Ambulance conveyance	1. Complete 2. App launched	ED attendances to commissioned plan M4 Baseline: +7% vs plan Emergency admissions to commissioned plan M4 Baseline: +5% vs plan	ED attends: Plan NEL: To plan	ED attends: M5: +10% (Variance +1300) NEL: M5: +8% (Variance +693)	**4**
2	4.6	CCG led schemes to manage acute demand	ELR CCG	Rachna Vyas	**6**	1. Launch Weekend AVS scheme 2. Launch care home service expanded across ELR CCG (provided by AVS)	Reduction in avoidable admissions from LLR care homes by 10% of 15/16 outturn	1. New Weekend AVS scheme to commence in August/ September specifically for complex, elderly, EOL and Care home patients covering 3-4% of the ELR population at greatest risk of admission 2. Go live 03/10/2016	Complete - service live	Reduction in attendances at ED and admitted breaches	ED attendance Emergency admissions Ambulance conveyance	1. Service launched. Activity and impact will be monitored 2. Service expansion complete and in place - impact monitored via care homes SUS data. Recorded a reduction in care homes admissions per month of 51 during the test bed period. Plan to extend service to all housebound patients from April 2017	Reduction in avoidable admissions from LLR care homes by 10% of 15/16 outturn Baseline requested	Awaiting data	Awaiting data	**4**
2	4.6	CCG led schemes to manage acute demand	West CCG	Rachna Vyas	**7**	1. Ensure adequate capacity in practices for non-urgent clinical presentations 2. Launch extended AVS service	Pharmacists in place as per trajectory (Gill Stead to confirm phasing plan) Reduction in avoidable admissions from LLR care homes by 10% of 15/16 outturn	1. Commissioning of Pharmacists in every practice / group of practices to provide workforce capacity to focus on cost effectiveness and medicines related admissions 2. Increase AVS timings from 9-5 to 9-8 M-F & 8-8 Sa-Su	1. Rolling programme 2. Complete	Reduction in attendances at ED and admitted breaches	ED attendance Emergency admissions Ambulance conveyance	1. Service launched. Activity and impact will be monitored	ED attendances to commissioned plan M4 Baseline: +7% vs plan Emergency admissions to commissioned plan M4 Baseline: +5% vs plan	ED attends: Plan NEL: To plan	ED attends: M5: +6.6% (Variance +843) NEL: M5: +4% (Variance +337)	**4**
2		Identify multi-agency solution in high user postcodes across LLR - these are predominantly in East and City	EMAS	Rachana Vyas	**29**	1. Review and Share activity by post code to support a reduction in activity reaching 999 services 2. Review and share H&T/S&T activity by postcode	Reduction of 999 activations by 5% per day.	- Baseline activity captured - 14/09/2016 - CCG produced postcode analysis report shared - 30/09/2016 - Alternative care pathway planning &implementation including comms package for patients and practices - Through November/December 2016 1. EMAS to provide post codes for four highest usage areas of LLR for CCGs to identify GPs 2. EMAS to provide R1-R2 and G1-G4 LLR postcode activity for H&T/S&T - CCGs to identify HDSUs, clinical themes and patient outcomes for those conveyed to hospital (Mick working with Faye)	As previous column	Reduction in attendances at ED and admitted breaches in minors/UCC	ED attendance Emergency admissions Ambulance conveyance	Postcode data received - difficult to attribute to practice level so a generic Comms and engagement programme is being planned at community level between CCG and EMAS	Reduction of 999 activations by 5% per day. Baseline requested	Awaiting data	Awaiting data	**3**
2		To ensure that patients discharged from the Acute Trust with a Nerve Centre PARR+ score of +5 are provided with adequate community support to prevent readmission within 30 days	UHL	Rachana Vyas	**66**	1. Roll out use of PARR30 tool 2. Update Nerve Centre with PARR score for at risk patients 3. Identify and implement community/primary care support within 48 hours of discharge	Reduction in readmissions for patients leaving the Trust with a PARR score of +5 by 10%	1. Nerve Centre being updated by 30/11/2016 2. Primary/community care support secured and implemented 3. CTR liaising with Jane Bulman for conf. that ICRS can undertake all LLR calls daily (anticipated volume 10 daily)	1. November 2016 2. November 2016 3. November 2016	Reduction in attendances at ED and admitted breaches	Reduction in readmissions	Initial pilot complete. Readmissions reduced in target cohort. Telephone f/u @ 24h + 1w post-discharge from Dec 2016 in Rutland as test bed using new BCF-funded WAC posts Rachel Dewar to d/w Jane Bulman	Reduction in readmissions for patients leaving the Trust with a PARR score of +5 by 10%	10% reduction	Awaiting data	**2**
2	1.8	Increase utilisation of step up capacity to prevent acute activity (interdependency with action 3)	LPT	Rachana Vyas	**67**	1. Develop additional guidance with GP's and circulate. This should include medical management template with pre-populated prescribing guidance and parameters 2. Improve engagement and understanding of service across General Practice through use of case studies 3. Consider viability of Bed Bureau referring to Step Up	Increase utilisation of step up capacity by > 2 patients per day by CCG	1. Guidance, template and Comms complete 2. Rolling programme of case studies and direct feedback to GP's to be implemented using Board GP's 3. GP review of clinical referrals into Bed Bureau to assess viability of proposing alternative pathway of care	1. 31 Oct 2016 2. 31 Oct 2016 3. 30 Nov 2016 TBC	Reduction in attendances at ED and admitted breaches	ED attendance Emergency admissions Ambulance conveyance	Team identified at City CCG to lead development of template and guidance in partnership with LPT. Includes LPT team, nursing & quality, Medicines optimisation, IT leads and lead clinician GW writing a review of the triage ambulance pilot by 30/11/2016 - will recommend that the referral link between paramedics + MH Crisis Team is revisited. Aim to take to MH Clinical Forum Dec 2016 or Jan 2017	Increase utilisation of step up capacity by > 2 patients per day Baseline: City CCG: 1 per day West: 3 per day East: 2 perday Total: 6 pts/day	> 8 pts/day	w/e 14.10: City CCG: 1 per day West: 2 per day East: 2 perday Total: 5 pts/day	**4**

2		All patients referred to UHL by GP should arrive either < 4 hours from time of referral or in a timely manner for a booked appointment/assessment	EMAS	Rachana Vyas	**69**	1. Assess viability of limiting the number of LLR practices using the direct EOC booking function 2. Reiterate to General Practice that all appropriate referrals to UHL must go via Bed Bureau for capacity planning purposes 3. Re-launch criteria for ambulance conveyance to General Practice *Linked to actions 4-6 above - if EMAS refer more CAT-triaged patients to CRT/AVS this should release EMAS capacity to convey patients into UHL earlier*	Reduction in number of GP urgents conveyed to hospital in total All patients conveyed within 4 hours of referral	1. Ability to divert all LLR requests to EOC to BB 2. Re-launch booking criteria and pathway to practices 3. Joint EMAS & LLR CCGs comms to GPs and UHL re: Card 35 SOP	1. 30 Sep 2016 2. PLT, Locality/HNN meetings in Sep 2016 3. Nov-Dec 2016	Reduction in attendances at ED and admitted breaches	ED attendance Emergency admissions Ambulance conveyance	1. In progress - turning EOC line off completely is not viable as the line services the whole region 2. Practice-specific Card 35 Comms package disseminated	All patients conveyed within 4 hours of referral Baseline requested	Awaiting data	Awaiting data	**5**
2		Frequent attenders should be known to the system and managed through a system network	CCG's	Rachana Vyas	**70**	1. Assess Cardiff model/local model in place 2. Formulate plan at CCG level 3. Implement and monitor plan	Reduction in known FA's presenting to 111, EMAS and ED	1. Plan to be formulated	1 + 2: Nov 2nd 3. Dec 2016	Reduction in attendances at ED and Non-admitted breaches in minors/UCC		Cardiff model circulated to CCGs - found to be very similar to Braunstone Blues pilot - Skype call with Cardiff Lead Anna Sussux 29/11 Helen Payne (ED FF Nurse) & Deborah Scouthern (EMAS FF Lead) to provide current activity via CTR - RV & SLS will f/u with mtg to discuss pathways and how FF work ties in with Vanguard-funded M/H nurses in UCC & ED 24/7 FF data triangulation (NHS111/EMAS/UHL Em Attends & UHL Em Adms) mtg 09/11 to identify top 10 postcode areas for LLR - to overlay on current Police and Fire heat maps to agree next pilot Jan-Mar 2017 as hub & spoke model with Braunstone	*See CCG specific metrics for reducing activity to plan*	*See CCG specific metrics for reducing activity to plan*	*See CCG specific metrics for reducing activity to plan*	**4**
Key Intervention Area 3: Ambulance Response Programme ***(Improve ambulance response and interface)***																	
3		Monitor and increase the use of CAD+ at the Leicester Royal Infirmary	EMAS	Mark Gregory	**30**	1.Set Current baseline 2. Working with UHL arrange for notify screen move 3. Working with EMAS PMIT, generate individual compliance report 4. Ensure consistent use by Amvale resources	90% of crews using CAD+	1. Baseline generated from UHL handover report 2. link UHL & EMAS IM&T teams re the move of the notify screen 3. PIN number report to be generated and shared with divisional managers 4. Liaise with Amvale and feedback non-compliance	1. 1st October 16 2 31st October 16 3. 31st October 16 4. 30th September 16	Accurately monitor handover times and track trends		Update 20 Oct 2016 1. Baseline taken from report dated 10-10-16. Baseline set at 65% 07/11/16 - Meetings held to outline IT issues and reporting metric. Current performance @ 69%	Oct 16 - 75% Nov 16 - 77.5% Dec 16 - 82% Jan 17 - 85% Feb 17 - 87.5% Mar 17 - 90%	90% of crews using CAD plus	*TBC*	**3**
3		Implement A&E Front door Clinical Navigator	EMAS	Mark Gregory	**32**	1. Identify individuals to undertake navigator role 2. Provide Supportive development with navigators to ensure appropriate challenge etc. 3. Monitor and report against findings 4. Look towards extension to hours via Vanguard Funding	Linked across all Non conveyance metric (Reduction of 4% by 31st March 2017)	1. Clinical team Mentors identified as navigators 2. Jay Banerjee to deliver training 3. Monthly reports to be fed into the appropriate meeting structure 4. Business Case to be submitted for extension to coverage	1. 1st Sept 2016 2. 1st Nov 2016 (Complete) 3. 10th of Each Month 4. 10th Oct 2016	Reduction in A&E attendances		1. Team identified and Briefed 1. Soft launch of confirm and challenge commenced 2. Dr Jay Banerjee contacted and dates for trailing being developed 20 Oct 2016 update Discussion and detail shared with commissioners to understand finance available. 07/11/16 - Paper submitted by J.Banerjee outlining project scope. Meeting held with CCG colleagues and BC to be drafted for upstream navigation.	Oct 16 Clinical Navigator role on site 3 x per week for >4 hours per day	Percentage of EMAS attendances where an alternative should have been used not to exceed 15% per month (Nov 16 Onwards)	TBC	**3**
3		Implement and enhance the use of Mobile Directory of Service	EMAS	Mark Gregory	**33**	1. Ensure registration of all eligible staff to MDoS (50% by March 16) 2. Train Staff in the use of MDoS (50% by March 16) 3. Increase the number of MDoS referrals 4. gain access to mobile SystmOne enabling care plan viewing	Linked across all Non conveyance metric (Reduction of 4% by 31st March 2017)	1. Project lead to be identified 1.1 Project lead to generate project plan to increase points 1 & 2 2. Train the Trainer sessions to be held ensuring MDoS super users can support training schedule 3. Project lead to monitor use and support non compliant staff 4. Work with Commissioners to secure SystmOne access	1. 30 Sept 16 1.1 15 Oct 16 2. 31 Oct 16 3. March 17 4. Feb 17	Reduction in A&E attendances		1. Project Lead identified and in post Update 20 October 2016 Trainning session held for super users to enable train the trainer sessions to be rolled out.	50% of staff registered to use MDoS (March 16)	50% staff trained to access and use MDoS (March 16)	TBC	**3**
3		Implementation of Dispatch on Disposition	EMAS	Mark Gregory	**34**	1. Trust identified as adopter site 2. Timescales for implementation Negotiated with NHSE 3. NHSE assurance review and sign off 4. Mobilisation 5. Secure exec lead for ARP/DoD at the delivery board 6. Map Nature of Call list against current keyword flows	Reduction of Resources to scene by 0.2 from 1.4 baseline Linked to above non conveyance trajectory	1. Work with NHSE to register as implementer site 2. negotiate and agree timescales for mobilisation 3. Assurance review to be arranged and undertaken 4. Mobilise scheme	1. September 16 2. September 16 3. 10th Oct 16 4. 31st October 16	Reduction in A&E attendances		1. Trust approved as implementer site 2. Timescales agreed Update 20 Oct 2016 DoD live as at the 3rd October. Further review of call codes being undertaken as progress is made towards ARP. Current RPI rate of 1.34 07/11/16 - DoD implemented succesfully. RPI rate currently @1.32	1.4	Oct 16 - 1.4 Nov 16 - 1.36 Dec 16 - 1.32 Jan 16 - 1.28 Feb 16 - 1.24 Mar 16 - 1.2	TBC	**4**

3		Left shift transportation of Urgent activity into UHL sites	EMAS	Mark Gregory	**34a**	1. Review current baseline 2. Scope resource availability 3. draft project and resourcing plan 4. Mobilise additional resources	Earlier attendance of HCP urgent calls	1. Working with PMiT gain average call to arrival time 2. Review current resources within LLR EMAS Pool 3. Liaise with Commissioners to plan additional commissioned resources 4. communicate launch and mobilise additional resources	1. 15 Oct 16 2. 20 Oct 16 3. 1 Nov 16 4. 30 Nov 16	Improved Flow		Update 20 Oct 2016 Operational deployment model of Urgent resources reviewed. Draft plan generated to allow specified resources to undertake Urgent Activity only (Exceptions apply) 07/11/16 - Project plan shared and implemented with EOC colleagues. Urgent resources now working to deliver calls within timescales	Percentage of patients arriving within their allotted timescale	TBC	TBC	**4**
3		Sustain Current High levels of Hear and Treat rates for LLR 999 calls	EMAS	Mark Gregory	**35**	1. Assess workforce capabilities to ensure robust 24/7 cover 2. Assess access for Clinical Advice Teams to the DoS 3. Communicate new access routes to Clinical Advice Hub once mobilised	Maintenance of the current baseline of 20% hear & Treat Rates for LLR generated calls	1. Workforce review undertaken and WFP generated 2. DoS access reviewed and available to CAT 3. Communication to be shared when CAH PID received	1. September 16 2. September 16 3. Nov 16			07/11/16 - on target and delivering	20%	20%	TBC	**4**
Key Intervention Area 4: Improved Patient Flow ***(Improve CDU, ED and Ward Flow at UHL)***																
4	NA	UHL to open additional emergency beds at the LRI to decrease bed capacity/demand mismatch	UHL	Gill Staton	**9**	1. Open and staff 28 beds on ward 7	1. Decrease outlying on non-medical wards (dependent on attendances and admissions remaining constant) 2. Decrease congestion in ED by improving flow 3. Contribute to an improved 4 hour performance 4. Improve staff experience by staffing a consistent ward therefore preventing staff moving from ward to ward	1. 10th October 2016 identified staffing to be confirmed 2. Equipment to be ordered and delivered by 22nd October 3. Planned opening 1st November 2016 4. Fortnightly progress update meeting in place with COO	Ward open 1 November 2016	1. Reduction in breaches linked to poor flow and ED occupancy	admitted breaches	1. Estates work on ward 7 started on 14/9/16 2. Communications have gone out to all staff in September 3. Equipment ordered on 25/8/16 4. Nurse staffing rosters set up and shifts sent out agency on 08/08/16 5. There is a fortnightly meeting in place chaired by COO to progress 6. On Track to open November 1st (The main risk to opening remains staffing) 7. Ward 7 delayed opening as a 28 bedded ward as unable to staff safely, continue to monitor weekly to establish if we can open a bay at a time 8. Ward to be used as discharge and transitional care ward (6-10 beds overnight) to support increase in morning discharges; appropriate staffing being sourced. 9. Ward opened as per above plan on 1.11.16.	0%	28 beds open on the ward	0%	**5**
4	NA	**Impact monitoring action:** UHL to open additional emergency beds at the LRI to decrease bed capacity/demand mismatch	UHL	Gill Staton	**9a**	1. Open and staff 28 beds on ward 7	1. Decrease outlying on non-medical wards (dependent on attendances and admissions remaining constant) 2. Decrease congestion in ED by improving flow 3. Contribute to an improved 4 hour performance 4. Improve staff experience by staffing a consistent ward therefore preventing staff moving from ward to ward	1. Opening of remaining beds, to create 28 bedded-ward 31.12.16 2. Ongoing review of use and impact on performance metrics	Ward fully open 31.12.16	1. Reduction in breaches linked to poor flow and ED occupancy	Admitted breaches	1. Weekly review of staffing levels and potential for opening additional beds on ward 2. New HCAs begin in December 3. Plan to open ward fully by end of December, HCA recruitment dependent.	55% of patients allocated a bed within 60 mins	75%	58%	**1**
4	NA	Trial senior acute physician in ED to challenge admissions	UHL	Julie Taylor (Lee Walker, Ian Lawrence)	**10**	1. Three day trial in September 2. Two further trials to take place to confirm results 3. Collate results and review outcome of trials 4. If results positive review medical job plans to check if it can be staffed within existing resource. 5. Implement (if outcome positive)	1. Reduced conversion rate to admission 2. Increase bed capacity 3. Decrease congestion in ED 4. Improve patient experience with 'home-first' mentality	1. 15th August complete 1st trial 2. 29th August completed 2nd trail 3. 26th September complete 3rd trial 4. 3rd October review outcomes and confirm benefits and decision to progress	Decide by ~~14/10/2016~~ 11/10/16 if this will be fully implemented COMPLETE	1. Decrease congestion in ED 2. Decrease breaches 3. Improve patient experience 4. Reduction in volume and % of patients admitted	Decrease admissior	1. First two trials complete-provisional data showing decreased conversion to admission 2. CHKS data to be used to benchmark target against peers, and develop key further actions for UHL. 3. Acute physician in ED not sustainable long term due to resource constraints. 4. GPAU to move to yellow zone space from 7.11.16 for GPAU patients, UCC referrals from ED, and pull from majors. This will allow challenge of admissions and appropriate pts to be pulled from ED to ambulatory stream by acute physicians. 5. Weekly review of model of working with GPAU next to ED	21.2% (ED conversion rate)	18.70%	21.30%	**5**
4	NA	Impact monitoring action: Trial senior acute physician in ED to challenge admissions - GPAU relocation to ED	UHL	Julie Taylor (Lee Walker, Ian Lawrence)	**10a**	Ongoing monitoring of impact of change of model for GPAU pull of patients from ED and UCC by senior acute physicians	1. Reduced conversion rate to admission 2. Increase bed capacity 3. Decrease congestion in ED 4. Improve patient experience with 'home-first' mentality	1. Monthly review of impact	Ongoing	1. Decrease congestion in ED 2. Decrease breaches 3. Improve patient experience 4. Reduction in volume and % of patients admitted	Decrease admissior	1. Weekly meetings in place to review impact	21.2% (ED conversion rate)	18.70%	21.30%	**1**
4	NA	Reduce handover times for medical team in ED	UHL	Julie Taylor (Ian Lawrence)	**15**	1. OD facilitated workshop with medical and nursing teams on handovers 2. Trial of suggested new format of handover 3. Embedding of newly agreed process in the department	1. Reduce handover times to maximum of 20 mins and reduce number of handovers.	1. Baseline current handover process & times - complete 27th July 2016 2. Implement bedside handover - will be complete 7 November 2016 3. Reduce number of doctors handovers - review 7 November 2016	All actions to be complete 27 November 2016	1. Reduction in wait to be seen in ED	breaches	1. Data on number of handovers obtained 2. ECIP to facilitate the required improvements 3. RAG reduction due to time slippage on actions 4. Senior team to observe handovers to produce 'perfect handover' action learning pack, with approach, key purpose and function. To be included as element of intensive coaching programme, starting in ED w/c 28.11 5. Associate Medical Director to support.	Handover time: Medical: 3 hours (out of 24)	Maximum 1 hour (out of 24)	3 hours	**2**

4	NA	Increase utilisation of yellow zone (ambulatory majors)	UHL	Julie Taylor (Lee Walker, Ian Lawrence)	**16**	1. Determine different staffing models to test 2. RCT models 3. Review outcomes 4. Develop model 5. Implement change	1. Reduce non-admitted breaches 2. Improve patient experience	1. 29.6.16 RCT an Acute physician model running this area 2. Collate results 3. If positive see if this model is viable (resources)	30.11.16	1. Reduction in breaches	breaches	1. Initial day trial (RCT) went well; needs longer trial to prove concept and collect meaningful data to support approach. LW to action. 2. Obtain data from Leeds Hospitals via ECIP re their model and criteria. 3. HOS to review criteria for local use 4. Daily reminder to clinical matrons to be responsible for ensuring patients are identified for yellow zone. 5. Yellow zone area to become ambulatory area for GPAU patients, UCC referrals to ED, and pull from majors beginning 7.11.16. This is in line with model that will be used in new Emergency Floor. 6. Weekly review of new model of care, including pull of ambulatory patients from ED, to take place following relocation of GPAU. 7. Monitoring as part of action 10a.	68% (Majors yellow area 4hr performance)	95%	61%	**4**
4	NA	Improve leadership and behaviours in ED.	UHL	Julie Taylor (Ian Lawrence)	**21**	1. Appoint OD consultant 2. Sept - Nov: delivering leadership interventions; delivering sessions with leaders and teams on behavioural competencies; integrating OD, comms, SOPS and IT. 3. Delivering coaching for key leaders within ED	Improved staff morale	1. OD consultant in post May 2016 2. Sept - Nov: delivering leadership interventions; delivering sessions with leaders and teams on behavioural competencies; integrating OD, comms, SOPS and IT. - on-going 3. Delivering coaching for key leaders (Heads of Service & Key managers) within ED - complete August 2016 4. Agreement with Exec colleagues on tackling challenging behaviour and reducing variation. 5. Implement consistent daily action learning	This is on-going work until 31 March 2017	Non specific	Breaches	1. Pulse check baseline complete July 2016 (174 responses) 2. Follow up taking place September 2016 (20 responses) 3. LiA recruitment & retention event planned Oct 16 4. NHS Elect (coaching leaders) began on 24.10 5. OD sessions complete - outcome and next steps discussed at 26.10 EQSG; multi-media alternatives being developed to increase uptake. 6.UHL change programme developed to focus on 30,60,90 day high impact actions. To be aligned with updated OD focus and plan (8 below) 7. Area of ECIP focus. 8. Following presentation at EQSG on findings from OD Sept-Nov actions, OD plan to be refreshed and refocused on delivering interventions and support to the team 'in situ' to support cultural change in ED. 9. Link to action 18: Intensive coaching programme, supported by OD team, Associate Medical Director, and senior leadership team.	Sickness rate: 3.9% Turnover: 9.7% Vacancies: 30%	Sickness rate:3% Turnover: 9.5% Vacancies: 10%	Sickness rate: 3.8% Turnover: 9.7% Vacancies: 28%	**4**
4	NA	Reduce overnight breaches	UHL	Julie Taylor	**22**	1. Senior leadership shift change (2pm - 10pm) over winter 2. Pro-active use of escalation areas to allow space in ED for decisions to continue to be made 3. Ensure consistent huddles over the night period 4. Open additional beds (as per previous action re ward 7)	1. Reduction in breaches 2. Improved patient experience	1. Implementation of the late shift rota (senior management 2pm -10pm) 3rd October 2. Increased clinical matron presence 7 days per week including evening 3rd October 3. Ensure safety huddles are completed during the night (SMOC or duty manager to lead) 5th September 4. Open additional ward capacity 1st November 2016	All actions to be complete ~~1 November 2016~~ 16 December 2016	1. Reduction in breaches overnight	Breaches	1. Shift change goes live 3rd October 2. Matron restructure complete 3. The opening of the ward has been pushed back to 1 November 2016 - on track 4. Matron 7 day rota now complete 5. Senior manager rota, initially planned to start on 3rd Oct, currently delayed; discussions ongoing. 6. Diagnostic to identify any other reasons for increased number of breaches overnight started - 1st review carried out 19.10. 7. Further diagnostics not yet complete due to annual leave and sickness; delivery date moved to mid-December to allow for completion of diagnostic and action plan. 8. Medical rota's to be reviewed for overnight. 9. Intensive coaching programme to include overnight in ED.	Currently 29% of patients arriving between 7pm and midnight are treated within 4hrs	70%	32%	**3**
4	NA	Decrease conveyance of Cardiorespiratory patients between LRI and Glenfield to increase EMAS capacity	UHL	Lisa Gowan	**27**	1. Establish baseline activity 2. Review the criteria 3. Case note review to determine if the patient was conveyed to the right location 4. Develop action plan 5. Implement any required changes	1. Decrease conveyance of cardiorespiratory patients from LRI to Glenfield 2. Improve quality to ensure that patient gets to the right specialty first time	3. Case note review to determine if the patient was conveyed to the right location 30 September 4. Develop action plan 31st October 5. Implement high impact and short term rapid interventions 30th November	Full implementation 30 November 2016	1. Reduce attendances at ED 2. Reduce overall breach rate	breaches	2. Audit to be completed for all those patients sent direct the LRI to ascertain reasons by end of September 3. 2 FY2's have been identified to carry out audit on those patients transferred from LRI to gather evidence on process and define next steps.	107 in August (Number of pts transferred from ED LRI to Glenfield)	96 (10% reduction)	50 to date in Sept (ED LRI to GGH)	**4**
4	NA	Rapid Flow (formerly - Implement Safer Patient Placement across UHL)	UHL	Julie Taylor (Ian Lawrence)	**36**	1. Launch communication throughout UHL 2. Project plan to be developed on how UHL roll-out on wards 3. Roll-out across Medicine 4. Full roll-out across UHL 5. Re-opening of discharge lounge	1. Increase discharges from wards before 1pm 2. Reduce breaches in ED 3. Reduce congestion in ED 4. Improve patient experience 5. Decrease use of escalation areas	1. Launch communication throughout UHL - complete 7th September 2016 2. Project plan to be developed on how UHL roll-out across wards - complete 14th July 2016 3. Roll-out across Medicine - go live 10th October 4. Full roll-out across UHL - phased roll out January to March 2017 5. Re-opening of discharge lounge - 14th November 2016	~~Go live of Safer across medicine on 10 October 2016~~ 30.11.16	1. Reduce breaches in ED 2. Reduce time from bed request to allocation	admitted breaches	1. Rapid flow to be implemented on acute medical wards initially 2. Task and finish group established to look at implementation and roll-out across all wards; space restrictions on the ward impacting on full roll-out. 2. Documentation produced in standard UHL format 3. Estates work required for new discharge lounge starts 17/10, with 4 week build time. 4. Use of ward 7 as discharge and transitional care ward is supporting the movement of patients from base wards. 5. Rapid Flow to AMU to start 21.11.16, supported by HOS and matron. This will then inform next steps for roll-out to across medicine, by end of December. 6. Continued push on early morning discharges on medical wards, to release 2 beds by 11am	55% of patients allocated a bed within 60 mins	75%	58%	**2**

4	4.1 4.3 4.4	Implement SAFER patient flow bundle Trust wide	UHL	Gill Staton (Ian Lawrence)	**37**	1. Baseline audit of wards to be completed on utilisation of the SAFER flow bundle 2. Develop actions to address gaps identified in audit 3. Re-audit once actions put in place 4. Phased roll-out across UHL	1. Increase in the number of patients discharged before 1100 2. Increase in the number of patients with EDD 3. Consistent board rounds on all wards 4. Decrease number of 'stranded' patients 5. Improve ward ownership 6. Increase patient experience by ensuring patient is part of the decision making process 7. (Percentages to be confirmed once baseline audit complete)	1. 29th August 2016 audit of 5 wards completed 2. 19th September 2016 baseline audit of 2 further wards to identify areas for improvement 3. Collation of results and feedback w/c 1st October 4. Action plan developed by 10th October 5. Implementation of plan to start 17th October on key wards 6. Start of baseline audit of remaining wards on 14th November 7. Action plan and full roll-out by mid-December	SAFER patient flow will be rolled out on two key wards by 01/11/2016 COMPLETE	1. Improve base ward capacity for admissions from ED.	admitted breaches	1. 29th August 2016 audit of 5 wards completed 2. Week of 19th September:2 further wards audited and data being collated for baseline 3. Resource for implementation of actions being identified 4. Re roll-out of professional standards 5. Increase rigour of board rounds to create consistency 6. Internal professional standards updated and will be re-launched with team throughout November. 7. Roll out across medical wards complete. 8. Trust wide roll-out - Area of focused support from ECIP; to be discussed further at UHL Beds Programme Board 3.11.16	5.82 (average length of stay for Medicine)	4.67	5.82	**4**
4	NA	Glenfield to open additional beds to decrease bed capacity/demand mismatch	UHL	Sue Mason	**39**	Open 28 beds on ward 23a	1. Decrease outlying on non-medical wards (dependent on attendances and admissions remaining constant) 2. Decrease congestion in CDU 3. Contribute to an improved LOS on CDU 4. Improve staff experience by staffing a consistent ward therefore preventing staff moving from ward to ward 5. Reduced frequency of CDU going on a 'stop'	1. 18th November 2016 staffing to be confirmed 2. Equipment to be ordered and delivered by 31st October 3. Planned opening 1st December 2016	Ward is due to open on Monday 5 December 2016	1. Decrease breaches linked to better flow to GGH	admitted breaches	1. Communication to staff started 15th August 2016 2. Compiled list of equipment requirements - ordered w/c 18th Sept 3. Out to recruit for staff 4. Discussed with medical staff to provide cover 5. Funding agreed and phasing needs finalising - now complete 6. Rota now agreed; ward sister position filled; ward kit etc being ordered for 5.12.16 opening.	0	28 beds open on the ward	0	**4**
4	NA	Implement specialty in-reach of referred patients to ED	UHL	Julie Taylor (Ian Lawrence Lee Walker)	**40**	1. Review Trust Watershed policy 2. Benchmark against specialty in reach services in other Trusts 3. Work with HOS and CD to communicate policy to all other specialty CDs 4. Re-implement Trust watershed policy	1. Reduced wait times for ED patients by releasing ED medical staff 2. Improve patient experience	1. Review Trust Watershed policy - complete by 17/10/16 2. Benchmark against specialty in reach services in other Trusts - complete by 17/10/16 3. Work with HOS and CD to communicate policy to all other specialty CDs - complete by 17/10/16 4. Re-implement Trust watershed policy - complete by 17/10/16	All actions to be complete by ~~17/10/16~~ 30.11.16	1. Reduction in breaches 2. Improvement in time to be seen by a doctor and time for a plan 3. Reduction in conversion rate	breaches	1. Clinical director discussed with consultant colleagues 2. Medical director discussed further with clinical director 3. GPAU move to yellow majors will support increase in medical in-reach to ED; 2 physicians in ED as part of job plan 4. UHL proposed professional standards, along with updated watershed policy, to be discussed at Clinical Directors meeting 26.10.16 5. Senior clinician leading clinical discussion among specialities on implementation of watershed policy. 6. Associate medical director supporting implementation of speciality in-reach.	21.2% (ED conversion rate)	TBC	21.30%	**2**
4	NA	Develop hospital internal professional standards (incl speciality in-reach to ED)	UHL	Sue Mason	**43**	1. Implement UHL Better Change project to decrease Cardiology inpatient LOS pre Cath Lab 2. Implement daily review of patients on monitored beds 3. Review capacity and demand of monitors available	1. Improved LOS in Cardiology 2. Decreased delay of transfer of patients from ED to CDU	1. Baseline data collection of cath lab waits - complete 2. Implement electronic referrals for Cath lab - complete 3. Implement Hot lab Cath lab sessions - complete 4. Reaudit Cath lab waits 11th November - this has been brought forward to October	All actions to be complete by 11 November 2016	1) Reduce delay of transfer of patients from ED to CDU	ED breaches	1. Baseline data collection of cath lab waits complete 2. Implement electronic referrals for Cath lab complete 3. Implement Hot lab Cath lab sessions complete 4. Reaudit of Cath lab waits taking place w/c 24.10 to confirm if changes have had necessary impact. 5. Post-change audit complete; shows decreased wait time for patients and decreased LOS. Contributing factors include improved communication between ward and lab; increase in timely referrals	`	3.5	3.4	**5**
4	4.2 4.5	Implement Red Day / Green Day as part of SAFER	UHL	Gill Staton (Ian Lawrence)	**47**	1. Investigate feasibility of method of capture of Red and Green Days (white boards or electronic) 2. Develop Red and Green Day Criteria for implementation 3. Develop launch pack 4. Communicate to and educate staff 5. Roll out across ESM -audit following roll-out	1. Decrease LOS for ESM	1. Agree Nerve Centre feasibility of recording of R&G days by 1st October 2. Agree R&G Day Criteria by 29th September 3. Roll-out of launch packs on 10th October 4. Audit 14th November 2016	All actions complete by 14 November	1) Improve base ward capacity for admissions from ED.	Admitted breaches	1. Red and green audit ongoing on two wards; initial feedback shows high numbers of red days 2.Launch days being planned throughout October 3. Focus of ECIP support 4. Project delayed due to resourcing and staff sickness - resourcing being reviewed by exec team. 5. New approach to implementation from 1.11 - director leadership and change team to work directly with one medical ward to change practice and implement approach; once embedded and resource identified, roll-out to other wards. 6. Focus of ongoing ECIP support 7. Safer Champions to be identified to support roll-out across Trust. 8. Further roll-out to all wards planned during November and December - PID being written to support process.	5.82 (average length of stay for Medicine)	4.67	5.82	**2**

4	NA	Implement direct admissions from ED to specialities	UHL	Julie Taylor (Ian Lawrence)	**68**	1. Develop a CMG wide clinical task and finish group to establish the type of patients that can be direct referred 2. Data analysis to determine impact change will have 3. Agree Patient criteria 4. Write SOP 5. Communicate process to teams 6. Implement 7. Feedback session to ensure the team capture any changes and improvements required	1. Decrease admitted breaches 2. Decrease overcrowding in ED 3. Improved patient experience	1. Develop a CMG wide clinical task and finish group to establish the type of patients that can be direct referred 10th Oct 2. Data analysis 31st Oct 3. Agree Patient criteria 31st Oct 4. Write SOP 11th Nov 5. Communicate process to teams 18th Nov 6. Implement 28th Nov 7. Feedback session to ensure the team capture any changes and improvements required 19th Dec	28.11.16	Decrease breaches	admitted breaches	1. Meeting planned with MD, CD to agree implementation plan 2. Electronic system in place for referrals/accepting patients directly onto acute medical wards 3. Discussions begun on directly admitting patients from ED to SSU. 4. GPAU move to yellow majors space 7.11.16, includes active medical in-reach into ED embedded in way of working.	80%	77%	TBC following data analysis	**3**
Key Intervention Area 5: Improved Discharge																
5	5.6, 5.1	Additional packages of care/DRT input will need to be purchased to reduce delayed discharges from the acute trust	UHL	Tamsin Hooton	**48**	Commission extended capacity in DRT to support discharge. £155k = up to 5 beds until the end of March 2016	Increased flow, Reduced delays in discharges	Funding source to be identified. Business Case to EQSG, Discussion at AEDB 5/10	01/11/2016	Reduction in LOS	% discharges before 12pm at UHL, Patients aged 75+ with LOS >10 days at UHL, % of UHL DTOC	Review after Help to Live At Home is implemented (review by 30th November) RAG rated Amber.	TBC	increase by 5	TBC	**3**
5	5.6, 5.1	Increase OPAT provision (up to 2 beds) to provide a service that delivers IV antibiotics in the patient's own home, in order to reduce LOS	UHL	Tamsin Hooton	**49**	Expansion of the current process that will allow patients who require IV antibiotics to be treated at home rather than in a hospital bed.	Increased flow, reduced LOS	MRET funding to be utilised to March (£100K) Advertise for 3 nurses (Sept 16) Identify consultant Pas (complete)	Expansion scheduled for 1/12	Reduction in admitted breaches, reduction in LOS,	Patients discharged from UHL	Awiting nurse recruitment (timescales not yet provided)	current numbers of patients supported	2 bed expansion up and running (can be phased if recruitment requires)	TBC	**4**
5	5.5	ICS to provide a programme of education to hospital ward teams in order to increase the usage of ICS.	UHL/LPT	Tamsin Hooton	**50**	Share referral criteria for ICS - 10/09 Clinical ward rounds to identify suitable people (joint with LPT)	More appropriate referrals, increased utilisation of ICS	Circulate ICS criteria Communication exercise internally and on wards Ward rounds weekly - senior LPT and UHL staff - agree frequency and put in place	30/09/2016	Increased flow, reduced admitted breaches, reduction in LOS, ICS Capacity utilisation (baseline 80%, increase to 90%)	% of LPT ICS Beds used by patients	Significant progress in ward coding on ward 16. Lessons from this ward to be rolled out across other wards Requires update	Number of referrals to ICS from UHL wards. Baseline TBC	TBC	TBC	**4**
5	5.1, 5.5	Review model of ICS for opportunities to increase usage, focus on County pathways	LPT	Tamsin Hooton	**51**	Integration of ICS with county POC provision/HTLAH model	More appropriate referrals, increased utilisation of ICS	Initial paper to Integration Exec 5/10 Full Cusiness Cases 5/11 Decision on further integration to go to Integration Executive Pilot in Loughborough of inreach/joint working with ICS	Initial STP paper 17th November	Reduced LOS/Reduced discharge delays, also supports 'step -up' and reduced ED admissions	% of LPT ICS Beds used by patients, % UHL DTOC	STP planning to include LLR 'rehab offer' which will include ICS	TBA following STP paper	TBA following STP paper	TBA following STP paper	**3**
5	5.1, 5.5	Review future model of ICS to support discharge to assess and 'Home First' model	UHL/LPT	Tamsin Hooton	**51a**	Discharge Steering Group to agree strategic direction for Discharge to assess,	Better integrated discharge to assess approach across LLR, increased use of ICS	Agree future integrated discharge to assess short term model by November 2016 Trial changes to ICS model by November - March 2017 Agree Business Case with commissioners/BCT - Jan 2017	31/03/2017	Reduced admissions, reduced admitted breaches, reduced LOS, improved flow	UHL DTOC %	Some ICS capacity decommissioned. Proposal to have a multi agency ICS review. Will form part of pathway 2 and pathway 3 discussions during November.	Discharge to Assess model agreed.	Reduction in numbers of patients assessed for CHC in acute setting (baseline TBC) but target only 10%	Business case for social care input to work alongside ICS agreed	**3**
5	5.1, 5.4, 5.6	Mobilise 'home first' discharge to assess model from hospital - go live 7th November 2016 for County	CCGs	Tamsin Hooton	**52**	Referral routes confirmed, UHL staff training, Use of MDS tool on key wards, referral form agreed	Improve flow at transfer of care stage as no waits for care packages. Improved pathway of care for non weight bearing patients, those requiring further assessment to identify true care needs, reduction in number and complexity of long term care packages. Reduction in number and complexity of CHC packages (including reduction in number of patients eligible for CHC). Reduced LOS in hospital as no eligibility assessments completed during hospital stay (possibly up to 5 days)	Procurement completed. Implement pathway on November 7th 2016. Conversation with City by 30/09/16	07/11/2016	Increased flow, reduced admitted breaches, reduction in LOS	% Discharged before 12pm at UHL, Patients aged 75+ with LOS >10 days at UHL, % UHL DTOC	6 lots on track to go live November 7th 2016 for long term care packages. 3 lots (in the West) now without provider, mitigating actions being taken. Existing providers being contacted and next group of 'successful tender' companies being contacted. HART team will commence 7th November to support hospital discharges.	Number of patients using pathway 2. Baseline: 0 cases. November 7th: 5 cases. December 7th: TBA	Number of CHC assessments completed post-transfer of care. Baseline: 0. November 7th: 5 cases. December 7th: TBA.	0	**2**
5	5.1, 5.4	Establish pathway for reablement patients (replaces D2A)	CCGs	Tamsin Hooton	**53**	1. Identify homes with spare capacity. 2. Agree referrals into spot placements 3. Agree inreach model 4. Identify in reach resource incl case managers	Improve flow at transfer of care. Improved pathway of care for non weight bearing patients, those requiring further assessment to identify true care needs, reduction in number and complexity of long term care packages. Reduction in number and complexity of CHC packages (including reduction in number of patients eligible for CHC). Reduced LOS in hospital as no eligibility assessments completed during hospital stay (possibly up to 5 days)	1. 28/09/16 complete, weekly refresh 2. Criteria agreed 30/10 3. Initial business case 4/10 4. Some existing staff - confirm resource 30/10 5. Full business case 02/11 6. Implementation group to commence 11th November 7. Service commences 1st December	Pathway running by November	Increased flow, reduced admitted breaches, reduction in LOS	% Discharged before 12pm at UHL, Patients aged 75+ with LOS >10 days at UHL, % UHL DTOC	Business case agreed with some caveats. Implementation group to meet 11th November to discuss specifics of service and implementation timescales	Pathway not in use (existing pathway has 50 patients)	20 cases per week	Existing D2A has 80 patients	**2**
5	5.2	Design and implement an electronic solution to support a trusted assessment upon transfer of care	CCGs	Tamsin Hooton	**55**	41. Trial of trusted assessment at UHL (using Nervecentre platform) prior to go live of pathway 2.	Reduced number of assessments by multiple people (potential LOS saving), no process delays between assessment and acceptance at onwards community service	Trial go live at UHL during August 2016	November 7th 2016	Increased flow, reduced admitted breaches, reduction in LOS	Patients aged 75+ with LOS >10 days at UHL	Trusted Assessment loaded on Nervecentre and initially tested . Has not yet been trialled on UHL wards. JB to create a project brief and timescales for this to be completed. Continue to await timescales from UHL. Project to be transferred to Tasneem at UHL on 10.11.16	Number of trusted assessments completed. Baseline: 0. November: 5. December: TBA	Number of accepted trusted assessments. Baseline: 0. November: 5. December: TBA	Reduced DTOC rate. Baseline UHL: 2.43% LPT: 2.85% Target 1.35% and 6.5%	**2**

5	5.2	Provide electronic means of sharing the trusted assessment with partner organisations at point of transfer of care	UHL	Tamsin Hooton	**56**	42 + 43. Commence a task and finish group to review and agree interoperability across LLR health, social care, and partner agencies. Hospital social care teams to use VPN connection in short term.	Provides initial access to trusted assessment for new pathways (enabler for success of pathways) Agree preferred option via BCT IMT group Progress Options analysis for information sharing, including Everis solution	Initial task and finish group 3rd October 2016 Options analysis to IMT group November ROI	March 31st 2017	Increased flow, reduced admitted breaches, reduction in LOS	Patients aged 75+ with LOS >10 days at UHL	Business case to be written for 'phase 2' to describe electronic data flows and available options eg MESH & reported back to LLR IM&T strategy/project groups. Requires action 55 to deliver an evaluation of trial.	Number of MDS assessments completed by UHL , number TBC at task and finish group	Number of MDS assessments accessed by other agencies. Baseline 0, December TBC	NA	**3**
5	5.2	Create trusted assessor roles across health and social care to support transfer of care process	CCGs	Tamsin Hooton	**58**	44. Create trusted assessor roles across health and social care as part of pathway 2 and pathway 3	Appropriate patient flow into the new discharge pathways, and clear management of the journey through the pathways to get the best & timely outcomes for patients	Agree use of existing case manager posts at UHL (October 2016) Agree job role (October 2016)	1st December 2016	Increased flow, reduced admitted breaches, reduction in LOS	Patients aged 75+ with LOS >10 days at UHL	Business case agreed with caveats. Implementation group to meet 11th November to describe roles/people in roles/timescales for delivery	Number of trusted assessors in post. Baseline: 0. November: 2. March: 6	Number of trusted assessors in post. Baseline: 0. November: 2. March: 6	NA	**3**
5	5.1, 5.4	Provide an efficient system wide 'D2A' pathway	UHL	Tamsin Hooton	**59**	45. Switch off existing D2A pathway to coincide with commencement of Pathway 3	Pathway 3 becomes the discharge to assess route out of hospital.	Initial discussion required with UHL to start closing the pathway down ready for January	30-Jan-17	Increased flow, reduced admitted breaches, reduction in LOS		See action 53.	Number of open cases. Baseline: 80.	November: 45. January: 30. March: 0	80 open cases	**3**
5	5.1, 5.2	Engage with partner organisations to clearly describe the D2A and Trusted Assessor offer	CCGs	Tamsin Hooton	**60**	46. Communications messages being agreed for implementation of new pathways	Clear criteria for which patients are suitable for each pathway, including principles of home first, trusted assessors and single assessment	Messages agreed during October discharge steering group	November 2016-January 2017	Increased flow, reduced admitted breaches, reduction in LOS	LPT and UHL Patients discharged to admitting address	See action 53. Comms messages to be designed during implementation meetings commencing 11th November	Communication materials agreed 31/10	NA	NA	**4**
5	5.1	Design and deliver a pathway to support effective transfer of care for patients with severe dementia	CCGs	Tamsin Hooton	**61**	47. Scope requirements of Severe Dementia Pathway using commissioning intentions. Describe pathway to include specialised care homes for this group of patients. Understand capacity requirements	Patients with severe dementia placed appropriately into the right care setting in a timely manner, follow same principles of 'home first' and 'discharge to assess'	Agree scope (October 2016). Define patient cohort (October 2016). Agree current capacity available (November 2016).	31/03/2017	Increased flow, reduced admitted breaches, reduction in LOS	Patients aged 75+ with LOS >10 days at UHL, % UHL DTOC	On agenda for next LLR Dementia group (November 2016)	TBA	TBA	TBA	**3**
5	5.1, 5.3?	Design and deliver short term improvements to capacity for end of life services in order to reduce people dying outside of their place of choice	CCGs	Tamsin Hooton	**62**	48. Scope short term capacity requirements for 'last few days of life' pathway	Patients in the last few days of life have choice about where to die and access the most appropriate care setting in a timely manner	New service specification for discharge at end of life. Workshop to test new ways of working (8th November)	Quarter 4	Increased flow, reduced admitted breaches, reduction in LOS	Patients discharged from UHL	Working towards a new service specification with UHL and LPT with regards to discharge for End of Life Care patients. Testing out the new ways of working at workshop on 8 November with a planned trial in Quarter 4	TBA	TBA	TBA	**4**
5	5.1	Monitor Hospital Housing Team offer and review model to support new D2A and TA models where indicated	CCGs	Tamsin Hooton	**63**	49. Continue to review successes and challenges of the expanded Housing team based at UHL and Bradgate Unit	Housing team reduce LOS and delays associated with housing. Currently building team skills and expertise.	New team members receiving training and upskilling (November 2016)	Ongoing	Reductions in DTOC, reductions in LOS	Patients discharged from UHL, % UHL DTOC	Continued attendance at Steering Group. Reviewing potential need for business case to outreach to pathway 2 and 3 once operational. Mental health rep now on steering group to support DTOC at Bradgate Unit. Review of metrics to demonstrate successes. Housing associations on board to review use of 'difficult to let' properties and enhance quicker processes from hospital	Number of patients supported by team: TBA.	Number of patients supported by team: TBA	Number of patients supported by team: TBA	**4**
5	5.1, 5.5, 5.6	Agree and produce a recognised delayed discharge measure across LLR to support operational and improvement work (in addition to DTOC reporting)	CCGs and Local Authorities	Tamsin Hooton	**71 (New)**	Create a task and finish group to amalgamate reporting requirements, and agree what will be produced	Improved information on delays and process issues relating to discharge, to support better targeting of actions including improved escalation and surge processes. Supports section 4	Group to meet (October 2016). Presentation to DSG (November 2016). Dummy report produced (January 2017)	March 31st 2017	Improved flow, reduced admitted breaches	% UHL DTOC, % LPT DTOC	Task and finish group met. Lack of assurance amongst group of how data is coded/who signs it off as many anomalies noted. Short audit to review this before moving forwards. Next meeting 7/11. DTOC reporting and monitoring to be included in Discharge Steering Group	Group to meet 3rd October	First draft report January 2017	0	**4**
5	5.3	Agree Policy and procedure to support patient and family choice	CCGs and Local Authorities	Tamsin Hooton	**72 (New)**	Discharge Steering Group to lead process to agree policy, with appropriate engagement with stakeholders	Reduced DTOC related to family choice, improved patient/family communication about expectations	Discharge Steering Group to agree action plan COMPLETE DSG to agree policy for approval Approval by CCGs, Las/Integration Execs? Implementation plan incl comms	05/10 1/11/16 23/12/2016 March 2017	Reduction in DTOCs, improved flow, reduced admitted breaches	% UHL DTOC, % LPT DTOC	UHL to discuss at exec nurses meeting - date to be re-arranged. Task and finish group to meet wc 28th November to describe policy and key staff/patient messages	No policy being consistently used	Agreed policy by March 2017	0	**4**
5	4.1, 5.6, 5.5	Adapt acute SAFER flow bundle to address the community hospital service requirements	LPT	Tamsin Hooton?	**link to 37**	Benchmark community inpatient wards and identify additional action required Share benchmarking with DSG and confirm required actions	Identify gaps and actions for delivery of SAFER bundle in community hospitals	Completed benchmarking exercise discussed at DSG Agreed action plan	5th October November DSG	Improved flow in CH, improved ability to discharge from acute, improved acute flow,	% LPT DTOC	Review undertaken. Red and Green reporting key action - not yet underway. LPT propose no target for am disharge	Benchmarking against 5 SAFER metrics	Agreed actions to address benchmarking gaps Nov 2016	Benchmarking completed. Red Green Day reporting key action	**4**

RAG Key:

1	Not started
2	Significant delay or no plan
3	In progress, some risk or delay
4	On track
5	Complete

UHL High Impact Action

Key Intervention Number	National Guidance reference / detail	Action Detail	Lead Organisation	Accountable Officer	Action number	Planned activity	Expected outcome/Impact	Key milestones	Delivery date	Contribution to ED recovery	Links to Dashboard	Update (All perf. Figures are dated)	Metric			RAG rating
4	NA	Reduce time from bed allocation to departure from ED	UHL	Julie Taylor	**14**	1. Establish baseline 2. Identify themes for delay 3. Allocate Rapid Flow team to ED 4. Communicate and promote change in process 5. Rapid cycle test the new process 6. Implement	1. When beds are available, patient will leave within 15mins	1. Establish baseline - complete 18th July 2. All other actions were completed in August	All actions complete 1 September 2016	1. Improve flow from ED 2. Decrease congestion in ED	admitted breaches	1. Work with the rapid flow team has shown an reduction in the average time from 30 mins to 19 mins. 2. Delay themes identified: * Photocopying issues - resolved * Patient status issues - resolved 3. Currently looking at issues around bulking of bed availability and transport issues. 4. Data requested on % of patients with bed request outside of LRI as impacting on 15min performance. Data will then be cleansed to provide a true reflection	26% (patients leaving dept within 15mins of bed allocation)	50%	31%	**5**
4	NA	Reduce handover times for nursing team	UHL	Julie Taylor	**15**	1. OD facilitated workshop with medical and nursing teams on handovers 2. Trial of suggested new format of handover 3. Embedding of newly agreed process in the department	1. Reduce handover times to maximum of 20 mins and reduce number of handovers.	1. Baseline current handover process & times - complete 27th July 2016 2. Implement bedside handover - will be complete 7 November 2016 3. Reduce number of doctors handovers - review 7 November 2016	All actions to be complete 7 November 2016	1. Reduction in wait to be seen in ED	breaches	Handover time : 20mins	Handover time: 15 mins	Maximum 15 mins	20 mins	**5**
4	NA	Reduce delays in diagnostics for patients in ED	UHL	Julie Taylor	**20**	1. Baseline audit to be completed 2. Identify reasons for delay from audit 3. Complete trial of dedicated porter for 3 days in ED	1. Decrease congestion in ED 2. Improved efficiency of diagnostics	1. Baseline audit - complete 18th July 2. Reasons for delays identified 25th July 3. Trial of dedicated porter - delayed due to availability of porters	All actions to be complete 17 October 2016	1. Reduction in patient wait times 2. Reduction in breaches	Breaches	1. Baseline audit - complete 18th July 2. Reasons for delays identified 25th July 3. Trial of dedicated porter - delayed due to availability of porters 4. Porter trial took place on 13-15 September; further meeting planned this week to discuss and review the data gathered and look at potential service improvements. Being picked up in workstream.	Transfer time from ED to imaging metric is being reviewed	TBC	TBC	**5**

1		NHS Improvement recommended presentation from South Warwick on how they improved system performance.	UHL	Lisa Gowan	**25**	-CD to make contact with South Warwickshire Trust - Invite to present to senior leadership team to identify any further actions for UHL to implement	Unable to comment on expected outcome until contact has been made	Unable to comment on expected outcome until contact has been made	Exchange visit to be complete by 1 November 2016	Unable to comment on expected outcome until contact has been made	Breaches	1. Clinical Director made contact with South Warks Director of Ops and Medical Director to confirm next steps. 2. Contact made; South Warwickshire to provide dates for UHL visit. 3. Action to be picked up by workstream	Unable to comment on expected outcome until contact has been made	TBC	TBC	**5**
4	NA	Improve discharge from UHL by decreasing transport delays	UHL	Gill Staton	**45**	1. Meet Arriva and CCGs to establish reasons for delays 2. Implement actions to address delays 3. Implement a weekly meeting to review patients that were re-bedded and identify themes and develop actions to resolve 4. Establish process of prospectively booking discharges 5. CCG to complete procurement of NEPTS	1. Increase early discharge 2. Decrease failed discharge	1. Set up meeting with Arriva & CCGs by 1st October 2016 2. Set up weekly review to start w/c 26th September	All actions complete by end of October	1) Reduction in breaches 2) Improved flow out of ED	admitted breaches	1. CCG UHL meeting 29.9.16 to discuss contract arrangements and overbooking processes to manage demand until new contract confirmed 2. Arriva UHL meeting 30.9.16 to jointly improve processes 3. Meeting took place with Arriva; new way of working agreed, including focus on discharge from assessment areas and increase ambulance utilisation.	4.5% (discharges pre 11am) 13% (discharges pre 1pm)	33% before 12.00	4.2% (discharges pre 11am) 12.9% (discharges pre 1pm)	**5**
4	NA	Implement low risk ambulatory service on CDU	UHL	Sue Mason	**26**	1. Business case to be written for EQSG 2. Meeting with CCGs to discuss commissioning 3. Implement if commissioned	1. Maintain LOS on CDU achieved during pilot (July/August) 2. Average LOS in low risk ambulatory service 2 hours 3. Improve quality for patients by decreasing time in CDU	1. Business case went to EQSG on 31st August 2. Met with CCGs to discuss commissioning 6th September 3. Implement if commissioned 1st December	If commissioned, 01/12/2016	1. Decrease in frequency of CDU going on a 'stop' therefore decreasing congestion in ED and number of breaches	breaches in ED	1. Funding agreed; service begins on 1.11, four days a week. Clinical lead actively seeking GP cover to provide five day service.	13 (Length of stay in CDU)	13 (target to achieve length of stay achieved during the pilot)	13.3	**5**

LLR A&E Delivery Board

Risk Register - November 2016

		Potential Risk Description	Initial risk level			Mitigating actions in place	Assurance	Further mitigating Actions	Expected date of completion	Reduced Risk Score			Comments
Risk Owner	Risk Ref	Should be high-level potential risks that are unlikely to be fully resolved and require on-going control	Impact	Likelihood	Rag Status	Systems and processes in place and operating that mitigate this risk	Evidence that this risk is being effectively managed	Additional actions required to mitigate this risk further	For further mitigating actions	Impact	Likelihood	Rag Status	
Tim Sacks	CL1	**RISK:** Keeping a patient in their usual place of residence with a treatable condition, managed by primary care and the patient dies. **CAUSE:** Capacity & confidence in primary care, OOH GPs adherence to pathways, availability of community staff to support primary care management, inconsistency across City & County. **Impact:** potential adverse outcome for patient	4	4	16	RAP - Area 2 Actions (link) Development of support services in community: - AVS/CRS, NHS 111, EMAS, OOH Workforce planning for primary care Consultant connect	Implementation of actions in RAP Area 2 by AEDB **KPIs:** ED attendance Unexpected deaths in the community	Undertake work to understand the variability across City & County Implement actions to change the culture of staff and patients regarding end of life care at home Support more GPs to take appropriate risk management in the community	TBC	4	3	12	
Rachana Vyas Mark Gregory	CL2	**Risk:** Too many people with a perceived need for emergency ambulance response **Cause:** Inappropriate assessment and or Access **Impact:** Patients waiting 'unsighted' in the community for a first response following initial telephone triage - EMAS crews unable to attend urgent cases in the community	5	5	25	RAP - Areas 2 and 3 (Links)	Implementation of actions in RAP Areas 2 & 3 by AEDB **KPIs:** SIs relating to patients waiting for ambulance response Red conversion rates Ambulance handover delays	Review actions relating to NHS 111 warm transfers Review interfacility transfers (UHL originated) Review Primary Care Access Rates	TBC	5	3	15	
Tamsin Hooton	CL3	**Risk:** Discharge breakdown **Cause:** Limited community capacity in health and social care, inappropriate early discharge, poor post discharge follow up, failure to plan discharge at the point of admission. CHC capacity, avaiability of HTLAH packages **Impact:** Patients not being discharged or patients being readmitted	4	5	20	RAP area 5 (Link)	Implementation of actions in RAP Area 5 by AEDB **KPIs:** DTOC Medically Fit for Discharge (MFFD) rates Stranded patient data Readmission data Discharges before 12pm	Review actions for post discharge follow up DTCO - conbined plan to be developed through discharge group CHC operational plan in pace HTLAH operational plan in place	TBC	4	4	16	
Caroline Trevithick	CL4	**Risk:** Management of a dying patient in the community results in hospital admission **Cause:** Lack of Advanced Care plan, failure to follow advanced care plan, lack of DNACPR, failure to follow DNACPR, pressure from families and carers **Impact:** Patients being admitted inappropriately at end of life.	3	4	12	End of life BCT plan	**KPIs:** Reports from UHL/EMAS regarding inappropriate admission			3	3	9	

Pete Miller	CL5	**Risk:** There is a risk that sufficient staff cannot be recruited or retained to fulfil the needs of the new operating models **Impact:** service changes the changes will either be delayed, or not made, or delivered at too high a cost, resulting in a failure to achieve the overall goals of the programme **Cause:** Insufficient staff	4	5	20	Workforce strategy complete Action plan in place to address known capacity risk areas (eg primary care, nursing)	BCT workforce group review	Develop approach to strategic workforce planning to assess new capacity risks as they arise - Ongoing Link with clinical workstreams to provide Ongoing workforce planning support - Ongoing Develop joint attraction strategy		3	5	15	

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

Leicester, Leicestershire & Rutland Local A&E Board

6th September 2016 submission

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

Initiative		Statement of good practice	B-RAG	Commentary
1. Streaming at A&E	**1.1**	All major specialties have a consultant immediately available on the telephone to provide advice & streaming for ED & primary care	**Amber**	24/7 on call cover across all major admitting specialities with 24 hr ED access. Consultant Connect available to GPs for acute medicine, Paediatrics and Geriatric medicine.
	1.2	There is a primary care stream available (if activity levels justify it) with the capacity to meet the true patient demand	**Amber**	Streaming service (Lakeside) supported by urgent care in place. Challenges around workforce and ability to recruit. Reduction in treated/redirected patients since November as service scale reduced. Winter approach to be finalised by 30/9/16
	1.3	Patients presenting with mental health illness are assessed, managed, discharged or admitted within the ED standard	**Green**	Access to 24/7 liaison mental health services is available, and this is part of our overall improvement plan. Standard not always met for pts requiring admission
	1.4	There is an ambulatory emergency care service available for 12 hours per day, 7 days per week which manages at least 25% of the emergency take	**Green**	Medical specialities. Access to ambulatory services exist but currently not taking 25% of patients. Surgical specialities via SAU with General Surgery offering a triage service Monday to Friday 0730 to 2000hrs at both LGH & LRI site.
	1.6	There is an acute frailty service available 12 hours per day, 7 days per week which treats all eligible patients	**Blue**	Access to frailty pathways are appropriate for the criteria described within 24 hours of admission.

	1.8	Community and intermediate care services respond to requests for patient support within 2 hours	**Amber**	ICRS (City) in place and responsive. CRS (County) in place but challenged with response time due to capacity constraints.
2. NHS 111 calls transferred to clinicians	**2.0**	Given there is a requirement to increase from 22% to an national interim threshold of 30% (or higher) of calls transferred to a clinical advisor by 31st March 2017, the A&E Delivery Board has plans in place to meet this requirement	**Amber**	Modelling for the Clinical Navigation Hub suggests that this will be delivered by 31/3/2017.
	2.1	Clinical expertise availability is planned according to demand	**Amber**	As above
		The A&E Delivery Board has a lead starting to integrate the NHS 111 service and local Out of Hospital Provision, particularly OOH	**Green**	Led by Director of Urgent Care. Will be in place as pilot from Oct 2016 and procured in 2017/18 as part of integrated urgent care model within the Vanguard.
	2.6	The A&E DoS service type is ranked as low as possible, apart from other A&E-type services and services not commissioned within the CCG	**Blue**	
	2.7	There are alternative services which can accept NHS Pathways outcomes for conditions that can be managed outside A&E E.g. limb injuries, bites, stings, plaster cast problems, suspected DVT, falls	**Blue**	
	2.8	The A&E Delivery Board knows demographics of the area, including if there is a greater demand for OOH services are generated from the elderly	**Amber**	Trialled urgent care system metrics and Board will receive regular dashboard.
3. Ambulance Response Programme (DoD and coding pilots)	**3.1 & 3.2**	There is an ambulance trust executive lead on the A&E Delivery Board able to deliver the required service changes	**Blue**	Acting CE of EMAS is a member of A&EDB **BLUE**
	3.2	There are working definitions of 'Hear and Treat' and 'See and Treat' agreed across the local health economy and a baseline workforce profile to deliver an increase in these dispositions	**Green**	
	3.2 & 3.4	There are alternative services which can accept ambulance dispositions or referrals and these mapped across localities	**Amber**	Services mapped through Mobile Directory of Service. However, some local pathway confirm and challenge required to confirm
	3.4	The A&E Delivery Board has established local mechanisms for increasing clinical input into green ambulance dispositions particularly at times of peak demand	**Amber**	Clinical Hubs being developed to support patients with a green disposition
	3.4 & 3.5	The A&E Delivery Board has agreed workforce and service plans in place to deliver an increase in 'Hear and Treat' and 'See and Treat'	**Amber**	In development across health and care economy

4. Improved Patient Flow	4.1	SAFER patient flow bundle implemented on assessment and medical wards as a bare minimum , to improve patient flow	Amber	Safer bundle' concept initiated two years ago across the Acute medical wards at the LRI site. Needs re-launching and more dedicated focus- ECIP are providing support to UHL to implement SAFER bundle, work will begin with 2 pilot wards 7th Sept 2016
	4.1	What percentage of the base wards on each acute site has SAFER in place?	Amber	100% of Acute medical wards at the LRI has the safer bundle in place but needs relaunching & refocus with support of ECIP
	4.2	The use of the red and green day approach has been considered	Amber	To be implemented- with assistance from ECIP- attending 2 medical wards on 7th Sept
	4.3	A baseline assessment of the effective use of EDDs and Clinical Criteria for Discharge has been carried out	Green	Audits are currently being undertaken on the medical wards at the LRI site
	4.4	Ward round checklists are in use in all wards in the acute hospital/s	Amber	Initiated about two years ago but not used consistently in practice - need to be relaunched.
5. Improved Discharge	5.1	A 'home first: discharge to assess' pathway is in operation across all appropriate hospital wards	Amber	Plans to deliver -pathways being implemented over next four months. Delays to discharge to assess need addressing. Significant work re comms and implementation across all wards. ICS has potential to enhance Home First approach.
	5.2	Trusted assessor arrangements are in place with social care and independent care sector providers	Amber	Amber in terms of pathway 2 and 3, with MDS as tool to shape the discharge work. Trusted assessor framework in place but risks to rollout.
	5.4	At least 90% of continuing healthcare screenings and assessments are conducted outside of acute settings	Red	Not currently in place. Existing plans for D2A will improve % assessed outside acute settings, but we have not established whether they will deliver 90% of assessments outside hospital.
	5.3	A standard operating procedure for supporting patients' choice at discharge is in use, which reflects the new national guidance	Red	Plans still to be developed - Discharge Steering Group to lead
	5.6	Systems are in place to review the reasons for any inpatient stay that exceeds six days	Amber	Baseline to be established in September, trialled on couple of wards. Roll out plan in development.
	5.6	There is a responsible director in the trust who will monitor the DToC situation daily and report regularly to the board on this specific issue	Blue	Chief Operating Officer

	5.6	Related to the above, there is a named senior individual in every CCG and SSD who will be the single point of contact for the nominated trust exec.	**Green**	Senior discharge leads in place, confirmation and communication across system required. DSG to lead

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

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

BRIEFING NOTE FOR REGIONAL EMERGENCY CARE ESCALATION MEETING

22nd NOVEMBER 2016

Background

The LLR Recovery Action Plan (RAP) has been signed off by NHS Improvement and NHS England as the right plan and has recently been assured as having the right amount of detail in it following further development.

Since the advent of the new A&E Delivery Board (AEDB), the LLR system has increased its level of rigour in terms of managing the plan. The AEDB meets fortnightly, on an alternating cycle of operational (short term) and strategic/Vanguard (medium term) focus. However, a RAP highlight report is presented to every meeting and this describes both recent achievements and any areas which are off track. The AEDB then agrees necessary remedial action, informed by discussions at the Urgent Care Improvement Group, chaired by the Urgent Care Director. The current status of the plan has also been discussed at each of the monthly sub-regional escalation meetings.

Notwithstanding better planning and programme management, the LLR system continues to under-perform badly. The focus of this paper is therefore on further actions that can be taken to improve performance in the short term. In almost all cases the actions/themes identified are already in the RAP; thus the actions mainly represent a more focussed and/or accelerated approach.

The paper also identifies the limited areas where assistance from NHSI and/or NHSE is required (identified by a *).

Demand management

Implementation of complete Clinical Navigation model by NHS 111 – this has been delayed by the knock-on effect of problems in Lincolnshire which have limited 111's ability to increase clinical call handling*

Face-to-face review of patients in nursing/care homes by GPs or alternative service before admission request. Validation system operated by EMAS and UHL (Bed Bureau)

Understand drivers of high Red Call EMAS demand in LLR and take action to reduce

Increase EMAS CATS activity (hear-and-treat/see-and-treat) back to previous high levels

Continue triage of Resus calls by EMAS HALO (as in IMI)

Increase redirection from UCC streaming to primary care hubs

Emergency Department

Move the ED assessment process to a rapid assessment model*

Improve the resilience of ED in the evenings and overnight*

Internal UHL Flow

Address medical variation on AMU (medical assessment unit)*

Roll-out Red/Green and SAFER Bundle*

Enhanced Gold/Silver Command system with more rigorous escalation actions

Implement system-wide recovery approach at times of critical pressure (as in IMI)

Discharge

Increase Social Care input at weekends

Resolve County Help to Live at Home (Pathway 2) implementation issues

Implement Pathway 3 (care homes) contingency plan

Implement new dashboard to give high visibility to all delays (NHS and Social Care)

Rapid senior review of key causes of delays and identification of remedial action

Improve D2A approach and reablement capacity*

Support Required (marked * above)

Although the bulk of the above actions are in the gift of the LLR system, we require support in the following areas:

NHS 111 Clinical navigation – the differing requirements and situations of the various parts of the regional 111 geography are producing tensions for the provider DHU. NHSE support to resolve these tensions would be helpful

Improving ED process (including assessment and resilience overnight) – We require intensive input from an experienced ED medical leader (minimum 2-3 days per week for 6 months) to work alongside ED nursing and operational leaders

Medical variation on AMU – ECIP support to tackle this key variation

Red/Green/SAFER – ECIP support for programme design and implementation

D2A/Reablement – ECIP support to help design improved support (potentially via Vanguard support)

John Adler

Chair, LLR A&E Delivery Board

21/11/16

LLR Urgent Care System Escalation Meeting 22nd November 2016

Action Notes

Escalation area/discussion	Action agreed	Lead	Timeframe
Implementation of complete Clinical Navigation model by NHS 111. Meeting discussed barriers, including need to a safe technical solution, which may be Regional, and requirement for funding/approval by Regional commissioners. Impact of Lincolnshire CATS on DHU capacity was recognised.	1. DHU to propose solution to triage green ambulances, with earliest possible start in 2016. Proposal to be discussed with CCGs including regional commissioners, including funding implications. 2. Plan for rapid implementation of green 2 triage and 24/7 triage to be shared with DB , confirming earliest date 3. RAP to be updated to reflect changed milestones 4. Identify when Lincolnshire will reduce reliance on DHU staffing for clinical advice	SB TH TH SB	23/11/16 25/11/16 28/11/16 23/11/16
Review of patients in nursing/care homes by GPs or alternative service before admission request/EMAS conveyance	1. EMAS to work with UC team and UHL to agree approach, either CATS team or SSAFA/other clinical review prior to conveyance 2. Add to RAP as new action	TSl/WL/RV TH	7/12/16 28/11/16
Understand drivers of high Red Call EMAS demand in LLR and take action to reduce	1. Put in place action to target practices with high card 35 rates or EMAS urgent calls not reviewed by a GP 2. Letter to be sent to GP practices to say that patients must have had clinical review before Urgent ED/admission by EMAS 3. EMAS and NHS 111 to meet to review causes of increased red activity from 111	RV CV/WL RH/SB	7/7/16 28/11/16 24/11/16
Increase EMAS CATS activity (hear-and-treat/see-and-treat) back to previous high levels	1. EMAS to confirm increased staffing levels within CATS team	WL	7/12/16
Increase redirection from UCC streaming to primary care hubs	1. Confirm dedicated capacity within Hubs for ED booking 2. LRI streaming staff receive message to increase	RV RM	25/11/16 25/11/16

	redirection		
Improve the resilience of ED in the evenings and overnight	1. NHS I to support UHL in identifying external Medical leadership support to ED 2. UHL to address clinical variation and impact on ED operations through OD (supported by 1. above)	JW JA	2/12/16 23/12/16
Roll out SAFER across UHL, including implementing Red Green Day process	1. UHL to share proposal on roll out [Post meeting note – full plan for roll out to be presented to AEDB 7/12, to include accelerated roll out to all LRI medical wards from 12/12] 2. RAP to be amended to reflect new process 3. ECIP support to be confirmed	RM TH RM	30/11/16 30/11/16 30/11/16
Enhanced Gold/Silver Command system with more rigorous escalation actions	1. UHL to put in place more rigorous process	RM	26/11/16
Implement system-wide recovery approach at times of critical pressure	1. Review recent 'IMI' and process for mobilising system recovery to learn lessons.	TSL/RM	30/11/16
Increased Social Care input to hospital discharge process, particularly at weekends. Social care to step up winter capacity	1. County to confirm date of increase to weekend social care input 2. City to confirm winter additional resource	JW RL	28/11/16 28/11/16
Implement Pathway 3 contingency approach, including setting out securing capacity for beds, case management and therapy. Plan needs to outline risks and plans to move patients out of D2A pathway.	1. TH to confirm plans, risk and mitigations 2. Review proposal to enhance therapy using locums, identify solution to mitigate impact on LPT agency cap	TH TH/RB	25/11/16 28/11/16
Develop enhanced discharge dashboard, to be used for senior (AEDB) review of trends and high impact interventions and to support the discharge steering group work	1. Group to meet – existing RAP action – escalate delivery of draft report to DSG 2. UHL data to feed into dashboard 3. Agree process for review of dashboard to escalate delays at senior level	TH RM TH	6/12/16 30/11/16 6/12/16

Increase focus on CHC in terms of part it plays in discharge focus	1. CHC delays to be added to RAP – determine most appropriate action	TH	1/12/16
Explore re-ablement bedded unit model	1. Feasibility study, looking at site, staffing, costs – to be discussed at AEDB	TH	1/12/16

Emergency Care Improvement Programme

Safer, faster, better care for patients

NHS England

NHS Improvement

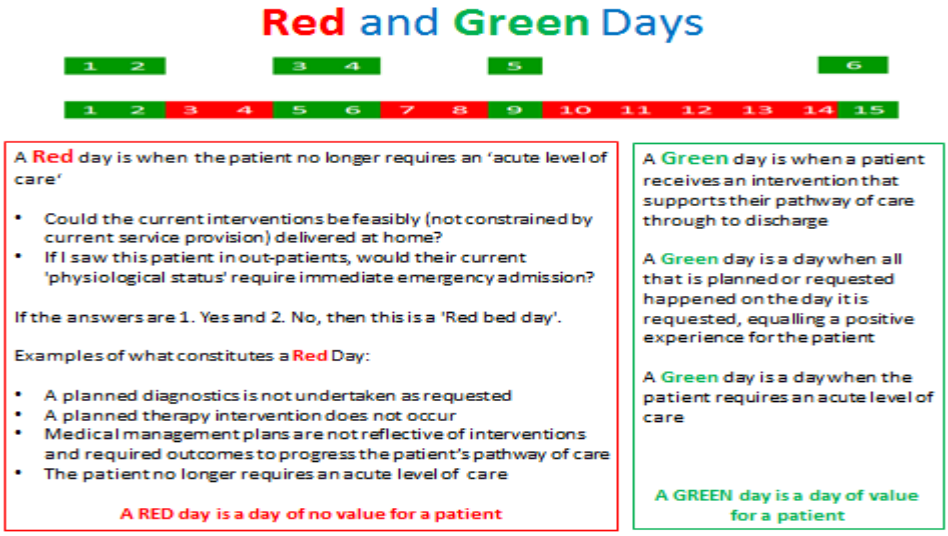
Midlands and East - Red2Green Campaign - Go Green this winter

A Quick Guide

Introduction

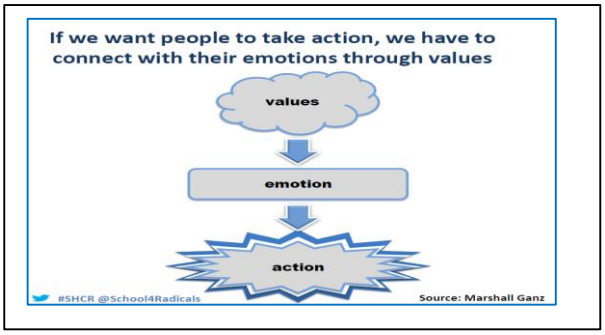
The red and green day approach (created by **Dr Ian Sturgess, NHS Improvement Senior Clinical Improvement Adviser**) resonates with clinical and managerial teams as a simple method to reduce unnecessary waiting for patients.

"Reducing unnecessary waiting for patients, and unnecessary chasing up by staff has to be a win win for everyone working in and using our health and care systems. The risks for our patients are well documented and significant" **Dr Ian Sturgess**



- **Imagine** a hospital where all patients and staff are able to describe what is going to happen this morning, this afternoon and tomorrow to necessarily progress the care a patient needs to get them to the desired result to leave hospital?
- **Imagine** patients and families reflecting that they always knew what was going to happen next or at least knew when something may take a day or two longer than expected?
- **Imagine** a 'no surprises' recovery as far as is feasible, where the only 'unexpected' was the biological process of recovery not the waits and frustrations of our systems?
- **Imagine** a system where the patient is in control and can describe their journey?
- **Imagine** a system where you come to work or receive care knowing that the next step is ready and there is no unnecessary waiting?

Engagement:



The approach is all about creating and delivering expectation for our patients and colleagues. **Red2Green** aims to ensure that everyone, especially the person receiving care, knows what the next steps are and knows that the system of care is ensuring there is no waste of their time.

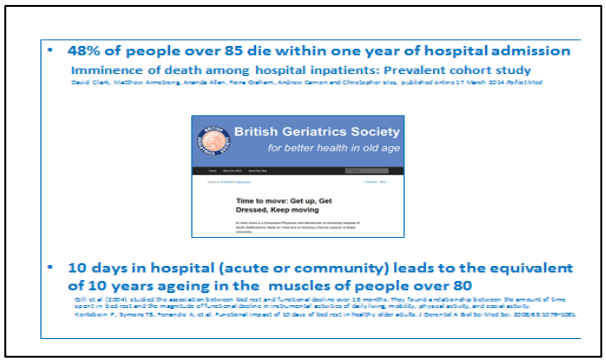
1. Clinically led
2. Executive buy in
3. Whole system buy in
4. Improvement rather than a performance management approach
5. Lots of green days means there's an opportunity for improvement
6. Create a social movement using **#last1000days** and **#red2green**

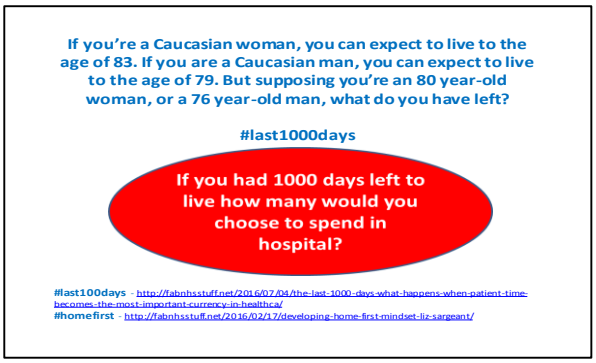
"Patients time is the most important currency in health care"
Prof Brian Dolan

Social Movement:

"A social movement that only moves people is merely a revolt.
A movement that changes both people and institutions is a revolution."
— Martin Luther King Jr., Why We Can't Wait

1. Create a social movement through creating a compelling story
2. Make your campaign matter to everyone with patient and staff stories
3. Engage communications teams to support and utilise all available methods to communicate to win hearts and minds, i.e. newsletters, posters, and social media. There are some useful examples available **@Red2Green webpage**





Approach

1. All multi-disciplinary team (MDT) members asking on every board and ward round if today is going to be a red or a green day.

2. If it's going to be a red day the MDT make every effort to resolve the problem in real time.

3. If the MDT cannot resolve the problem i.e. prevent the patient from having a red day, there are clear and simple escalation processes in place that involve all levels of health, social care and other staff groups (including the voluntary sector) again responding to delays in real time.

4. Afternoon board round to check actions have been undertaken (todays work today)

5. Recording red and green days in a visual manner i.e. so it's clear for all to see the number of red and green days on patient status at a glance boards (ward boards) and IT systems.

6. After testing it out on a couple of wards, devise a plan to implement it across a hospital site (with system wide health and social care support) so it starts to be part of **'the way we do things around here'**

Process

Recommended Process for Effective Board Rounds (Ideally no longer than 15-20 minutes):

1. Start the daily, morning multi-disciplinary Board Round with all patients marked as 'Red'

2. The day remains as 'Red' if there is inadequate senior presence at the Board Round to allow firm decisions to be made.

3. The day remains as 'Red' if there is no clinically owned expected date of discharge (set assuming ideal recovery and no unnecessary waiting) with clinical criteria for discharge and a clear case management plan.

4. The Board round should ensure that a patient's case management plan is progressed and converts the day to Green. If a patient requires an investigation that day to progress their care, then the day will only become Green if the investigation occurs that day and there is a clear plan of action with regard to the result. If the patient has not met their CCD and is receiving active interventions to get them to that state by tomorrow, the day is only 'Green' if the discharge prescription medications are ready by the evening before the expected date of discharge.

5. The team must be clear what actions constitute a day being 'Green'. For example, these do not include observations being undertaken, oral medications, IV antibiotics etc. as these can be delivered out of hospital unless the patient is physiologically unstable.

6. The Red and Green days process is linked to the **SAFER patient flow bundle.**

7. It is helpful to link flow, safety and reliability with visual demonstration using a 'Ward Improvement Board' as described in the Productive Ward Programme. Examples of ward level metrics that might be used include:

   a. Impact Metrics – statistical process control run chart (SPC) of weekly average length of stay of discharges from the ward. These should reduce significantly as Red days are proactively reduced.
   b. Process Metrics – e.g. % discharge drugs ordered and prepared the day before discharge, % of patient records with an EDD and CCD recorded in the medical notes etc.
   c. Balancing Metrics – number of unplanned re-admissions.
   d. Quality Metrics – pressure sores, HCAI, catheter days, cannula days, falls.

8. The constraints identified by wards to converting a Red day to a Green day need to be proactively managed at the Board round. Those that cannot be immediately resolved need an in-day escalation process.

9. The escalation process needs to pro-actively manage the constraint. Failure to resolve constraints proactively and just 'report them' is a non-value adding process.

10. At the end of each week, the top five constraints that could not be resolved by ward teams or following escalation should be considered by senior operational managers and where appropriate, added to local improvement plans.

Recommended Afternoon Check and Challenge Process (Ideally no longer than 10 minutes)

1. Review the Red and Green Bed Day tracking list / audit form to check whether the required actions are completed for each patient.

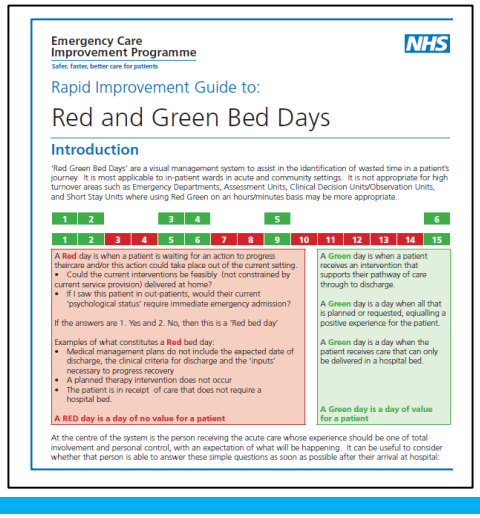
2. If not complete, explore further possibilities for resolution that day or as a priority action for the following morning.

3. Identify issues or delays for escalation.

4. Update the tracking list / audit form; ensuring delays and issues are recorded.

5. Record what worked well that day and any opportunities for improvement.

Check out our
Rapid Improvement Guide
and other useful resources
@Red2Green webpage



Emergency Care Improvement Programme
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NHS

Rapid Improvement Guide to:

Red and Green Bed Days

Introduction

'Red Green Bed Days' are a visual management system to assist in the identification of wasted time in a patient's journey. It is most applicable to in-patient wards in acute and community settings. It is not appropriate for high turnover areas such as Emergency Departments, Assessment Units, Clinical Decision Units/Observation Units, and Short Stay Units where using Red Green on an hours/minutes basis may be more appropriate.

1 2 3 4 5 6

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

A Red day is when a patient is waiting for an action to progress theircare and/or this action could take place out of the current setting.
- Could the current interventions be feasibly (not constrained by current service provision) delivered at home?
- If I saw this patient in out-patients, would their current 'psychological status' require immediate emergency admission?

If the answers are 1. Yes and 2. No, then this is a 'Red bed day'

Examples of what constitutes a Red bed day:
- Medical management plans do not include the expected date of discharge, the clinical criteria for discharge and the 'inputs' necessary to progress recovery
- A planned therapy intervention does not occur
- The patient is in receipt of care that does not require a hospital bed.

A RED day is a day of no value for a patient

A Green day is when a patient receives an intervention that supports their pathway of care through to discharge.

A Green day is a day when all that is planned or requested, equalling a positive experience for the patient.

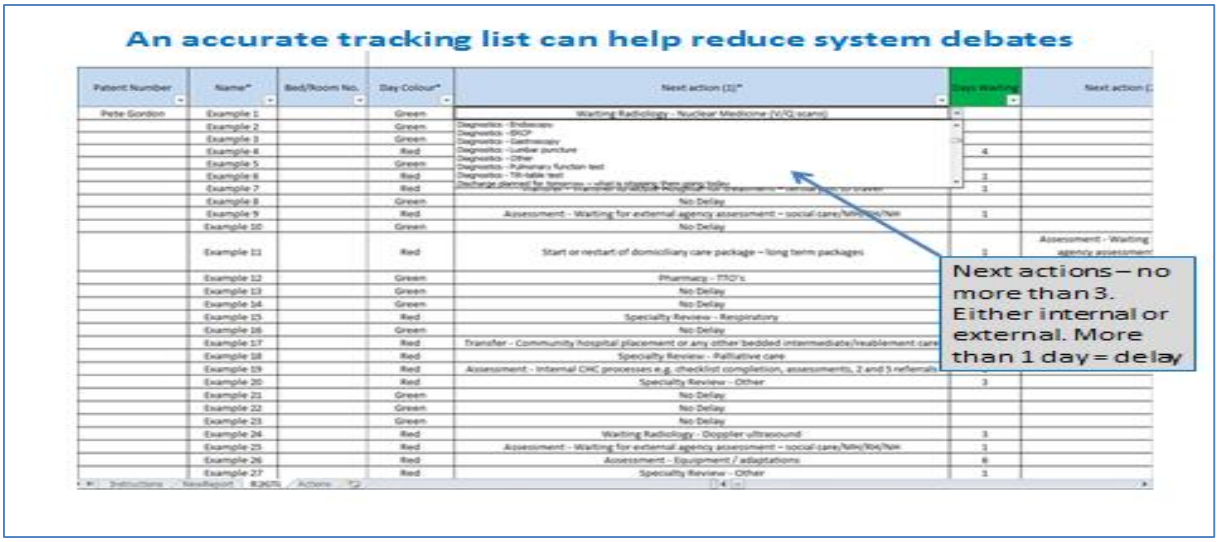
A Green day is a day when the patient receives care that can only be delivered in a hospital bed.

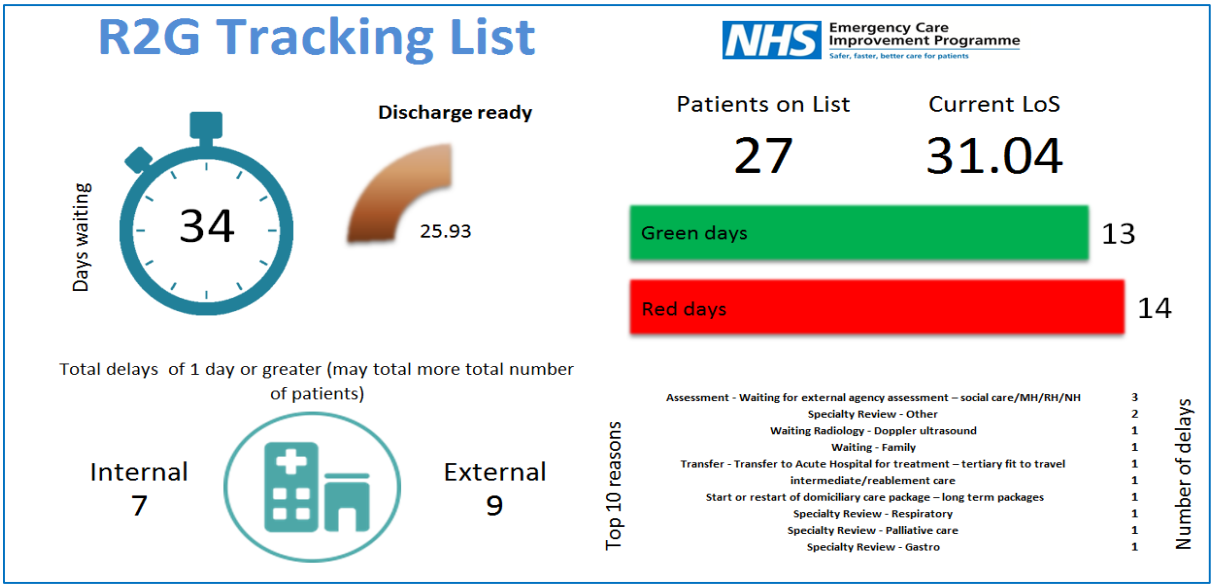
A Green day is a day of value for a patient

At the centre of the system is the person receiving the acute care whose experience should be one of total involvement and personal control, with an expectation of what will be happening. It can be useful to consider whether that person is able to answer these simple questions as soon as possible after their arrival at hospital:

Continuous Improvement - Red2Green Tracking List

Red days should be visible to all – every effort should be made to convert red days to green days today (Todays work Today). We have developed a Red:Green visual management tool that can support teams in managing Red:Green days. The tool is available to download:
@Red2Green webpage





Try it, it should be fun, it is not a reporting tool it is a learning tool. The power of the tool is not in the tool but how it is used. If we all remember and value the thought *that* ***"patients' time is the most important currency in healthcare"*** we will without doubt see improvements that will ultimately benefit our patients and our hard working clinical and managerial teams."
Dr Ian Sturgess

For further tools, resources and support please visit the Red2Green website:
http://www.ecip.nhs.uk/Tools-and-Resources/Midlands-and-East-Region---RedGreen-Campaign

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

Base ward workstream summary

9th November 2016

What has gone well?

- Ward 7 opened 1/11/16, supporting an improved discharge process within ESM
- 2 bays / 12 beds of Next Day Discharge patients (post-breakfast discharges)
- 2 bays / 6 beds and 6 recliners of bedded Discharge Lounge (earlier transfers / earlier discharges)
- SAFER being widely publicised, and increasingly implemented (more TTOs prepared day pre-discharge)

SRO update – position against RAP metrics

Action detail	Delivery date	Update	Metric target	Metric current	RAG
Implement Rapid Flow	30.11.16	Use of ward 7 as discharge and transitional care lounge Looking at process for agreeing approach on all wards for having additional patients on wards; focus of ECIP support	55% bed allocated in 60 mins	58% (Oct)	
Implement SAFER patient flow bundle	01.11.16	Completed for medical wards – November 2016 Trust roll-out to be supported by ECIP, alongside roll-out of updated internal professional standards	4.67 (av LOS)	5.82	
Red to Green	14.11.16	Roll out on all ESM base wards Attendance at national ECIP launch date To be focus of A&E Implementation Group meeting to discuss system support and ways of working	4.67 (av LOS	5.82	

Next Steps

Describe what actions are being taken to improve performance against RAP amber/red metrics, to get them back on track

Action/Initiative	Next step	Revised delivery date
SAFER bundle implementation	Wards 29 and 38 are Exemplar Wards, working with ECIP on consistent processes (Safer, Faster, Better)	Ongoing
Stranded patient reviews	Weekly circulation of post 10 day patients, and 'super stranded' patients	Ongoing
Readmission prevention	Implementation of the PARR30 tool, and feedback to clinicians	Ongoing
Red to Green roll-out on all ESM base wards	Launch of Red to Green on all ESM base wards, with Comms programme, including Yuletide Senate and Chief Exec briefing	12/12/16

Risks/issues impacting on delivery of key metrics

Risk/issue	Impact	Mitigation/Support required
Lack of resource support for the launch of Red to Green on ESM base wards in early December 2016	Brand damage for Red to Green, and another 'failed initiative'	Dedicated support for each ESM base ward (?Execs / Non Execs)
Non recognition / Denial of UHL internal delays	Red days are not recognised, and delays persist	Medical Director support for Internal Professional Standards for Imaging, Specialist Opinions and Interventions
Non recognition / Denial of non-UHL external delays	Red days are not recognised, and delays persist	LLR A&E Delivery Board support for External Professional Standards (Social Services and LPT)

University Hospitals of Leicester NHS
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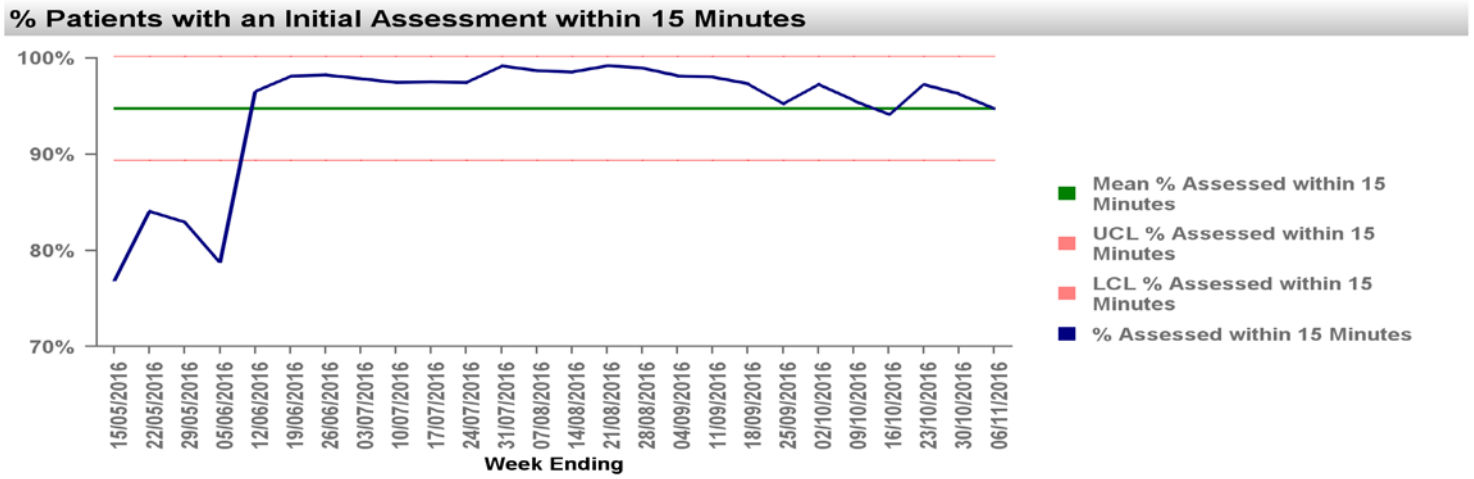
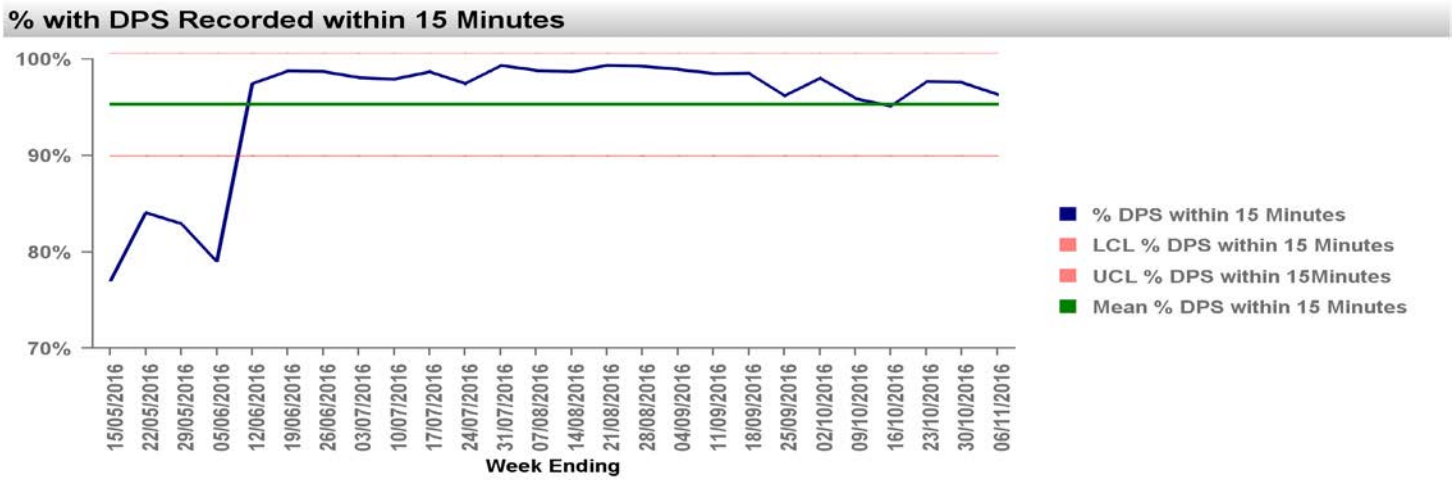
Caring at its best

Paediatric workstream summary

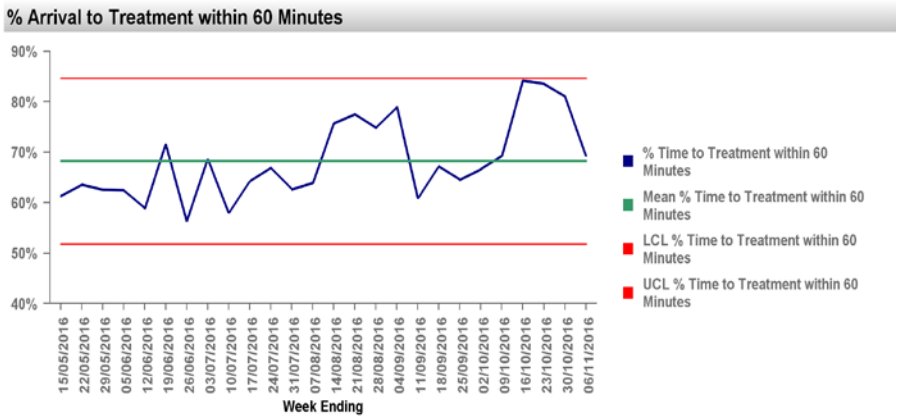
EQSG 9th Nov

What has gone well?

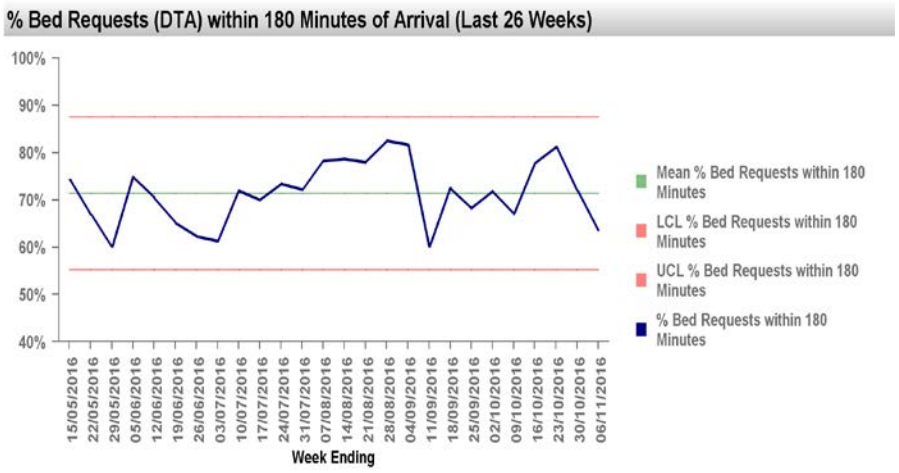


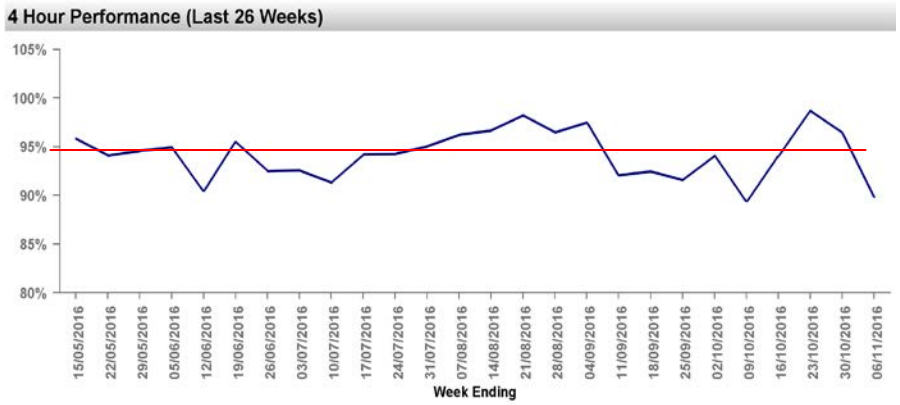


SRO update – position against RAP metrics



- No Paediatric specific RAP metrics
- Time to treat within 15 mins – general upward trend but variance in metrics against target
- Bed requests within 180 mins –around 70% mark but noteable variance around this
- ? How this fits with 4 hr target of 95%





Next Steps

Describe what actions are being taken to improve performance against RAP amber/red metrics, to get them back on track

Action/Initiative	Next step	Revised delivery date
Paed specific metrics	Meet with IT to better explore the variance in the metrics in light of 95% performance	21st Nov.

Risks/issues impacting on delivery of key metrics

Risk/issue	Impact	Mitigation/Support required
Paed GP referral stream through PED	Deterioration in 4 hour performance	Working with Childrens Hospital to optimise patient flow.
No VAC nurse	Deterioration in 15 minute performance	Continue to work with recruitment to fill this role
Nursing Workforce – recruitment, retention and morale	Risk to time to treat	Met with band 6/7s to hear concerns. Further meetings planned. Understanding recruitment strategy. Ensuring Paediatric issues are considered alongside and not amalgamated into overall ED plans
Increase activity	Deterioration in 4 hour performance	CH shared winter plan with PED. PED plan to align with this. Weekly meeting with Paed senior team to