UHL Emergency Performance

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

Executive Summary

Context

The key items covered in the emergency performance update are:

1. Emergency Care Improvement Programme update
2. Updated emergency care action plan
3. Prioritisation plan
4. Update on ward 23a/ ward 7
5. Update on Urgent Care Centre
6. Integration dividend

Questions

1. Does the Trust Board feel sufficiently sighted to the drivers of the poor performance?
2. Does the Trust Board feel sufficiently sighted to the updated plan?
3. Does the Trust Board feel sufficiently sighted to the capacity pressures UHL faces this winter?

Conclusion

1. The current position is caused by an imbalance of demand and capacity and process issues in ED.
2. It is essential that the health system supports and implements plans to reduce attendance at UHL.

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: October 2016

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

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

REPORT TO: **Trust Board**
REPORT FROM: **Samantha Leak Director of Emergency Care and ESM**
REPORT SUBJECT: **Emergency Care Performance Report**
REPORT DATE: **1 September 2016**

The key items for discussion and noting are on pages 1-4 in this report. Everything else included is for information.

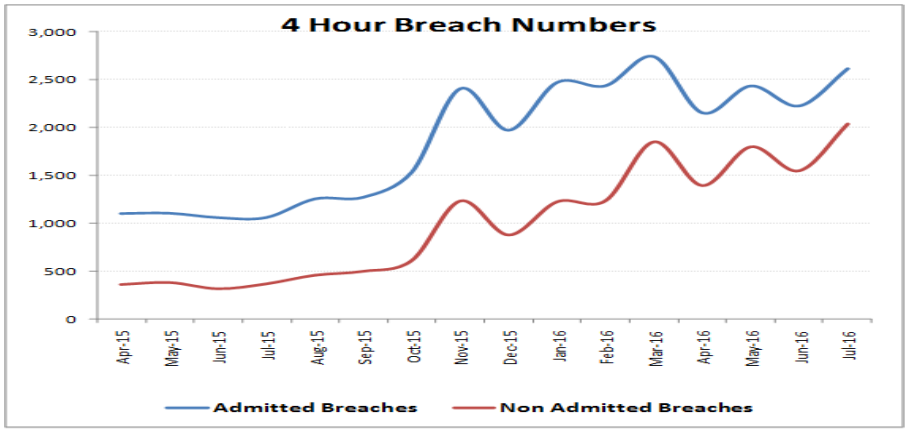
1. 4 Hour performance

2016/17 YTD

- 16/17 performance YTD is 79.9% and last month's performance was 76.9%
- 15/16 performance YTD was 92.3% and July 2015 was 92.2%
- YTD attendance 6.7% up on the same period last year
- YTD total admissions 1.3% up on the same period last year.

August 2016

- Month to date - August 1st to 16th: 82.2 %



The key reasons for the level of performance continue to be:

1. The imbalance of bed demand and capacity
2. Lack of space in ED resulting in process breaches
3. Process delays in ED, assessment wards and base wards

STF

In quarter one our average performance was 81% against the average STF requirement of 78%. Although July did not hit trajectory, August month to date is showing over performance which will support the quarter 2 position.

	STF Trajectory 4hr Performance	**Actual 4hr Performance**	STF Achieved?
Apr-16	78%	**81.2%**	Achieved
May-16	78%	**79.9%**	Achieved
Jun-16	79%	**80.6%**	Achieved
Jul-16	79%	**76.9%**	Not Achieved
Aug-16	80%		
Sep-16	85%		
Oct-16	85%		

2. Emergency Care Improvement Programme update

Two members of the ECIP team visited us in late July/ early August. Their detailed findings are attached as an appendix to this paper and their key recommendations were that the existing plan remains too large and that the relatively newly established emergency care leadership team need to be given greater responsibility and autonomy for delivering the plan. Both of these points will be picked up in conversation between the executive team before Trust Board. The five key areas where ECIP will support delivery are:

- Review the current ambulance assessment process to improve streaming to alternative areas/depts and reduce the time taken for assessment (re-visit Unipart work).
- Reduce variation in leadership, command and control of the ED (including management of rotas)
- Protect and continue to test the Yellow Majors Area to provide ambulatory care, with a focus on rapid turnaround and discharge
- Focus on reducing non-admitted breaches
- Review and improve the ED/AMU interface/flow

3. Updated emergency care action plan

The UHL emergency care action plan is also attached and includes updates on how the actions have progressed over the last two weeks. A number of the actions are reliant on support and input from ECIP, but they are unable to join UHL until October, so the timelines for these actions need to be reviewed. This action plan has been shared with our commissioners and was discussed at an LLR emergency care workshop on 24 August 2016. It is our intention to keep the action plan as short and as focussed as possible. The delivery of the actions will be measured through key metrics which will be in place from next week.

The UHL plan will feed into the wider LLR plan which will be picked up through the new AE recovery board for LLR chaired by John Adler.

4. Update on ward 23a/ ward 7

Agreement has been reached to open ward 7 at the LRI and two meetings have taken place with input from W&C, MSS, ESM and CHUGGS CMG. The opening of ward 7 will be delayed until mid-October because of the requirement to decant wards 42 and 43 onto ward 7, whilst the flooring is re-layed.

An agreement on ward 23a was reached at the Executive Performance Board last week and it has been confirmed that vascular and ICU will not be decoupled this winter. Funding for both of these wards is currently being agreed.

It is positive news that these wards are opening in time for winter. Both of these wards were open last winter and it means that GGH will have a similar level of emergency capacity compared to last winter and that LRI will go into winter with a slighter larger gap than last winter, peaking at a circa 40 bedded deficit if demand doesn't further increase above plan.

5. Prioritisation plan

As detailed above and confirmed at the last EPB, IFPIC and Trust Board, even with all known schemes factored into our plans, we are forecasting a deficit in capacity this winter. This is unlikely to change

and reductions in internal inefficiencies will only get us so far, so we have identified a way of prioritising and therefore protecting RTT and Ca standards. This does put the delivery of the emergency care trajectory at risk but we collectively feel this is the right thing to do.

For winter 2017-18 reducing demand, reducing the imbalance between demand and capacity AND improving internal flow are the three key areas to focus on.

6. Update on Urgent Care Centre

We have been working with Lakeside and Ursula Montgomery on a plan for extending the front door triage service beyond the end of September until 31 March at the earliest. These plans have been clinically led, are fully supported by the UHL team and are costed. They are now with commissioners for sign off and it is essential that an agreement is reached within the next fortnight so the front door triage service can continue without interruption. A verbal update on this will be given at Trust Board.

7. Integration dividend

Mark Wightman and Richard Mitchell attended a lock in workshop on Friday 19 August to look at practical ways in which LLR could integrate more, which would reduce the level of admissions to UHL. The slide pack for the meeting is attached and Mark will provide a verbal update on the session and the next steps.

Other updates:

Ambulance handovers

Handover data (CAD plus) 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	51.8%	48.2%	36.9%	23.5%	14.1%	8.7%	1.5%
Aug-16	59.2%	40.8%	28.3%	15.9%	7.4%	4.2%	0.4%

UHL and EMAS continue to meet to progress actions in order to improve ambulance handovers however due to space constraints in the assessment area and reduced flow out of ED we will continue to fail the target until the mismatch between demand and capacity is decreased. The move to the new EF will enable some improvements due to the increased assessment bay capacity.

Delays in discharge

Over the last quarter we have repeatedly been experiencing delays in organising packages of care for patients. Ian Lawrence gave a verbal update at EPB on this and the required actions from health system partners

Conclusion

Key decisions which will be confirmed within the next fortnight are:

- Urgent Care Centre this winter
- Required support for the new ED leadership team

Recommendations

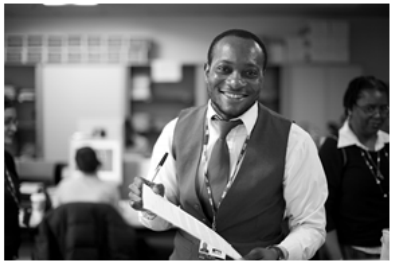
- **Note** the contents of the report
- **Note** the continuing concerns about four hour performance
- **Note** the continued pressure on clinical staff with increasing demand and overcrowding

Emergency Department Enquiry
University Hospitals of Leicester NHS Trust
27, 28 July & 2 August 2016

Steve Barnard
Intensive Support Team Manager, ECIP, NHSI

Kevin Reynard
ED Consultant & ECIP Clinical Lead





Emergency Care Improvement Programme

Safer, faster, better care for patients

Aims of the visit

To work with the UHL Senior Leadership team to review the:

- embedding of Consultant clinical leadership within the team (are the job plans right)
- relationships and team working between medical and nursing team
- current ED practices
- definition of roles and responsibilities within the Medical team (medical handover, consultant lead)
- tackling of poor performance
- current workforce model
- current pathway model

Review Process

- Reviewed previous diagnostic/review reports, current Board Reports and action plans
- Completed a walkthrough of the Emergency Department and associated departments (Paediatric ED, EDU, UCC etc.)
- Attended Gold Site Meeting, ED handover meeting and ED Board Round
- Met with:
  - Senior ED Leadership Team (3 Heads of Service, Head of Nursing and Head of Operations)
  - ESCMG Leadership Team
  - ED Consultants and Senior Nursing Team staff
  - Site Management Team
  - HR and OD leads
  - Members of Trust Executive Team

Feedback

- The ED (and Trust) have been subject to large number of diagnostic/review processes over the past two years, which have generated a comprehensive and valid range of recommendations and actions
- The Trust has a good understanding of the current challenges and opportunities – demonstrated within the most recent Board of Directors pack
- The current Emergency Care Plan is comprehensive
- A recently appointed and enthusiastic ED leadership team already identifying opportunities for improvement
- Good examples of innovative practice such as the EDU and EFU
- There is significant emphasis on the new ED Floor resolving current issues with a lot of planning and activities focussed around this

Feedback

- While the Emergency Plan is comprehensive, it is very large and does not focus on key priority work streams for the short to medium term
- There is a perception within the ED team that many of the actions are ‘done to them’ and not with them
- Current Emergency Care governance structure is complex and of a ‘top down’ nature
- The staff spoke positively of a number of the diagnostics/reviews but felt that the recommendations had never been fully implemented
- There was evidence of rapid implementation of new initiatives (often off plan), which were in response to another crisis – often leaving the ED team confused and change fatigued
- Rapidly implemented changes were often not planned, communicated or evaluated sufficiently, with a tendency to stop them if there was no immediate improvement observed

Feedback

- The ambulance assessment process is currently taking too long; delays and ambulance queues develop frequently and quickly. There is also limited streaming of ambulance cases to other areas or departments prior to assessment
- There is a significant amount of variation in the leadership, command and control of the ED department depending on which staff are in coordination/lead roles as well as the number of staff in senior roles on duty
- The department is running with high rates of agency and locum staff, with variable levels of experience and competencies, which adds to the variation
- The CMG senior management team will often visit the department to offer assistance or request an immediate change. However, this is often at a time of ‘crisis’ and is often perceived negatively by the ED team and seen as a disruptive, unhelpful and counterproductive (despite the offer of help being well intended)

Feedback

- There is currently a high turnover rate of ED staff (approx.14%) with a vacancy factor of about 16% and sickness rates generally higher than the Trust average
- The ENPs and ANPs are not fully utilised due to their rota not being aligned to the medical rota
- Supply of staff recognised as an issue but, recruitment of new staff was frequently delayed by up to six months due to delays in internal processes, such as scheduling of induction programmes. This is resulting in high drop out rates for new appointments
- There was evidence of good workforce planning and initiatives to overcome the current issues (such as the GP fellowships for UEC)
- A functional review – looking at tasks and roles was described as already underway
- The current OD work is predominantly focused on the new ED Floor opening in March 17.

Recommendations

- The current Emergency Care Improvement Plan is too large and needs to be prioritised and segmented into:
  - A reduced number of high impact actions that can be delivered in the next 90 days
  - What the ED Team can progress and what the wider CMG/organisation/system can progress
- The ED Leadership team need to be provided with greater autonomy to allow them to develop their leadership skills and team working. On this basis, the ED Leadership Team should be enabled to develop their own 90 day improvement plan for five high impact work streams
- Work with the ED Leadership to identify the support required and to agree a governance structure that is enabling and supports a ‘bottom up’ approach
- Re-focus some of the current OD work to provide short-term, intensive support to the ED team

Recommendations – 5 ED-led Actions

1. Review the current ambulance assessment process to improve streaming to alternative areas/depts and reduce the time taken for assessment (re-visit Unipart work).

2. Reduce variation in leadership, command and control of the ED (including management of rotas)

3. Protect and continue to test the Yellow Majors Area to provide ambulatory care, with a focus on rapid turnaround and discharge

4. Focus on reducing non-admitted breaches

5. Review and improve the ED/AMU interface/flow

Recommendations

- The ED team should agree with the CMG/organisation the principles for management in-reach into ED i.e. attending scheduled huddles and/or a single point of contact for the dept.

- The CMG/organisation should focus on progressing the following areas in the next 90 days:
  - Implementation of SAFER and Red to Green Bed Days to improve flow and reduce exit block from ED
  - Improve recruitment processes to reduce delays
  - Review and improve GP referral processes to reduce impact on ED
  - Introduce speciality in-reach into the ED

- Development of improvement skills and methodologies to ensure correct application of PDSA and rapid cycle testing.

Initial ECIP Support

1. Initial follow up session to support ED Leadership team with development of improvement plan and PDSA methods

2. A two day visit to support implementation of SAFER and Red to Green Bed Days (early Sept)

3. Support from NHS Elect to:
    1. Coach and develop the ED Leadership Team
    2. Facilitate a session between the ED Leadership Team and the CMG/organisation to agree principles for a new way of working together

Objective	Action Note	Action	Lead	Added to Log	By When	Supporting Information	Progress Update	Rag Status*
Metrics		Implement a new set of metrics to measure performance against this action plan	Sam Leak	22/07/2016	01/10/2016	A clearer, shorter set of metrics is key to understanding what is working and what is not working	Metrics will be circulated next week	4
Improved flow ED		Open additional ring fenced beds for medicine = 28 beds for medicine / CHUGGS	Gill Staton	22/07/2016	01/10/2016	Confirmation of the following will be required: Financial agreement to open the ward, Staffing, New flooring on ward 42 and 43 which will delay ESM moving onto ward 7, CHUGGS beds requirement	Ward opening will be delayed until mid October because of 42 and 43 flooring requirements	2
Improved flow wards		Implement Safer Patient placement - All base wards to sit out two patients and pull two patients before 10 am and the safe reopening of the LRI discharge lounge.	Julie Taylor/Gill Staton	22/07/2016	01/10/2016	HON implemented this initiative at HEFT with positive results and will be taking the lead on role out within UHL. 2 patients form each ward will be sat out at time specific points in the day to allow pull from ED and assessment wards. Discharge lounge will re open phase one for seated patients phase two + trollies	Project plan complete. First meeting of the DC lounge task and finish group 27.7.18 Estates input 1.8.16 to review requirements for phase 2	4
Improved flow wards		Review current utilisation of the SAFER flow bundle and identify ways to improve if required	Gill Staton	22/07/2016	01/11/2016	Baseline audit for all wards will be done in August then an action plan developed where improvements are required.	Data collection sheets have been developed. CMG has identified leads for implementation.	4
Improved flow wards		Reduce process delays by implementing 3Ws using UHL change methodology	Gill Staton	22/07/2016	Roll out delayed due to CQC sepsis work	Key function of this is implementing learning for NHSI improvement day looking at non-value added time	Audit of delay from 10 sets of notes is complete 03/08/16 - this is currently on hold due to focus on CQC sepsis work	On hold
Improved discharge		Purchase additional packages of care/DRT input to bridge discharge	J Dixon	22/07/2016	01/11/2016	DRT outcomes paper supports the benefits of this team. £155k = up to 5 beds until the end of March 2016	Request for funding has been submitted to the August BCF meeting.	4
Improved flow wards		Planned outliying: Cancel elective cases to allow medicine to outlie onto surgery	I Lawrence/C Chadwick	22/07/2016	01/10/2016	Medicine continues to have 15+ outliers every day in July. Choosing to implement outliers in a prospective way will mean a better experience for patients on the emergency care pathway and less on the day cancellations	We are unable to do this because of the impact on RTT and Ca A plan to manage at times of escalation (no beds and ambulance handover delays) is being developed.	6
Decrease admisions		Run a three day trial to understand if the introduction of an increased senior decision maker in ED reduces the volume of patients admitted. If it does, identify the actions that need to be taken to embed the learning.	Paul McNally/Lee Walker / Lisa Gowan	22/07/2016	Trial and benefits identified by 19/08/16	This will be in advance of 'Super challenge' days to start in September where three days a week an appropriate clinician will be challenging all decisions to admit.	Currently have 2 acute physicians fulfilling this role in ED. Collecting data to assess the impact they have had on medical admission rates (available 17/08/16) 16/08 - data received on 16/8 and impact on medical admission rates is being reviewed. One further trial is to be performed from 9am-5pm for 5 weekdays (date TBC). Results to be discussed with medical team	2

Improved discharges		Increase OPAT provision = up to 2 beds	Elaine Graves	22/07/2016	01/11/2016	Expansion of the current process that will allow patients who require IV antibiotics to be treated at home rather than in a hospital bed.	Project team progressing	4
Decrease attendance		Maximise current use of the Ambulatory Care pathways, including: -Applying of the AEC grid -Educating ED staff -Up skilling and educating GPs by providing rotations and joint working in UCC & ED -Reviewing impact of a specific chest pain clinic	Catherine Free	22/07/2016	01/11/2016	ECIP AEC audit tool / description	The link to the ambulatory care directory has been sent to all relevant ED doctors and ANPs and UCC and ED GPs	4
Decrease attendance		Review the opportunity for delivering a fundamental change to the frail elderly pathway across LLR	Mark Wightman	22/07/2016	01/11/2016	This is building on the conversation from the Trust Board Thinking Day in July	This was discussed at the recent 'lock in' integration workshops with CCG colleagues	1
Improved flow CDU		Confirm if ward 23A at GGH could be used for RRCV medical patients this winter	ESB	22/07/2016	01/11/2016	If ward 23A is not used for medical outlying in winter 16/17, RRCV will have fewer beds than winter 15/16. The long term plan is this ward is to be used for vascular surgery	Paper with recommendation on (de)coupling vascular and ICU going to ESB in August 2016	4
Improved flow ED		Understand why we are admitting more short stay patients and agree a plan to either reduce the demand or rebalance the capacity required for this demand	Ian Lawrence	22/07/2016	Confirm understanding 31/08/16 Confirm plan 30/08/16	We have previously identified we are 17 AMU beds short at LRI. This number will have increased as demand has increased in Q1 2016-17. A decision is required as to whether there is benefit in increasing the volume of AMU beds at the expense of the base ward beds.	This will be discussed at EQSG on 31/08	4
Improved DC		Identify how Oxford FT have reduced their DTOC rate and confirm which learnings can be implemented within UHL. http://shelfordgroup.org/article/delayed-transfers-of-care-reduced-at-oxford-university-hos	Sam Leak	22/07/2016	31/08/2016		Contact made: 'Health system hired 60 care support workers who provide social care in people's homes after discharge from hospital. These recruits came from outside the health and care sector, and were employed on more attractive terms and with better prospects for career development They also commissioned extra intermediate beds in care homes, and staff to work closer with other clinicians, such as GPs and care home nurses, to increase capacity and capability outside the acute hospital.' Paper is going to ORG for LLR support as it requires additional finance and workforce	6

Improved flow ED		Work with the ECIP team to implement a plan that decreases delays from bed allocation to leaving ED	Lisa Gowan	22/07/2016	01/09/2016	Analysis of FY15/16 data showed approx 30 mins on average is spent from 'bed allocation' to patient departure in ED (variance up to 300 mins). This initiative will reduce turnaround times by improving processes of rapid flow team with clearly defined roles and responsibilities	01/08/16 - work with the rapid flow team has shown an initial reduction in the average time from 30 mins to 19 mins. This has been discussed with ECIP, but ECIP will not be able to join UHL until October - query change of date?	2
Improved flow ED		Work with the ECIP team to implement a plan that reduces the length of time medical and nurse handovers take	Ian Lawrence	22/07/2016	01/11/2016	Observed handovers vary in length and form. ECIP will work with the team to support the implementation of a streamlined efficient handover process.	This has been discussed with ECIP, but ECIP will not be able to join UHL until October - query change of date?	2
Improved flow ED		Work with the ECIP team to maximise yellow zone as fast track home pathway	Vivek Pillai	22/07/2016	01/09/2016	An additional 9 cubicles (yellow zone) were added to majors on 11.7.16. The pathway is for fast track home patients identified from assessment bay, UCC or majors. This will decongest majors and decrease non admitted breaches	This has been discussed with ECIP, but ECIP will not be able to join UHL until October - query change of date?	2
Improved flow ED		Work with the ECIP team to improve rapid assessment in assessment bay	Ian Lawrence/ECIP	22/07/2016	01/09/2016	Observed processes in assessment bay vary in length and form. ECIP will work with the team to support the implementation of a rapid assessment process.	This has been discussed with ECIP, but ECIP will not be able to join UHL until October - query change of date?	2
		Work with the ECIP team to improve speciality in reach to meet the 30 mins target	Ian Lawrence		In place by 1 October 2016	The current policy states patients should be reviewed	This has been discussed with ECIP, but ECIP will not be able to join UHL until October - query change of date?	2
		Work with the ECIP team to implement a plan where 90% of patients are seen by a decision maker within 90 mins.	Vivek Pillai	22/07/2016	01/10/2016		11/07/16 - Yellow zone opened 20/07/16 - ECIP KPI's include review of job roles which will ensure there is clear responsibility and accountability to achieve this metric. 28/07/16 - Review of the tracker roles to ensure all patients have plans 28/07/16 - Review of huddles - to occur 24/7 to ensure senior overview of the department as a whole and clear escalation policy. This will link with the review of the senior medical/nursing roles in the department This has been discussed with ECIP, but ECIP will not be able to join UHL until October - query change of date?	2
Improved flow ED		Work with the ECIP team to implement a plan where decisions are made on 90% of patients within 180 mins. Key actions are: -responsible and accountable leads -space -appropriate staffing and skill mix	Vivek Pillai	22/07/2016	Implemented by 1 October 2016		This has been discussed with ECIP, but ECIP will not be able to join UHL until October - query change of date?	2

Improved flow ED		Implement plan to reduce diagnostic delays	Lisa Gowan	22/07/2016	01/09/2016	82 % of diagnostics are Xray, 93% of patients are scanned within 1 hr (internal standard) of request. 16% of diagnostics are CT and 18% are reported on within the hour (internal standard). Super diagnostic days are to be run 2 days a week in September as an RCT to challenge test requested and ensure turnarounds are faster	Agreement from Radiology to support 2 "super diagnostic" days in ED starting 1.9.16	4
Improved flow ED		Deliver the OD plan based on the ideas of "listening, developing, leading and being led"		22/07/2016	01/03/2017	OD plan has been developed and is being implemented within the team		4
Improved flow ED		Work with ECIP to systematically review what can be done to reduce the surge in breaches overnight and in the evening and identify actions which will deliver an improvement. The exam question is 'what is the most effective way at keeping flow going?'	Lisa Gowan/Julie Taylor/Rachel Williams	22/07/2016	Review delivered by 31/08/16 Benefits delivered by 30/09/16		16/8 Pushing flow earlier in the day to ensure in a later evening the department has room for the inflow . Yellow majors is key to this. This has been discussed with ECIP, but ECIP will not be able to join UHL until October - query change of date?	2
Ambulance handover		Continue the improvement in processes and maximise space opportunities to decrease ambulance handover times	Sam Leak	22/07/2016	01/11/2016	Working with EMAS to ensure processes are as efficient as possible. Fully achieving this is dependent on decreasing demand / opening the new floor.	22/07/16 - increase ambulance cohorting (4-5 patients) for times of escalation was implemented on 21/07/16	4
Improved flow ED		Deliver the new Emergency Floor	Sam Leak/Catherine Free	22/07/2016	01/03/2017	Ensure capacity and staffing is modelled to ensure maximum performance within the financial envelope.	Picked up through separate EF group	4
Improved flow ED		Work with ECIP to examine the South Warwick model to identify how we can change the use of our assessment bays in majors. Confirm actions that can be taken	Ffion Davies/Vivek Pillai	22/07/2016	Work with ECIP 31/08/16 Confirm actions 14/09/16		This has been discussed with ECIP, but ECIP will not be able to join UHL until October - query change of date?	2
Decrease admissions		Confirm if GP ambulatory support will continue at the front door of CDU to deflect patients	Ursula M	22/07/2016	03/08/2016	Extended GP Pilot commenced on the 9th May for 8 weeks this will be formally reviewed at EQSG first week of August	Outcome presented to EQSG on 3/8/16 business case to be completed for EQSG on the 31/8/16 and then presented to commissioners in September 2016 date TBC	2
Improved flow CDU		Complete a demand and capacity review in Respiratory Medicine with recommendations for closing the gap	Sarah Taylor	22/07/2016	12/08/2016	Baseline activity and demand data complete, job plan analysis being supported by EY	Baseline data complete review with clinical teams planned for 2nd September to agree efficiences and gap business case to then be developed	2
Improved flow CDU		Complete a demand and capacity review in cardiology with recommendations for closing the gap	Sarah Taylor	22/07/2016	12/08/2016	Baseline activity and demand data, job plan analysis completed locally	Baseline data complete review with clinical teams being planned for mid September to agree efficiences and gap business case to then be developed	2
Improved flow CDU		Deliver a UHL Better Change project review to decrease Cardiology inpatient LOS pre Catheter. Implement the recommendations.	Sarah Taylor	22/07/2016	Review complete 26/08/16 Implement by 30/09/16	22/07/16 - initial data collection complete, this shows an average pre-op LOS of 5.5 days across all procedures	Hot lab sessions in place for 3 days of week and start on Saturday from 3rd September. Outcome to be reviewed at end of September	4

Improved Discharges		Increase the usage and improved recording of ICS through ward education	Sue Mason	22/07/2016	30/09/2016	Use of ICS	Significant progress in ward coding on ward 16. Lessons from this ward to be rolled out across other wards	4
Improved flow CDU		Explore alternative pilot on CDU for emergency chest pain presentations being seen in an emergency clinic	Sarah Taylor	22/07/2016	30/09/2016		Business case being developed to embed GP pilot and ambulatory services - will be complete by end of August 2016 and discussed with commissioners on September 2016	4
Improved flow ED		Review CDU criteria to ensure appropriate patients are taken by EMAS to Glenfield first	Sarah Taylor	22/07/2016	01/09/2016	In April there were 142 transfers from LRI to GGH CDU, and in May 171.	Awaiting confirmation of meeting date from EMAS this is expected to take place in last week of August	4
Improved flow CDU		Deliver a space review for CDU	Sarah Taylor	22/07/2016	19/09/2016		Option of modular pod between Ward 20 and CDU is being explored to locate low risk ambulatory clinic, costs awaited from Estates	4

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Better care together

Leicester, Leicestershire & Rutland health and social care

Sarah Prema, Director of Strategy and Implementation, LCCCG

Outputs from the Integrated Teams Lock In

Rutland County Council

Leicester City Council

Leicestershire County Council

NHS

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Our task was to agree the model for integrated care across LLR

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MCP care model framework – areas to consider

Which populations are MCPs Accountable for?

The health and care needs of the GP registered list of patients within a population budget plus an estimated population for those in the MCP locality not registered with GPS

What outcomes and quality standards are MCPs responsible for?

All health and social care outcomes for the defined population a MCP is serving. MCPs are delivering the triple aims set out in the 5YFV using a population health based approach to provide more responsive care, which is more cost effective and centred around the whole needs of the person

What population size does a MCP serve?

Each MCP hub typically covers a population size of 50-150,000 people, however there is scope for a MCP to cover a much larger population size. Early thinking by vanguards suggests larger MCPs (e.g. 100k+) may each provide services on several neighbourhood footprints of 30-50,000 people

Which services is a MCP comprised of?

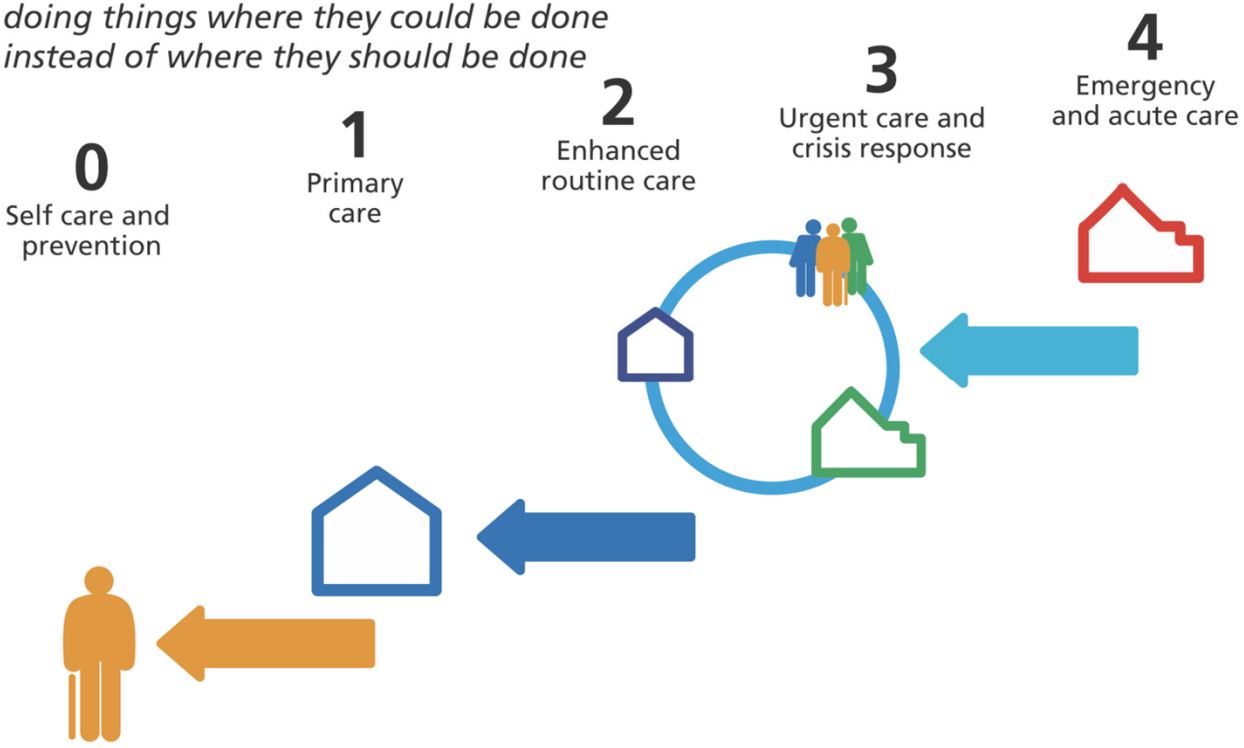
Potentially all health, care and wellbeing services for all ages that do not, from a quality or safety perspective, need to be delivered as a hospital based service: i.e. Public Health, primary and community care, secondary care outreach, mental health, wellbeing and voluntary sector services

Organisation /BCT Work stream reps

- WLCCG- Angela Bright, Caroline Trevithick, Arlene Neville, Diane Eden
- LCCCG - Sarah Prema, Helen Mather, Rachana Vyas
- ELRCCG - Jane Chapman, Paula Vaughan, Dr Andy Kerr
- BCT PMO– Nikki Bridge, Lisa Sharples
- LPT – Rachel Bilsborough, Rachel Dewar
- LCC – Sandy McMillan, Cheryl Davenport
- LC – Steven Forbes
- Rutland – Mark Andrews
- UHL – Gino Distenfano, Sam Leak, Mark Wightman, Bina Kotecha

Our Ambition

Inappropriate use =
doing things where they could be done instead of where they should be done



Left shift = moving care from where it ***could*** happen to where it ***should*** happen

Our Vision

The LLR vision for integration is health and social care teams, supported by specialists and the third sector, clustered around groups of general practices within identified placed based teams. These are designed to improve our communities health outcomes, increase our clinician and staff satisfaction and at the same time moderate the cost of delivering that care.

Overarching Goals

1. Increase the proportion and range of care we provide in local communities and peoples own homes.
2. Target our resources more effectively based on detailed understanding of population need.
3. Focus on prevention, the individuals responsibility for their own health and wellbeing, early diagnosis and management of risk factors.
4. Through redesign create far more cost efficient and clinically effective models of care.
5. Through an allocated placed based budget and integration of health and social care providers care will be delivered in the right place, first time.
6. The integrated team will operate “as one”, delivering joint outcomes for the population they serve.

Our Model

- Over the next 5 years our model for integrated care will be realised through the development of MCPs.

- The practice and the primary health care team will remain the basic unit of care, with the individual practice patient list retained as the foundation of that care.

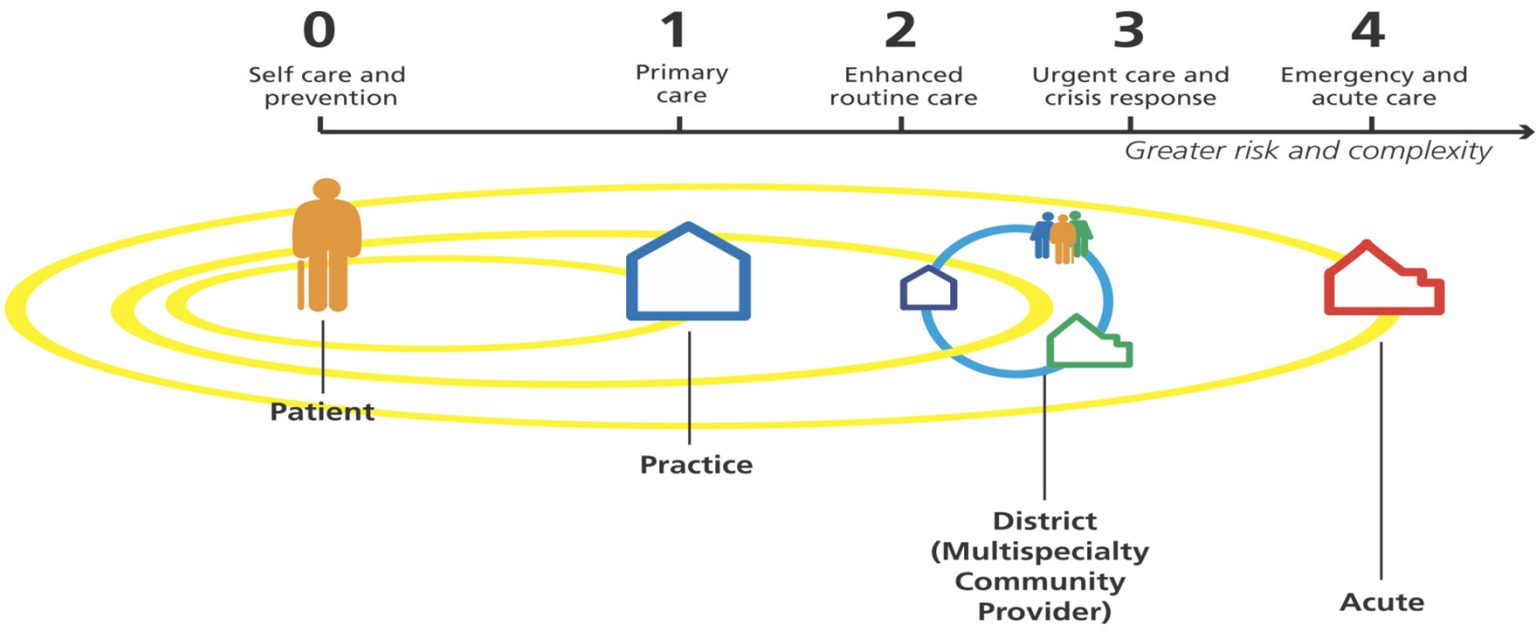
- **Whilst a large proportion of care will remain with in a patients own practice, an increasingly large proportion will be delivered by locality based integrated teams coming together to deliver care for an identified population.**

- Our integrated teams are the geographical unit at which care is commissioned, coordinated and provided. These are then subdivided into smaller sub localities.

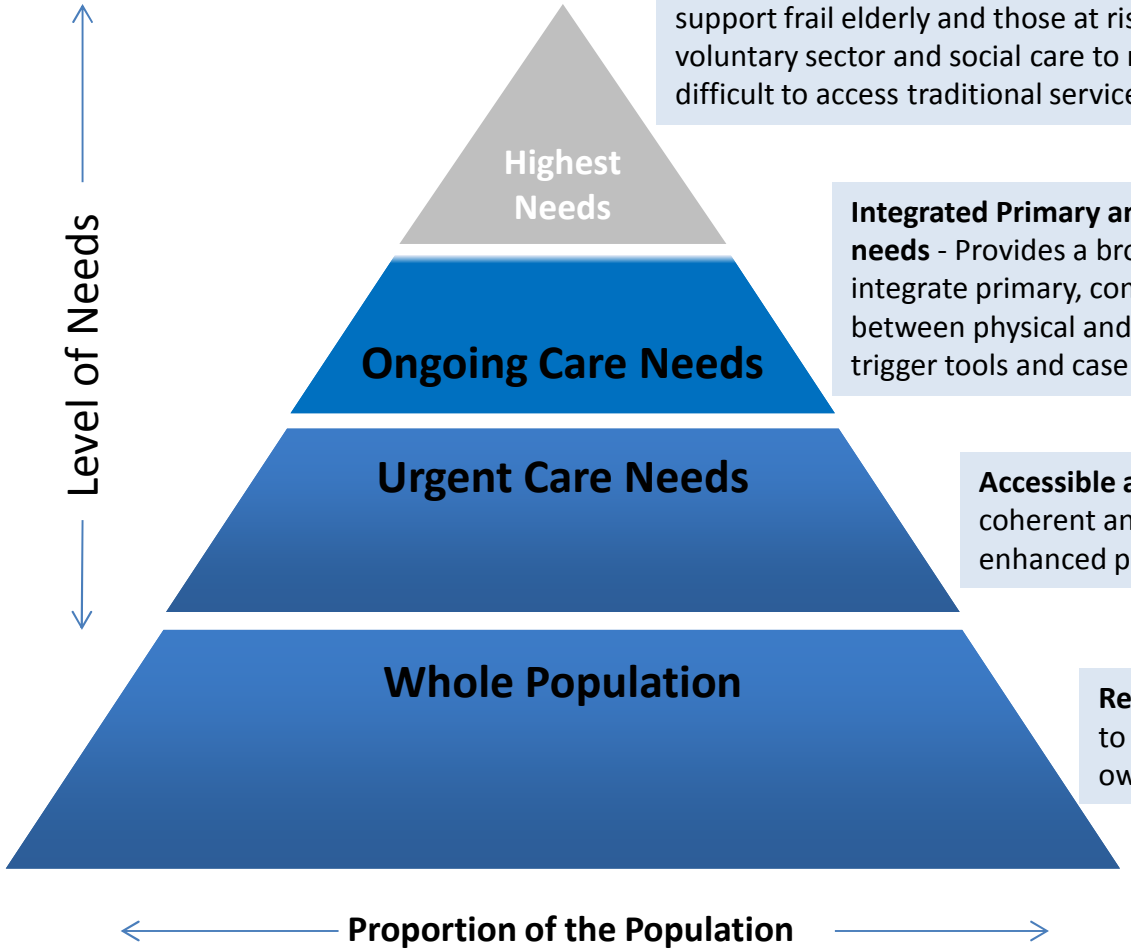
- The model places the patient or service user at the centre, with the GP as the primary route for accessing care. The GP is also the designated accountable care coordinator for the most complex or vulnerable patients in community settings.

- Our model of integration wraps around the patient and their GP practice, extending the care and support that can be delivered in community settings through multidisciplinary working, with the aim of reducing the amount of care and support delivered in acute settings, so that only care that should/must be delivered in the acute setting will take place there in the future.

New Model


0
Self care and prevention
1
Primary care
2
Enhanced routine care
3
Urgent care and crisis response
4
Emergency and acute care
Greater risk and complexity
Patient
Practice
District (Multispecialty Community Provider)
Acute

The four levels of the MCP care model



Implementing an extensivist model - Provides an extensivist service for the small group of patients with high needs and high cost e.g. developing care plans to support frail elderly and those at risk of unplanned admission. MCP works with voluntary sector and social care to reach out to vulnerable people who find it difficult to access traditional services.

Integrated Primary and Community based care for people with ongoing needs - Provides a broader range of services in the community that integrate primary, community, social and acute care services, and between physical and mental health. Uses risk stratification supported by trigger tools and case finding to identify patients who would benefit.

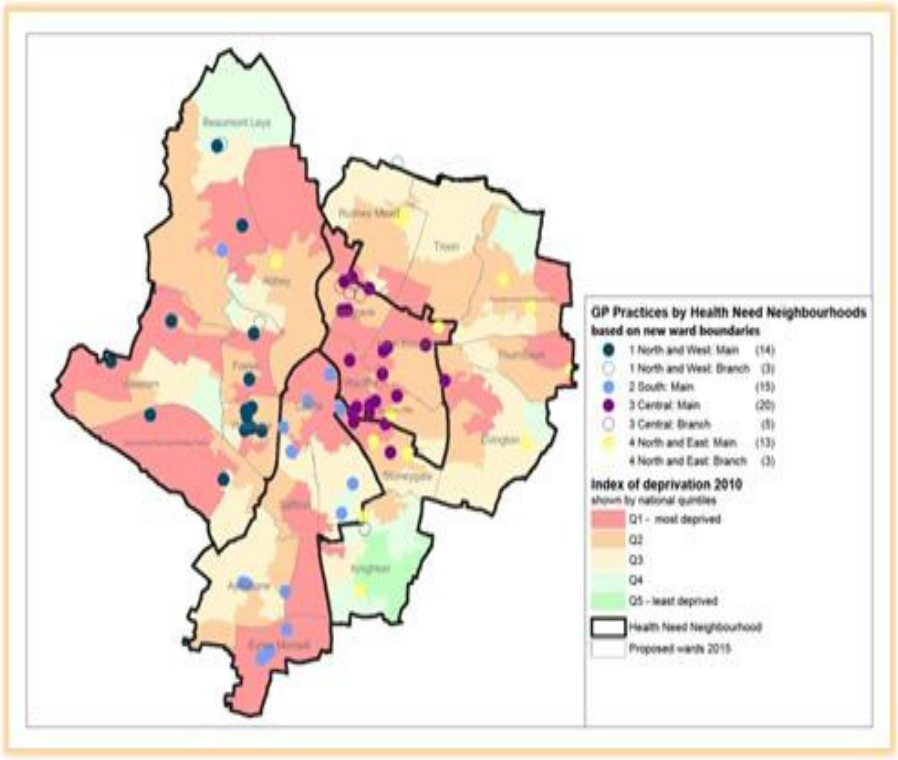
Accessible and responsive urgent care - Provides a more coherent and effective local network of urgent care using enhanced primary care as the core model.

Reducing Demand - Provides support for the population to stay well, change unhealthy behaviours and manage own health.

Locality Placed Based Integrated Teams

CCG	Locality Integrated Team	Population Size	Sub locality team	Population Size
LCCCG	4	75,000 – 100,000	10	Variable
ELRCCG	3	63,000-100,00	8	Circa 35,000
WLCCG	4	75,000 - 121,000	10	Circa 35,000

Localities

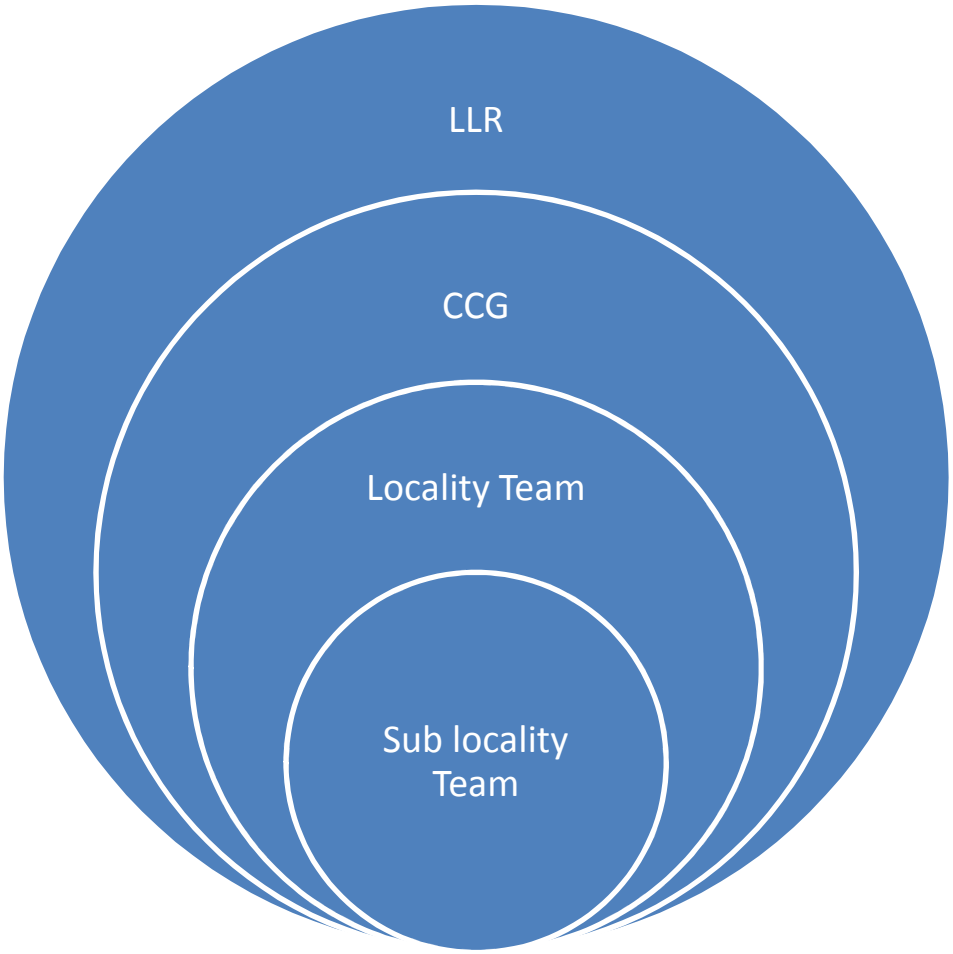


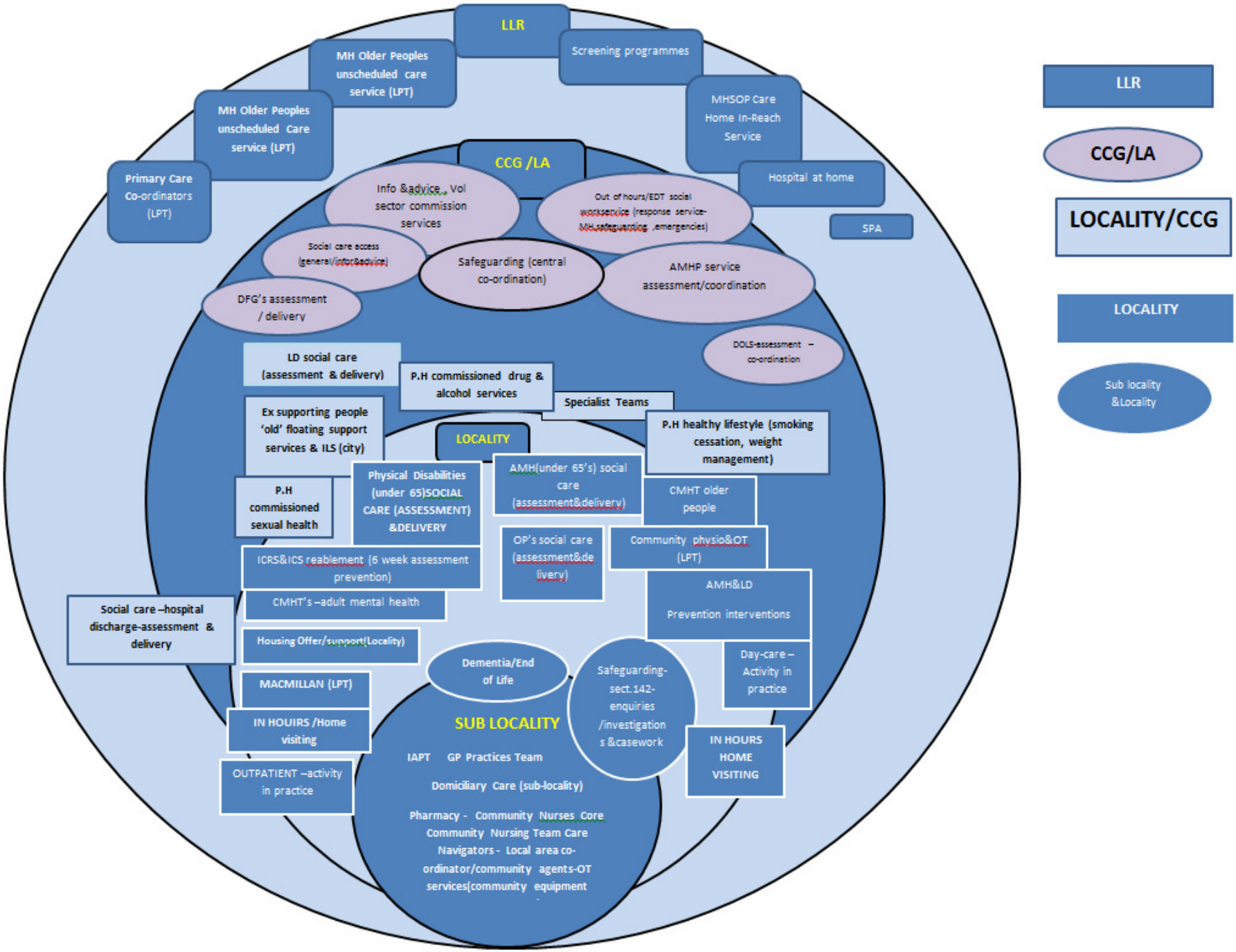
- To follow

Outcomes

Outcome	Metric
Improve population Health	Health function status Risk Status Mortality/Morbidity
Improve the individual patient /service user experience	Patient experience – safe , effective, timely, efficient, patient centred.
Moderate per capita spend	Total cost per member of the population per month. Hospital and ED utilisation rate.

Delivery Footprint




LLR
Screening programmes
MH Older Peoples unscheduled care service (LPT)
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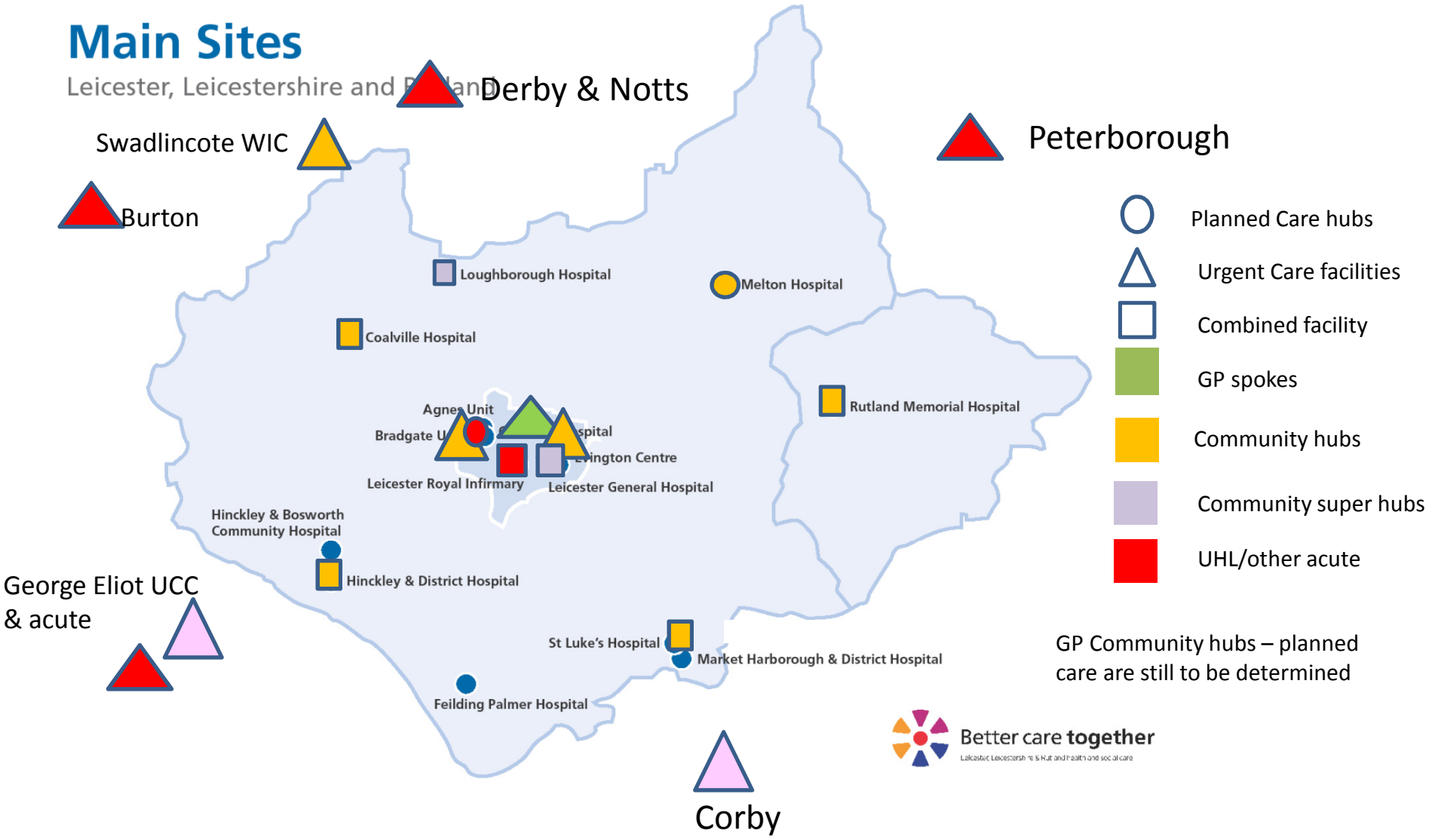
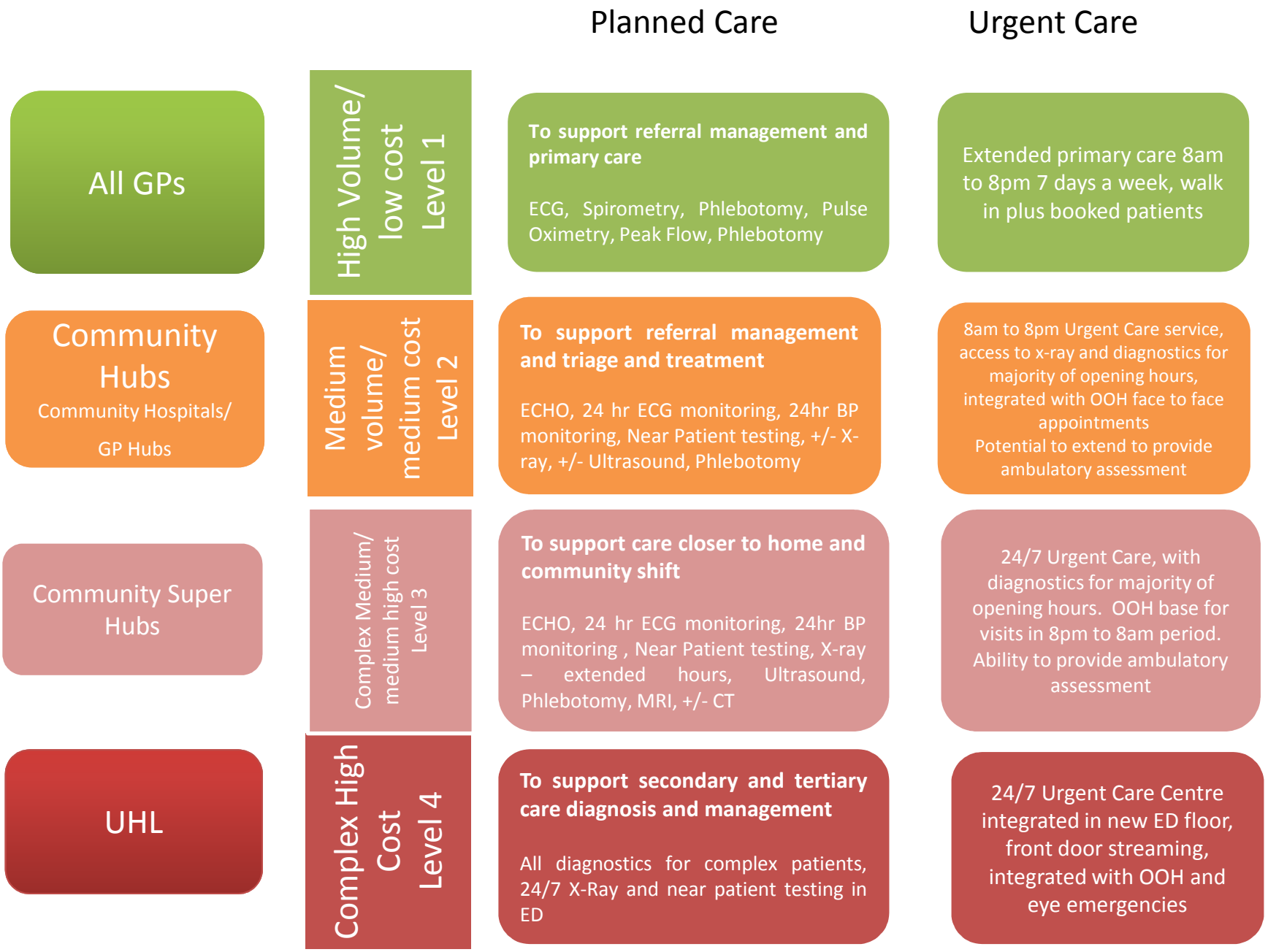
MHSOP Care Home In-Reach Service
Primary Care Co-ordinators (LPT)
CCG /LA
Hospital at home
Info &advice , Vol sector commission services
Out of hours/EDT social worksevice (response service-MH,safeguarding ,emergencies)
SPA
Social care access (general/infor&advice)
Safeguarding (central co-ordination)
AMHP service assessment/coordination
DFG's assessment / delivery
DOLS-assessment – co-ordination
LD social care (assessment & delivery)
P.H commissioned drug & alcohol services
Specialist Teams
Ex supporting people 'old' floating support services & ILS (city)
LOCALITY
P.H healthy lifestyle (smoking cessation, weight management)
P.H commissioned sexual health
Physical Disabilities (under 65)SOCIAL CARE (ASSESSMENT) &DELIVERY
AMH(under 65's) social care (assessment&delivery)
CMHT older people
OP's social care (assessment&delivery)
Community physio&OT (LPT)
ICRS&ICS reablement (6 week assessment prevention)
AMH&LD Prevention interventions
Social care –hospital discharge-assessment & delivery
CMHT's –adult mental health
Housing Offer/support(Locality)
Dementia/End of Life
Safeguarding-sect.142-enquiries /investigations &casework
Day-care – Activity in practice
MACMILLAN (LPT)
SUB LOCALITY
IN HOUIRS /Home visiting
IAPT GP Practices Team
IN HOURS HOME VISITING
OUTPATIENT –activity in practice
Domiciliary Care (sub-locality)
Pharmacy - Community Nurses Core Community Nursing Team Care Navigators - Local area co-ordinator/community agents-OT services(community equipment
LLR
CCG/LA
LOCALITY/CCG
LOCALITY
Sub locality &Locality

Health Community assets to support the MCPs




Planned Care
Urgent Care
All GPs
High Volume/ low cost Level 1
To support referral management and primary care
ECG, Spirometry, Phlebotomy, Pulse Oximetry, Peak Flow, Phlebotomy
Extended primary care 8am to 8pm 7 days a week, walk in plus booked patients
Community Hubs
Community Hospitals/ GP Hubs
Medium volume/ medium cost Level 2
To support referral management and triage and treatment
ECHO, 24 hr ECG monitoring, 24hr BP monitoring, Near Patient testing, +/- X-ray, +/- Ultrasound, Phlebotomy
8am to 8pm Urgent Care service, access to x-ray and diagnostics for majority of opening hours, integrated with OOH face to face appointments
Potential to extend to provide ambulatory assessment
Community Super Hubs
Complex Medium/ medium high cost Level 3
To support care closer to home and community shift
ECHO, 24 hr ECG monitoring, 24hr BP monitoring , Near Patient testing, X-ray – extended hours, Ultrasound, Phlebotomy, MRI, +/- CT
24/7 Urgent Care, with diagnostics for majority of opening hours. OOH base for visits in 8pm to 8am period. Ability to provide ambulatory assessment
UHL
Complex High Cost Level 4
To support secondary and tertiary care diagnosis and management
All diagnostics for complex patients, 24/7 X-Ray and near patient testing in ED
24/7 Urgent Care Centre integrated in new ED floor, front door streaming, integrated with OOH and eye emergencies

Questions

How should we take this forward ?

Who should take this forward ?

How do we ensure political /Board sign up?

How do we support the empowerment of teams whilst minimising fragmentation?

Considerations:

Implementation Timeline – waves/pilots?

Contractual form and impact on providers ?

Things that we need to make this work

- A clear vision statement for LLR MSCPs and an overarching description of the model
- A consistent framework for change and implementation that is supported by clinical and executive leaders, and is applied consistently to this development (and future developments)
- An outcomes framework for the MSCP model, with supporting metrics, based on the 3 triple aims
- Strong visible clinical leadership to front the changes
- A set of high impact changes for the MSCP operating model which is co produced with locality teams and has the backing of chief officers.
- A new approach to clinical risk management and clinical governance for "home first"
- Building a new integrated model of provision supported by integrated commissioning with the clear intention to commission on locality based budgets in the future
- An initial model based on adults and older people but with the intention to include children and young people's services in the future
- An initial costed model of what is assumed to be included in the financial envelope.
- Design an engine room - A suggested approach to implementation including how delivery and governance will be assured