UHL Emergency Performance

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

Executive Summary

Context

Despite a recent levelling out of demand, compared to this time last year, University Hospitals of Leicester's four hour emergency performance remains very poor. The report details the actions that are being taken across LLR and the further work that is required. The report also includes, for the first time, a dedicated update on work at the GGH.

Questions

1. Does the Board agree with the LLR action plan?
2. Are the Board content with the focus on non-admitted breaches?
3. Are the Board content with the plan to have a systematic review of progress at July's Thinking Day.

Conclusion

1. Whilst delivery of all the actions within the plan is important, the current position is caused fundamentally by an imbalance of demand and capacity. Resolving this is needs to be a relentless focus for UHL and our partners.
2. Reducing non-admitted breaches is probably the quickest way of improving four hour performance, in the short term, but wider LLR actions are required for longer term sustainability.

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: Trust Board 7.7.16

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:	**Rachel Williams on behalf of Samantha Leak Director of Emergency Care and ESM**
REPORT SUBJECT:	**Emergency Care Performance Report**
REPORT DATE:	**2 June 2016**

Despite activity (emergency admissions) in May being at a similar level to last May (see graph below), performance remains much worse. The two key reasons for this remain consistent with the challenges identified in May's Trust Board:

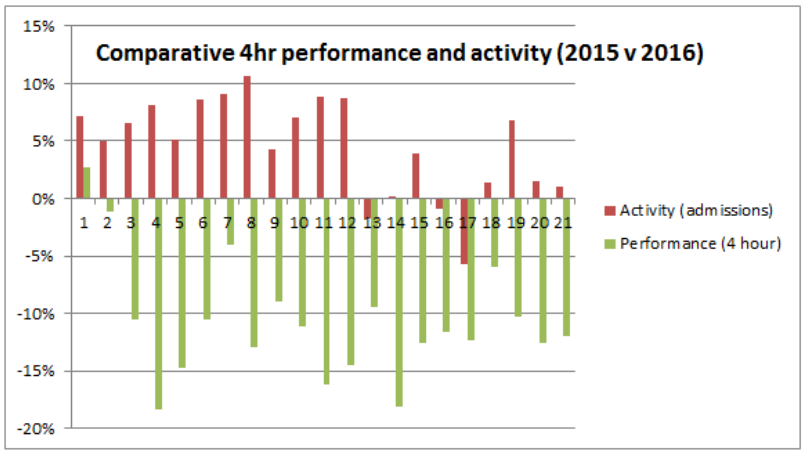
- Increased imbalance between base ward demand and capacity this year than last year
- Poor process resulting from the pressure of running on high alert for extended periods of time (circa 40 weeks).

2016/17 YTD

- 16/17 performance is 80.82% and April 2016 was 80.82%
- 15/16 performance was 92.0% and April 2015 was 92.01%

May 2016

- Month to date is 79.47%.
- YTD attendance 0.8% up on the same period last year.
- YTD total admissions 0.5% up on the same period last year.



The graph shows four hour performance and admissions for the first 21 weeks of 2015 compared to 2016. Overall, activity is up, although more recently is in line with last year. Overall performance is much lower than last year and performance has deteriorated disproportionately greater than activity has increased. This *may* be because we have passed the tipping point of how much activity/ pressure the Trust can absorb. It is important to note that medicine has access to 28 fewer beds 2016 v 2015 because of CQC estates work.

LLR improvement plan

The most recent update to the LLR plan is attached. Key UHL updates include:

- EMAS and UHL continue to have weekly conference calls to manage improvements in ambulance handovers. Validation takes place weekly with EMAS of all >90 mins ambulance delays.

- The new Head of Nursing and Head of Operations begin in June 2016 and substantive recruitment to the clinical lead post is ongoing. A Deputy Head of Operations and Service Manager have also been appointed.
- We continue to work closely with Lakeside on front door triage whilst trying to recruit our own GPs. Recent recruitment has identified seven applicants.
- We trialled all ward admissions being reviewed by an ED senior decision maker or Acute Physician in April and a further trial during June and July of the Acute Physician reviewing admissions is planned.
- The CMG has increased its management presence within ED to support and push performance improvements during May. This does not appear to have worked.

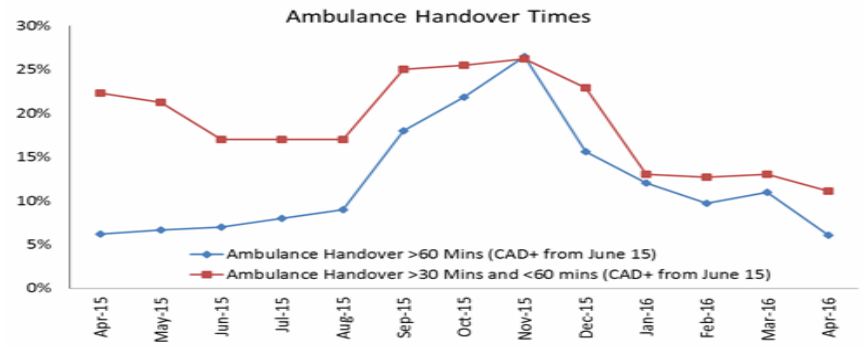
Ambulance handovers

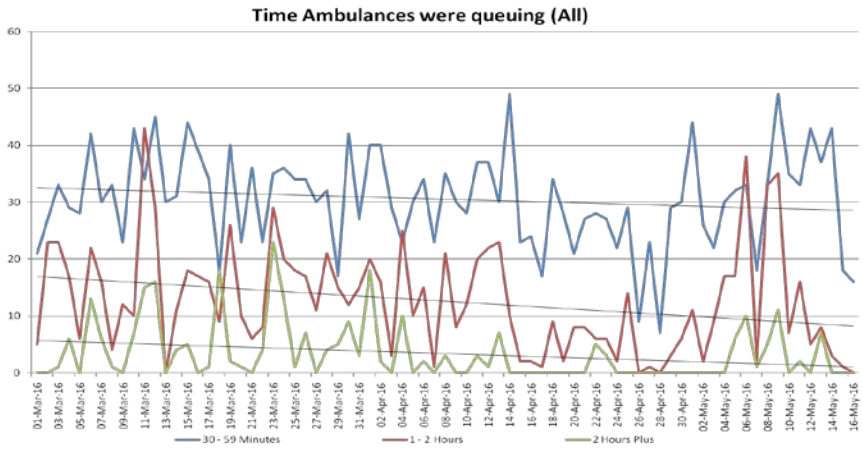
All Handovers using CAD data for the last five months are detailed below:

	% Delay Over 15 mins	% Delay Over 20mins	% Delay Over 30 mins	% Delay Over 45 mins	% Delay Over 60 mins	% Delay Over 120 mins
Dec-15	62%	50%	32%	20%	12%	3%
Jan-16	63%	50%	34%	21%	14%	4%
Feb-16	57%	43%	27%	16%	11%	3%
Mar-16	60%	47%	29%	17%	12%	3%
Apr-16	58%	41%	22%	11%	6%	1%
Up to 16th May-16	62%	46%	25%	13%	8%	1%

The team has continued to improve internal processes and a CMG escalation process for patients on ambulances (POAs) has been introduced (in hours) to support early decision making and management of flow, decreasing long waits for handover. Improvement is still required as UHL remains an outlier for long ambulance handovers, and as such this is a priority for the CMG to improve.

Performance:





Front Door Process since 1st May 2016

The process for front door streaming changed on the 1st May with a reduction in Lakeside GPs from 4 GPs to 2 GPs. The streaming availability from the Lakeside reduction has been covered in house by UHL staff (UCC) to stream patients either into Primary Care slots, ED, Ambulatory Care or direct admissions via Bed Bureau.

The streaming service prior to May 1st included initial assessment by a Lakeside GP at the desk and this role is currently being trialled by the use of the Acute Care practitioners and Band 7 Triage Nurses, with further recruitment taking place. By using this model the patients are aligned to the most appropriate patient pathway at the earliest opportunity.

A full assessment of the streaming function and recent changes is being conducted by UHL and CCG colleagues. This will be shared in full with Board colleagues once it has been through the urgent care board process.

Key actions at LRI in June

There are no medical outliers on wards seven and ASU, and we have committed to keeping these wards clear of medicine over the next year, irrespective of emergency pressures. Further work is required to reduce length of stay and delays on all wards (3Ws), in particular the medical wards at LRI, to make sure we don't creep back onto these wards.

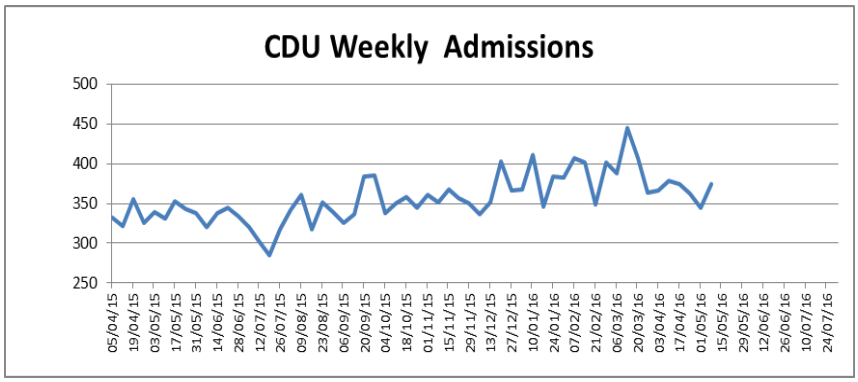
However the most important action we can take to quickly improve four hour performance and patient experience is a reduction in the number of non-admitted breaches. We know exit block, high inflow and high ED occupancy impact on breaches including non-admitted breaches, but 42% of our total breaches ytd are non-admitted. This is unacceptably high. There is an expectation that as we move into June and the (historically) easier summer months, we see a reduction in the non admitted breaches. It is essential that the new management team within ED and ESM focus have non admitted breach reduction as their primary priority.

CDU

As requested, a detailed update on CDU will now be included at every Trust Board. The following performance measures are being monitored as part of the Emergency Programme Leadership Board.

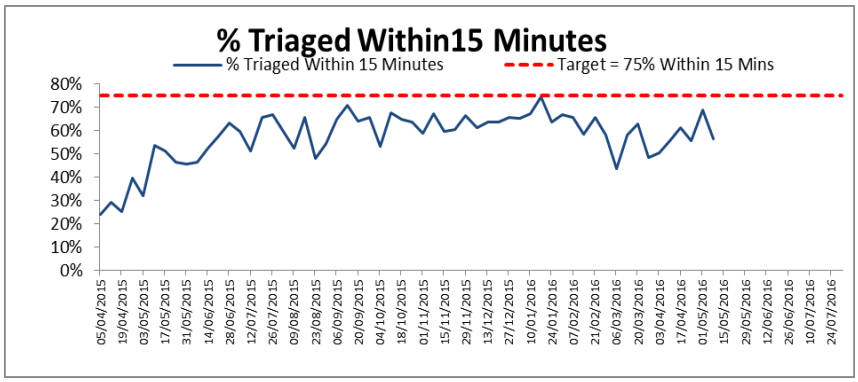
Number of patients attending CDU

The following graph demonstrates the increase in admissions from April 2015 to May 2016.



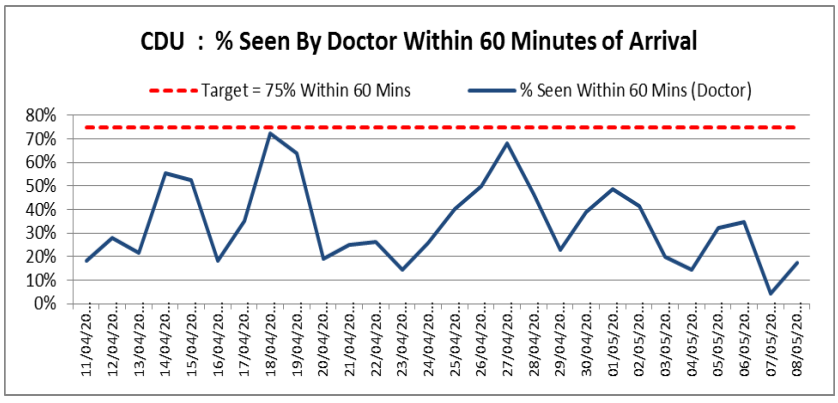
Initial Assessment targets of 90% and 100% for DPS1 (within 15 mins)

At present performance against the previous target of 75% is reported weekly, this will be changed for future performance reports. The service will be reviewing the workforce linked into demand and capacity with a view to addressing this.



95% of patients seen by doctor/ANP/ENP within 60 minutes

At present review by an ANP / ENP is not captured and the previous target of 75% was applied. This will be reviewed and changed for future reports



Current GGH actions

- A review of the CDU floor space has been undertaken and the team have identified a number of actions regarding reviewing the services that need to be located at the front door and the clinical adjacencies, but have struggled to develop solutions for the physical space. Support is requested

to have an expert review (Healthcare Planner) of the space and the proposal for this is being developed at present.

- Extended GP Pilot commenced on the 9th May for 8 weeks. This will be formally reviewed in July 2016.
- Demand and Capacity review in Respiratory Medicine. This will look at all the elements of the service and will overlap with CDU. The work is anticipated to be completed in July 2016
- Demand and Capacity in Cardiology. This will look at all elements of the service and will overlap with CDU. The work is anticipated to be completed in June 2016.
- Review of Cardiology inpatient LOS pre Catheter Lab, aiming to reduce pre-op waiting times and therefore aid flow from CDU.
- Increase usage and improved recording of ICS.

Risks/Mitigation GGH

Risk	Mitigation
Overcrowding in CDU at times of high inflow	Ensure appropriate review throughout the day and escalation via GOLD meetings
Cancellation of Elective activity	Ensure clinical review of cancellations as escalation per policy
Long trolley waits on CDU	Ensure appropriate review throughout day and escalation via GOLD meetings

Conclusion

We have entered a time of year when we should see an improvement in performance. However performance at UHL has not improved at the rate we expected it to and remains very poor.

Whilst the short term focus needs to be on UHL reducing its non-admitted breaches and improving internal flow, we are only 15 weeks (105 days) from the start of winter. I am concerned about the lack of progress LLR has made on admission avoidance and preventative care. These two elements are essential for a better winter.

The Chief Executive and I have recently discussed the options within UHL's control to improve performance and a paper will come to the Trust Board Thinking Day in July, and then a Trust Board with the purpose to:

- Describe the current position and a diagnosis of why we are where we are
- Describe the range of work being done to improve performance
- Describe the constraints involved
- Identify further approaches/actions that we can take

This is a way of describing our "best endeavours" to maximise performance in accordance with our improvement trajectory. The report will include the demand and capacity context and the actions we are taking to address the current and projected imbalance and to protect the elective pathway. The report will very much focus on the issues identified as well as the solutions we are taking to tackle them.

Recommendations

The Trust Board is recommended to:

- **Note** the contents of the report.
- **Note** the concern about four hour delays at a time of year when we would expect performance to be getting better.

LLR URGENT & EMERGENCY CARE

Urgent Care Programme Board

26th May 2016

Title of the report:	Urgent and Emergency Work Plan (2016/2017)
Action Log /Paper Reference (if applicable)	Paper I
Author	James Wray
Presenter:	Tamsin Hooton
Purpose of report:	
The purpose of this report is to set out objectives and work plan for the LLR urgent and Emergency Care Programme.	
Key issues or points to note	
Actions required by Group:	
Urgent Care Programme Board are requested to sign off this document	

Urgent and Emergency Care Programme 2016/2017

Version Control

Date	Change	Author
6th May	Minor amendments to S2 work plan, S4 work plan	JW/EA
9th May	Added in Keogh System Principles	JW
16th May	Additions to Discharge workplan from TY	EA
18th May	Additions to Discharge section and workplan from SM & RAP and edits for punctuation etc	EA
19th May	(V6.1) Replaced S1 work plan sent by LW	EA

Contents

The vision for the LLR Urgent and Emergency Care System

The vision for the Leicester, Leicestershire and Rutland urgent and emergency care system is that, through exploiting available data and technology, we can better predict demand and flow within the system. This information will be used to harness the potential of integrated services, staffing and governance structures to develop a smarter system that can pre-emptively respond to patient needs and changes in demand.

"…will bring together all our providers of health and social care to work as one network"

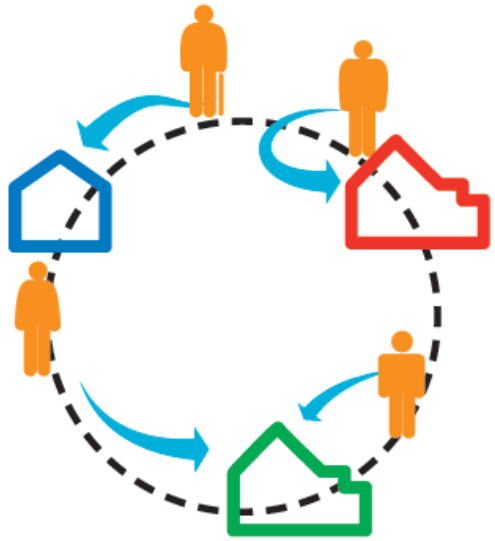
Integration will be a key part of the future success of the system. Urgent and emergency care pathways will be based around patient needs not organisational boundaries, and silo-based working will be refocused onto whole system outcomes. To support integrated working, we will work with providers to develop joint governance arrangements, with clinical risk being managed at a system level, and with an integrated workforce able to move between services providing capacity where it is most needed.

"Simplify things for patients, and get them the care that they need, without having to worry about having to navigate a complex and sometimes disjointed system."

This responsive ability will be coupled with improved assessment and navigation at the beginning of the urgent and emergency care (UEC) pathways to simplify access routes into the system, ensuring that patients get the best care from the most appropriate service, booking patients directly into services and enabling better use of resources across the system. We will develop consistent and streamlined models of urgent care services across the LLR system, reducing duplication and fragmentation.

The result of these changes will be an urgent and emergency care system that can respond to demand, is simple for patients to access and which provides improved health outcomes for the LLR population.

In addition, the Programme will also cover the development of flow and discharge pathways within the system to reduce delays and improve flow, making best use of available resources.



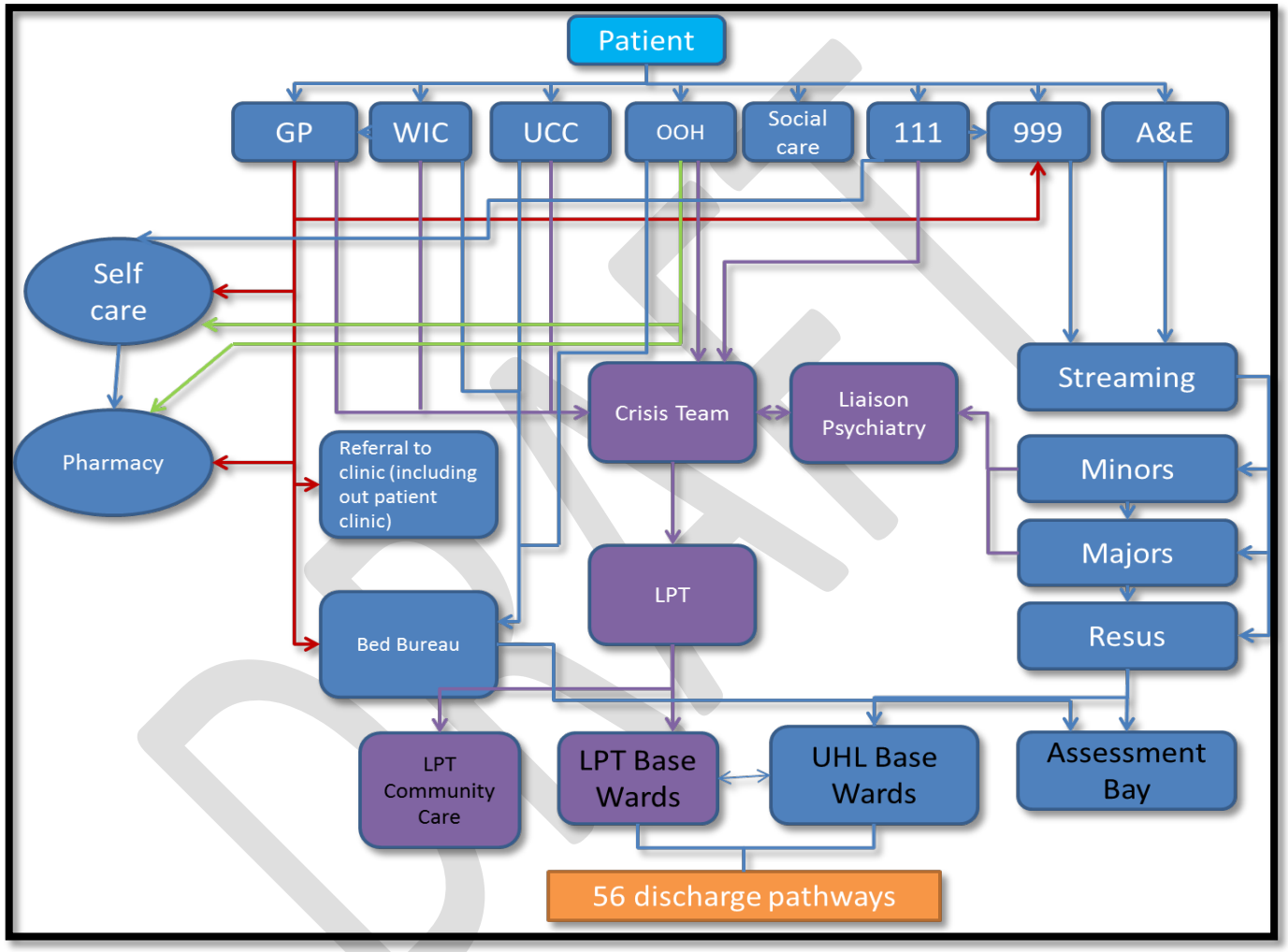
"Traditional"—the patient travels to where the clinicians are, often visiting several different settings.

"Integrated"—GPs, specialists, community and social care providers work out of the same building, so that patients visit only the single setting of care appropriate for them.

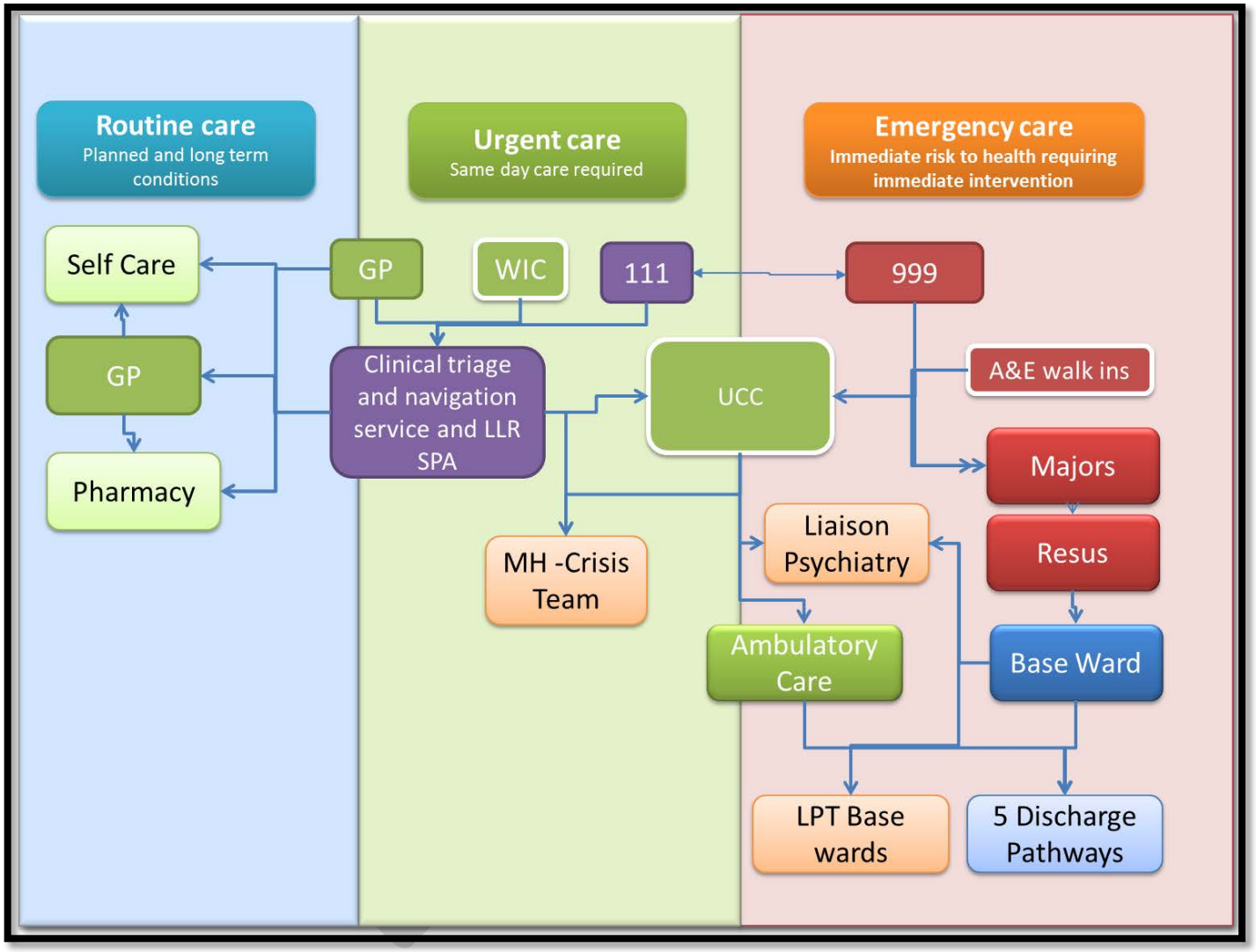
Aims

Aim	Description	Objective
Reduced duplication and fragmentation of services, simplification of patient pathways	Development of services and pathways that minimise patient handoffs, are readily understood and accessed by patients and enable efficiencies within the system through integration.	• Improved patient outcomes and experience • Patient receives the right care in the right place at the right time • Decreased costs to the health economy • Improved system resilience
Aligning providers to work towards common system goals	Service offers that blur organisational boundaries and enable patient care to be wrapped around the patient not constrained by organisations.	• Improved patient outcomes and experience • Patient receives the right care in the right place at the right time • Decreased costs to the health economy • Improved system resilience • Integrated clinical governance • Integrated workforce plans
System Management	Understanding patient flow, resources and capacity in a real time way will enable the system to flex and respond, providing resources and moving capacity to ensure that the right care is available in the right place.	• Improved patient outcomes and experience • Patient receives the right care in the right place at the right time • Decreased costs to the health economy • Improved system resilience

Current State


Patient
GP
WIC
UCC
OOH
Social care
111
999
A&E
Self care
Pharmacy
Referral to clinic (including out patient clinic)
Crisis Team
Liaison Psychiatry
Streaming
Minors
Majors
Resus
LPT
Bed Bureau
LPT Community Care
LPT Base Wards
UHL Base Wards
Assessment Bay
56 discharge pathways

Post Transformation System


Routine care
Planned and long term conditions
Urgent care
Same day care required
Emergency care
Immediate risk to health requiring immediate intervention
Self Care
GP
Pharmacy
GP
WIC
111
Clinical triage and navigation service and LLR SPA
MH -Crisis Team
UCC
999
A&E walk ins
Majors
Resus
Base Ward
Liaison Psychiatry
Ambulatory Care
LPT Base wards
5 Discharge Pathways

Case for Change

National Drivers

The national Keogh Review of Urgent and Emergency Care (November 2013) summarised the key issues with current systems[1]:

- The current system is confusing for patients and health and social care professionals. Fragmentation of the system and inconsistent service provision means patients do not know how to access alternatives to ED
- There are missed opportunities for meeting patients' urgent and emergency care needs closer to home. Patients can be cared for outside of hospital if innovative technology and virtual ward care models are adopted
- There is also a high level of variability between ED departments and urgent and emergency services in different areas
- Nationally and locally, the increasing number of people using the emergency care system has contributed to the challenge of achieving the national 4-hour ED standard. This is an indicator that is critical to the success of flow within the hospital and which many hospitals are struggling to achieve and maintain. This increase in demand is also linked to the fact that the urgent and emergency care system is complex and fragmented and patients cannot easily understand where they can access urgent and emergency care
- The system needs to ensure suitable alternatives are in place that are as readily accessed and easily understood by the public to positively impact this position

Local Drivers

Services cannot continue to be delivered in the same way and hospitals cannot be expected to cope with rising demand and sicker patients. LLR must change to meet the needs of its changing ageing population and address the £398m funding gap predicted locally by 2018/19. The LLR health and social care economy is working to address these challenges to ensure that high quality, effective and efficient emergency and urgent care services are in place. System Principles for delivery of changes to the LLR care system were agreed at the Urgent Care Board (UCB) in 2015 (See Appendix 3).

Much work has been done to reduce delayed transfers of care (DTOCs) and with the refresh of the UCB improvement plan for the new governance structure, we will continue to focus on inflow, hospital flow and improving discharges. Included within the Urgent Care Programme Board (UCPB) improvement plans are our Vanguard plans, further building on the previous work of the Urgent Care Board improvement plan, taking us further towards an integrated UEC system.

LLR is experiencing a number of key challenges to service delivery. These can be broadly categorised as system and patient access challenges.

[1] High Quality Care For All, Now and For Future Generations: Transforming Urgent and Emergency Care Services in England - Urgent and Emergency Care Review End of Phase 1 Report

System Challenges:

- Inconsistent service offer over the 7 days of the week, lack of consistency across different urgent care services and across geographies
- Geographical layout of LLR and physical location of a city centre Emergency Department/county town UCCs and space limitations within Leicester Royal Infirmary (LRI)
- Lack of capacity and staffing in the right place to meet demand at the right time
- Ineffective integration of services
- Demand management based on service utilisation
- Sustainable use of available resources that delivers affordable, appropriate care

Patient Access Challenges

- Patients accessing the right services at the right time, caused by:
  - Urgent care services which are complex to navigate
  - Patients not knowing which services to go to at which point in time
  - Demand and flow are not always effectively management, causing 'log jams' within services
- A need to increase self-care and timely access to primary care
- Rising demand within the population linked to demographic growth in numbers of older people and young children

Problem statement:

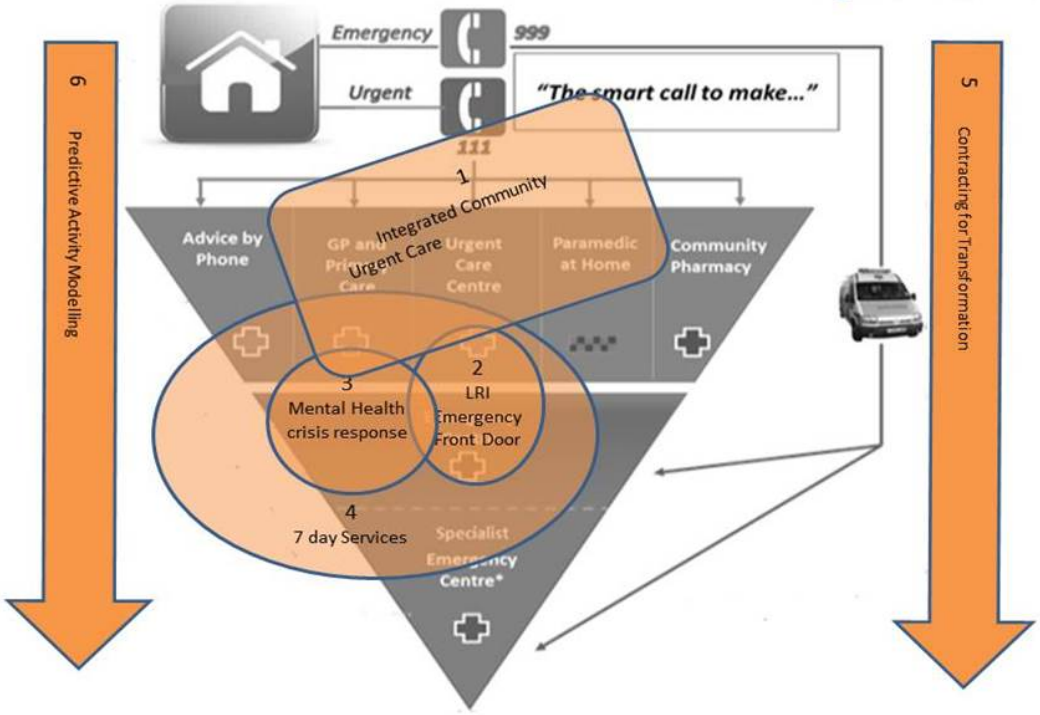
- There are major challenges in capacity and resources available within the urgent and emergency care system
- The health and care economy is financially challenged – for instance University Hospitals Leicester (UHL) has a forecast deficit this year of £36.1m
- Demand for ED and UCC services is high and rising
- 24/7 access to urgent and emergency interventions is expected by patients and the current system does not always meet this expectation
- LRI estate site constraints and fragmented services across UHL sites hinder patient flow
- Current poor system performance on A&E waiting times and ambulance handovers means there are potential risks to patient safety and poor patient experience
- The current system is too complex for patients to effectively navigate, is inefficient and contains duplication. ED is perceived as the 'default option', when the system is too complex or appointments are not easily accessed

Programme of Change: Summary

The aim of the Urgent Care Programme is to ensure the delivery of a safe, responsive and integrated system of urgent care for the residents of LLR. The Urgent Care Programme covers the Vanguard, plus improvement workstreams on inflow/demand, hospital flow and community discharge support services.

The Programme will implement the recommendations of the Keogh review of urgent and emergency care, with an emphasis on better self-care, a more consistent, seven day urgent care system and a redesigned emergency department at Leicester Royal Infirmary.

The diagram below shows the structure of the 6 Vanguard elements of the Programme, overlaid against the elements of the Keogh Review.



These form six of the eight workstreams within the Urgent Care Programme that will report into the UCPB, which together will form the Urgent Care workstream of the Better Care Together Programme. The eight elements of the Programme are:

1. Integrated Community Urgent Care (including Clinical Triage and Navigation)
2. Redesigning the LRI Emergency Department Front door
3. Improving urgent Mental Health services
4. Early implementation of 7 day working in acute hospitals
5. Contracting and payment mechanisms
6. Predictive modelling
7. ED Pathways (Flow)
8. Discharge

Scope of Programme

The Programme of work outlined in this document is the Better Care Together urgent care work stream and incorporates the LLR Vanguard as well as additional workstreams reporting into the Urgent Care Programme Board.

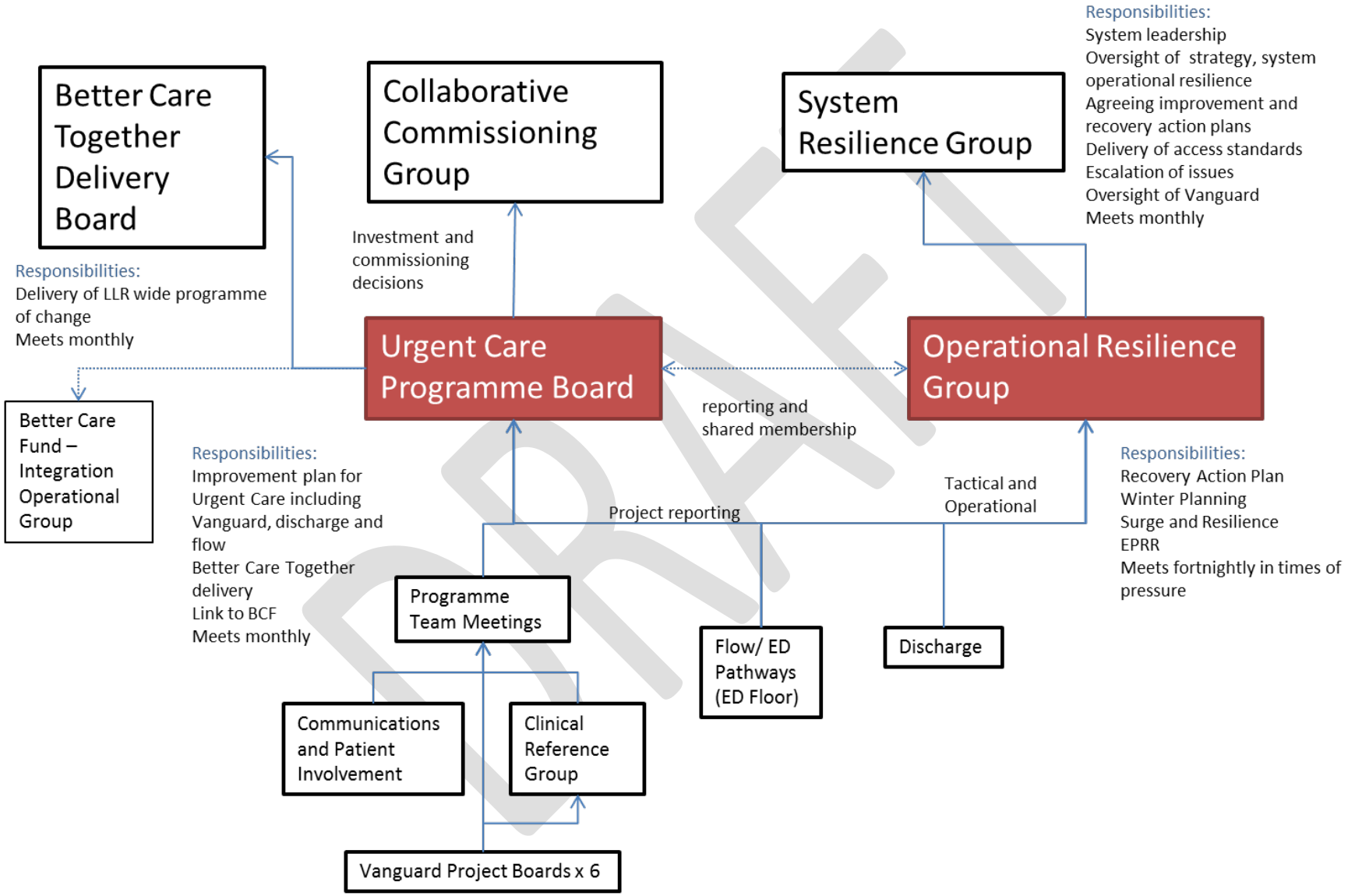
The LLR Operational Resilience Group (ORG) and the Urgent Care Programme Board (UCPB) are the two main governance groups for Urgent care in LLR. When taken together, their work covers resilience, tactical service improvement and longer term system transformation. Both forums were formed in March 2016 to reflect the changing needs of the LLR urgent and emergency care network. The Urgent Care Programme Board will act as the implementation group for the urgent care work stream of the Better Care Together Programme, covering both the legacy Urgent Care Improvement Projects and Vanguard Programme. The ORG will focus on the operational and tactical aspects of the system.

The UCPB and ORG forums will operate together with complementary objectives and agendas. The minutes of ORG will be formally received by the Systems Resilience Group, which will have oversight of operational resilience across the system. UCPB minutes will be received by the Better Care Together Delivery Board. There will be formal cross membership between the two groups, and they will send updates between the two groups. This will ensure that there is strategic alignment for medium and longer term developments. Both forums are multi-stakeholder, multi-disciplinary groups.

The UCPB will have responsibility for the approval and delivery of the Urgent Care Programme Plan and receive monthly updates from all projects on progress, risks, issues, finance and achievement of improvement trajectories.

Vanguard Programme

The Urgent Care Programme will be led by the Vanguard PMO office who will take on the leadership and PMO functions required for the delivery of the Urgent Care Plan, reporting to the Director of Urgent and Emergency Care and the UCPB.


Better Care Together Delivery Board
Responsibilities:
Delivery of LLR wide programme of change
Meets monthly
Collaborative Commissioning Group
Investment and commissioning decisions
System Resilience Group
Responsibilities:
System leadership
Oversight of strategy, system operational resilience
Agreeing improvement and recovery action plans
Delivery of access standards
Escalation of issues
Oversight of Vanguard
Meets monthly
Urgent Care Programme Board
reporting and shared membership
Operational Resilience Group
Better Care Fund – Integration Operational Group
Responsibilities:
Improvement plan for Urgent Care including Vanguard, discharge and flow
Better Care Together delivery
Link to BCF
Meets monthly
Project reporting
Tactical and Operational
Responsibilities:
Recovery Action Plan
Winter Planning
Surge and Resilience
EPRR
Meets fortnightly in times of pressure
Programme Team Meetings
Flow/ ED Pathways (ED Floor)
Discharge
Communications and Patient Involvement
Clinical Reference Group
Vanguard Project Boards x 6

Operational Resilience Group and Recovery Action Plan (RAP)

The LLR Operational Resilience Group (ORG) is a subgroup of the LLR System Resilience Group. It was formed in March 2016 to reflect the changing needs of the Leicestershire Urgent Care Network and to complement the work also being carried out by the LLR Urgent Care Programme Board and its subgroups. The minutes of the Operational Resilience Group will be formally received by the SRG. There will also be formal cross membership and updating at meetings with the LLR Better Care Together Board and the LLR Urgent Care Programme Board. This will ensure that there is strategic alignment for medium and longer-term developments.

The ORG is a multi-stakeholder multi-disciplinary group that will lead the LLR Health and Social Care community in resolving operational, clinical and managerial issues that cross existing organisational boundaries impacting on the delivery of quality and effectiveness of urgent care services.

The ORG will deliver:

- Improved interagency collaboration across the urgent care network
- Whole system monitoring to help improve quality and accountability
- The development of a culture which is comfortable with challenge and continuous improvement
- The avoidance of unnecessary or clinically inappropriate care in a hospital environment, which leads to poor quality and outcomes, and affects performance across the whole system.

The ORG will lead this by identifying the underlying causes of poor performance across the whole system urgent care network, and holding partners to account for delivery.

The Operational Resilience Group has been delegated responsibility from the System Resilience Group to:

- Oversee the performance management and delivery of any system wide urgent care recovery plans
- Oversee recommendations as to the best use of the relevant non-recurrent funding allocations and any seasonal non-recurrent winter pressures money to support the delivery of urgent care development
- Supervise any additional non-recurrent or recurrent resources specifically allocated to the delivery of urgent care standards including the recovery of operational performance
- Promote the adoption of care pathways across all components of emergency health and social care which deliver best practice and meet national emergency care standards and guidance
- Hold the whole system to account to ensure that productivity and efficiencies are delivered through patients being treated and cared for by

evidence based services that meet their needs in the least intensive environment

- Ensure that individual organisations develop service resilience plans that are reactive to service fluctuations and also support the health economy response to a system wide approach to pressure e.g. winter planning, business continuity planning and emergency planning
- Ensure local service developments provide support to specific groups of patients who are likely to be at increased risk of needing urgent care services e.g. the frail elderly, children with disabilities or long term illness, vulnerable adults including people with Mental Health problems, learning disabilities and substance misuse problems
- Ensure that the patient and carer perspective and quality of care are the priorities in planning emergency/urgent healthcare in the local health and social care community
- Ensure that assurance is received that stakeholder organisations are carrying out root cause analysis (RCA) in relation to breaches and system failures and that these RCAs are resulting in action improvement and that the learning is being shared across the health and social care system
- Manage a programme of work to improve and maintain the urgent care system including the delegated power to commence, evaluate and close projects at completion or when assessed to be failing to deliver key performance indicators

Recovery Action Plan (RAP)

The ORG are the accountable body for the system wide Recovery Action Plan (RAP) which is a high impact plan with key objectives aimed at improving performance in all areas. The RAP is managed by the ORG and leads on the operational and tactical issues associated with the LLR UEC system. There are a number of key linkages and dependencies between the ORG and UCPB deliverables.

There are currently five objectives within the plan, with associated actions, as follows:

1 Minimising presentations from primary and community care to LRI ED assessment services
   a. Maximise use of alternatives to admission by primary and community providers – to continuously review activity data to identify patients/groups potentially amenable to alternative care plans / services
   b. Maximise use of alternatives to admission by EMAS crews and reduce EMAS conveyances to LRI – implement mobile device (smartphone) with MDoS access
   c. Provide system navigation facility to referring GPs bed bureau EMAS OOH Care homes to promote alternatives to admission
   d. Review timing of GP home visits with a view to move earlier in the day / improve transportation to UHL to bring the evening peak forward reducing the likelihood of admission
   e. Maximise use of step up ICS capacity by Primary / Community Care
2 Reduce delays in ambulance handover times at the LRI site

a. Ensure that all EMAS crews have PIN numbers and use the CAD+ system for every handover
b. Implement recommendations of nursing skill mix review in ED
c. Redefine the role of the HALO and who should undertake it and undertake a rapid cycle test of the HALO working with an ED consultant / acute physician at time of escalation to facilitate flow
d. Agree and implement a direct streaming SOP
e. Trial the deployment of a private ambulance crew (contracted by EMAS) and an HCA (provided by UHL) to care for patients in the 'red zone' (subject to satisfactory prior risk assessment signed off by EMAS and UHL)
f. Relocate the Ambulatory Assessment Unit to the UCC and expand capacity (business case has been approved)
g. Agree a formal UHL task and finish group to drive forward actions
h. Review protocols/guidance relating to handover and understand if align in practice

3 Remodel LRI 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 services
a. Rapid Cycle Test of urgent care GP at front door of assessment bay (9am – 9pm) to stream patients into appropriate care setting reducing pressure on assessment bay and Majors
b. To relocate OOH service from clinic 4 to the UCC
c. To increase the range of near patient testing within UCC
d. To establish an observation room in the UCC to both reduce admissions and, if appropriate, enable direct admissions bypassing ED
e. To ensure that patients who do not require an admission are redirected to ambulatory care wherever possible
f. To accelerate the admission process

4 Reduction in the number of emergency admissions
a. Implement feedback loop to GPs regarding inappropriate admissions as a learning exercise
b. Rapid Cycle Test of streaming patients who are 'likely admission' and 'likely discharge' in ED to reduce occupancy and front load senior decision making in department
c. Rapid Cycle Test of all patients being seen by Senior Decision Maker (Emergency or Acute Medical ST4 or above) prior to admission to medicine
d. Expand ACPs if high volume potential is identified
e. Analysis of what comprises 0-6 hour LoS– identify opportunities to reduce LoS further/identify patients who should not have been admitted
f.

5 Remodel the discharge process across the whole system to ensure that patients are transferred to the most appropriate service according to their clinical need at the right time in their treatment plan, reducing avoidable delays

The RAP is intended to be short term/high impact, and thus the above objectives will change on a very frequent basis to meet the ongoing operational issues which are raised at the ORG.

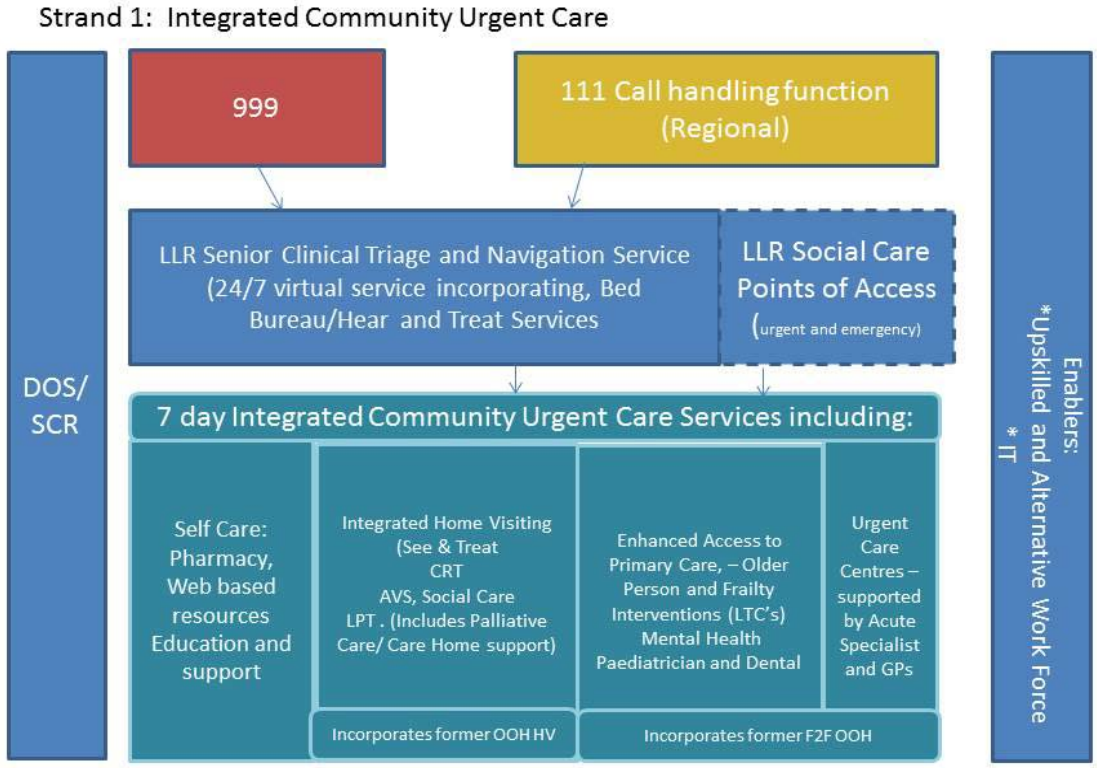
Urgent Emergency Care Programme – Project Detail

1: Clinical Navigation Hub, Clinical Triage and Integrated Community Urgent Care:

The scope of this workstream covers introducing clinical triage and navigation integrated with 999 and NHS111, and redesigning the range of community urgent care services into a consistent, streamlined and responsive system of 7 day services. An important deliverable for this work stream is to put in place a 'test', or initial trial, of a local clinical navigation model linked to the NHS111 service from October 2016, which will provide senior, multi-professional clinical capacity to triage and assess patients' needs and provide them with the right service at the right time and in the right place.

It will deliver the integration of pathways across ambulance, NHS111, Out of Hours (OOH) and the Single Point of Access (SPA) services for health and social care, via a telephony based senior clinical navigation service providing clinical triage, advice and signposting. The new model of care will deliver senior clinical triage and will be supported by support local services that offer patients appropriate health and social care appropriate to their need as early as possible in their patient journey. The clinical navigation service will offer a multi-disciplinary approach including GPs, hospital generalists with specialist skills, Mental Health practitioners, crisis response practitioners, pharmacists and dentists as well as social workers, who will triage, advise and deliver best healthcare pathway information to patients.

Clinical triage specialists will also provide support for front line clinicians, GPs and other health and social care practitioners and advise on the most suitable clinical pathways available within and across LLR. This may include the use of telemedicine/telehealth. Non-urgent clinical calls will be diverted to the clinical navigation service via NHS111 at an early stage in the call. The senior clinical team will offer early clinical triage and intervention that may include specialist advice, self-management advice (including navigation to supportive voluntary groups and interactive/web based resource), arrange an appointment at a GP practice for the next day or walk in appointment for



the same day, and where required prepare a prescription to collect at their practice the same/next day, thus offering the right care in a timely manner and where possible avoiding unnecessary attendances to hospital. This supports patients living in a rural setting across LLR. The new models of care will be supported by a robust and seamless IT infrastructure including a shared patient record and knowledge of local services (Directory of Services – DOS). This will include wider availability and use of Summary Care Records (SCR) across the seven day service to all clinicians and associated health professionals including paramedics, crisis team and other practitioners.

In addition, the strand will offer a seven day response to integrated community urgent care. This will be achieved by remodelling current primary and community care service pathways, building on what currently exists within primary care services, walk in centres and urgent care centres and incorporating the out of hours response. We will increase same-day access for urgent primary care needs and ensure consistent access to seven day primary care. Our high level service model has been developed in partnership and following detailed consultations with primary, secondary and social care. The aim is to deliver a consistent model of care across LLR, which can be delivered by integrated provider collaborations at locality level and remain responsive and flexible to local population needs. We are exploring models that consider and incorporate both Multi-specialty Community Providers (MCP) and Primary and Acute systems (PACs) to deliver some elements of the integrated urgent care offer and will build this into our test phase.

The development of the integrated urgent care offer at local level will be led by each of the CCGs who will provide regular updates to the project group ensuring that all linkages and dependencies are managed in the most efficient way. Some initial principles have been developed regarding the integrated community services within LLR, set out below.

The aim is to provide an integrated community urgent care service that:

- Offers 7 day access to urgent primary care assessment and treatment, both in and out of hours (in conjunction with GP practices within the area)
- Provides an enhanced level of access to GP services 8am to 8pm, 7 days a week, where patients require urgent treatment that cannot be delivered by their own practice. This should incorporate access to out of hours GP advice and treatment
- Incorporates a home visiting service 24/7 for patients assessed as needing a clinical visit to their home or place of residence
- Establishes home visiting services which have access to senior medical support (GP or equivalent) and which are able to arrange urgent prescribing and administration of controlled drugs
- Offers access to an urgent care centre as an alternative to ED for patients requiring urgent clinical assessment and treatment that cannot be delivered by a standard primary care service (including full range of diagnostics and ability to assess ambulatory patients to avoid a possible admission)

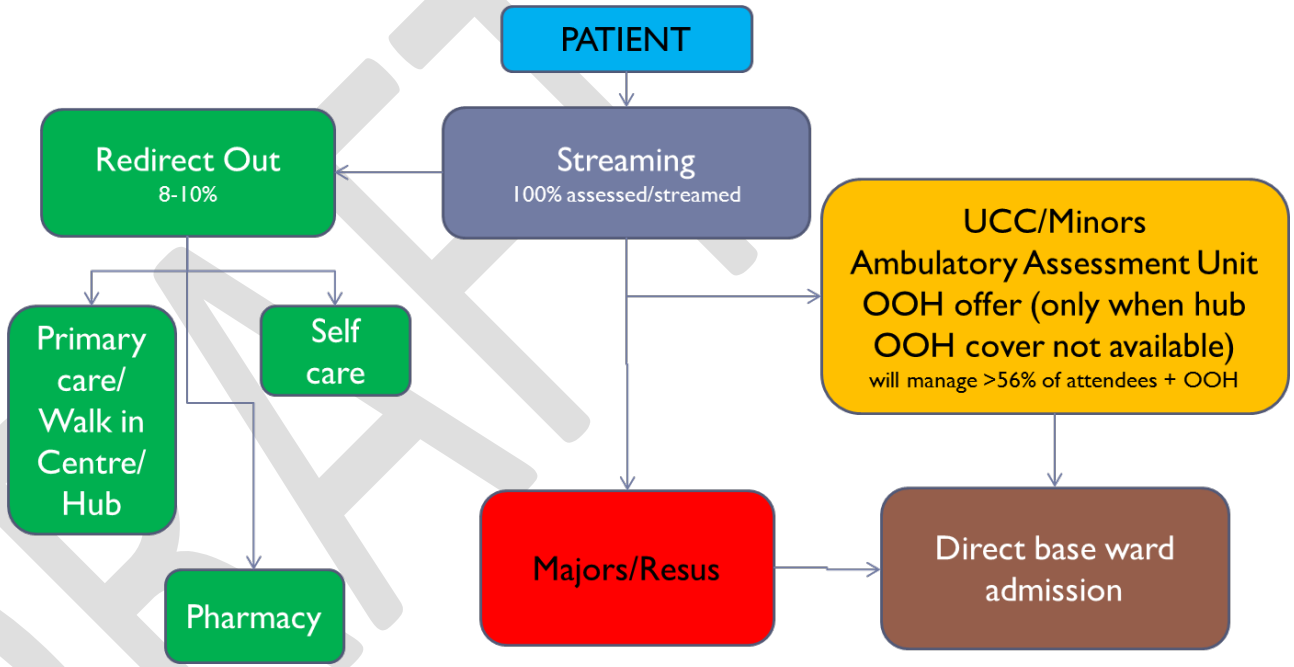
In particular the integrated community urgent care service must adopt the following principles:

- Interfaces with the clinical navigation hub, adopting agreed clinical thresholds for access to elements of the integrated community urgent care service
- Avoids re-triage of patients and accepts the clinical recommendation of clinical navigation service following their assessment
- Accepts direct booking from the clinical navigation service into: home visiting services, face to face GP/nurse appointments and UCC appointments Also exploring whether it will be possible to implement direct booking of appointment with registered GP
- Promotes self-care and self-management, referring to pharmacy or health management resources
- Supports functional integration of urgent care services for a given geographical area
- Demonstrates value for money (across the health economy)
- Enables and promotes the sharing of patient information between services (within limits of current IT interoperability)
- Provides full post contact information to patient's registered GP within 24 hours
- Has joined up clinical governance across services
- Supports the development of the urgent care workforce and provides clinical support and opportunities for shared learning between professionals in different functional services

2: Redesigning the LRI Emergency Department Front door:

Creation of an integrated service including primary care-led streaming of patients, an urgent care centre and minors treatment area, with supporting diagnostics.

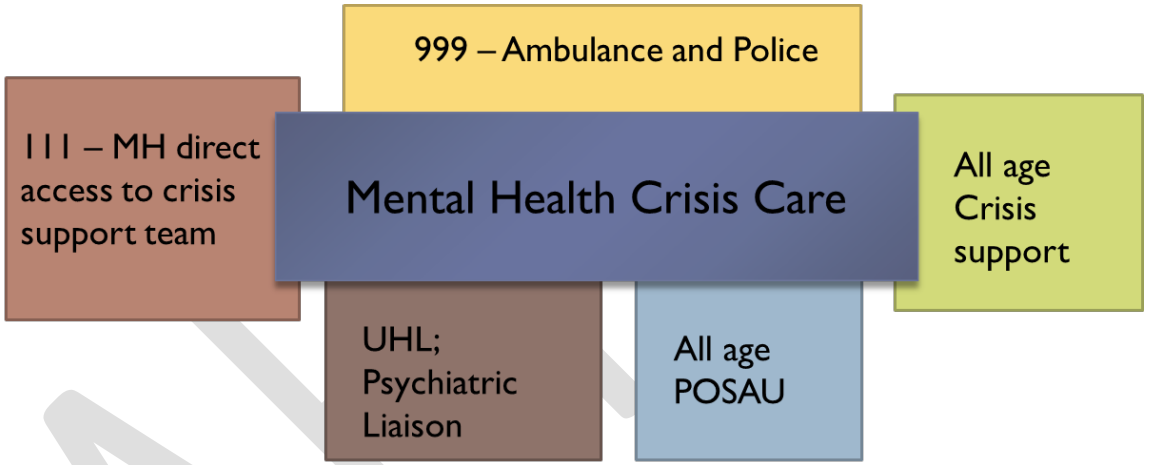
Through the redesign of the Leicester Royal Infirmary (LRI) front door a simplified service will be developed, providing a single service to assess, stream and treat all patients who attend LRI ED and who do not require majors or resus. The model described is similar to one that has been trialled in similar forms in other acute hospitals across the United Kingdom and will see the streaming, OOH, primary care and UCC service integrated with minors into a single cohesive service. We will adapt and learn from their experiences. In parallel with the transformation work of the Vanguard, a physical redesign of the emergency floor at LRI is being undertaken. These capital works have key dependencies with Strand 2 and the two will work closely together to optimise patient flow.



This integration will make the LRI model consistent with the rest of the UEC system, including the configuration of out of hospital services and the emergency pathways flowing from ED. The service will have a strong primary care ethos and will be integrated within LRI ED, operating under a shared clinical governance structure. The complexity of conditions treated within the UCC is dependent upon access to a range of diagnostics including x-ray. Based on a review of HRG codes it is anticipated that 56% of patients attending the LRI campus will be treated within the new integrated UCC model.

3: Improving Urgent Mental Health Services:

We will develop an all age crisis support service, spanning 999, NHS111 and acute services. This will result in an all age acute psychiatric liaison and place of safety assessment unit (POSAU), Mental Health crisis triage via 999, integration of Mental Health crisis support into NHS111/ clinical triage services (strand 1) and improving Child and Adolescent (CAMHS) community support services.



The development and redesign of the UEC system will enable a set change towards parity of care between physical and mental health. Current provision for crisis response does not cover children and young people and the service for adults is only accessible to patients through GP referral, resulting in patients experiencing acute mental health symptoms attending the ED in crisis. The current Liaison Psychiatry service within the acute hospital is an adult-only assessment service in the ED, which responds to patients within a reasonably timely manner but is unable to provide any intervention or treatment. This frequently means that the hospital is unable to adequately meet their needs, which is both distressing and provides sub-optimal care for patients and also has a negative impact on the staff working in the department. Strand 3 contains the following areas of focus:

- All age liaison psychiatry
- 999- community triage
- CAMHS community crisis
- Improved access to crisis support via NHS11
- All age Place of Safety Assessment Unit

Though links with other strands we will scope IM&T interoperability between all partner organisations and develop a sophisticated and fully populated DOS. Work is ongoing to develop an integrated electronic patient record between Mental Health liaison, ED and UCC (currently three systems are in use). Clinician Reported Outcome Measures are currently recorded under the Mental Health minimum dataset. Patient Reported Outcome and Experience Measures are not routinely collected at present. We will seek to rectify this.

4: Early Implementation of 7 day Working in Acute Hospitals

UHL is a designated national early implementer site for 7 day services, including improving access to diagnostics 7 days a week. Strand 4 seeks to enable this change and encompass it within the whole system integration work of the Vanguard. It will achieve the following standards from the Keogh review by March 2017:

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

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

(6) Intervention/key services: Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on site or through formally agreed networked arrangements with clear protocols, such as: Critical care; Interventional radiology; Interventional endoscopy; Emergency surgery.

(8) On-going Review: All patients on the Acute Medical Unit (AMU), Surgical Assessment Unit (SAU), Clinical Decisions Unit (CDU), Gynaecology Assessment Unit (GAU), Trauma Assessment Unit (TAU) and Children's Assessment Unit (CAU) must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, and others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks. Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined, based on objective criteria, that this would not affect the patient's care pathway. All patients must have an Expected Date of Discharge (EDD) set within 14 hours of admission. There is an assumption this may not be met in some cases and variation will be monitored based on HRGs to learn from and refine the model.

Through dependencies with other Vanguard strands we will also achieve:

(7) Mental Health: Where a Mental Health need is identified following an acute admission the patient must be assessed by psychiatric liaison within the appropriate timescales 24 hours a day, seven days a week: Within 1 hour for emergency care needs; Within 14 hours for urgent care needs. This will be achieved through the work on Strand 3 (Mental Health).

(9) Transfer to community, primary and social care: Support services, both in the hospital and primary, community and Mental Health settings must be available seven days a week to ensure that the next steps in a patients care pathway, as determined by the daily consultant led review, can be taken.

The Vanguard will also aim to improve seven day services within social care linked to discharge within the scope of this strand. The creation of seven day services within the acute and primary care sector has the potential to create a bottleneck within social care services and limit the impact of the work unless the whole system takes the changes forward in unison. Scoping work and discussions are currently underway with the Local Authorities to understand the changes that can be made and the potential impact.

5: Contracting and Payment Mechanisms:

Underpinning the service redesign elements of the Vanguard, we will develop new contractual arrangements which aim to incentivise and support providers to work together to deliver integrated services. This may include Alliance contracting models, incentivising a 'one system' approach to collaboration in delivering urgent care in LLR. New payment mechanisms that move away from traditional Payment by Results tariffs, such as the 'three part payment mechanism' will also be explored and implemented where there is a fit with overall Programme objectives.

Our aim is to begin to contract for a new service model from April 2017, including new contracts for clinical navigation and integrated community urgent care.

As we begin to redesign services and develop new ways of working through 2016/2017, we will encourage collaboration between service providers, using contracted resources flexibly to progress towards functional integration, and to test new models. Our aim is to get best value from the money spent on urgent care, redeploying resources, particularly clinical time, to deliver care in new ways.

The approach to contracting from April 2017 will need to be developed taking into account procurement guidance, as well as reflecting the development of integrated service models. We will begin this work early in 2016, and developing a more defined approach as the model of care in strands 1, 2, 3 and 4 becomes clearer.

6: Predictive Modelling

This workstream involves creating a system that will, using real time data, assess demand and capacity across the urgent care system, and use this to predict future demand and direct system resources to respond appropriately.

The project will use real time data from key Urgent and Emergency care providers and where possible primary care showing demand and capacity within the system at any given time. In addition it will develop an algorithm that will use this data and data from other sources to predict demand over the next 7 days allowing for resources to react to changes in surge.

The project will also work with UEC system partners to develop a whole system escalation plan allowing the better mitigation of surge and risks within the system.

Further work on developing a system wide integrated clinical governance and potential changes to enable a system wide workforce will also be linked closely to the work of this strand. The scope of where these elements of the project will sit has yet to be defined.

7: ED Pathways (Flow)

ED Pathways covers the key elements of ED patient flow within UHL. The scope of this work incorporates two key areas; improving flow within and out of LRI ED (which links to the RAP) and the new LRI ED Floor Programme. The ED Pathways strand will provide updates on both of these key areas, ensuring that the key interdependencies of these schemes and the wider Urgent and Emergency Care Programme are managed.

The new ED floor build at LRI is a major programme of works within the LLR system. As such it has a number of impacts and dependencies on the other strands of work accountable to the UCPB. The ED floor will provide a regular report to the UCPB on progress and the ED pathways that are being developed through this work.

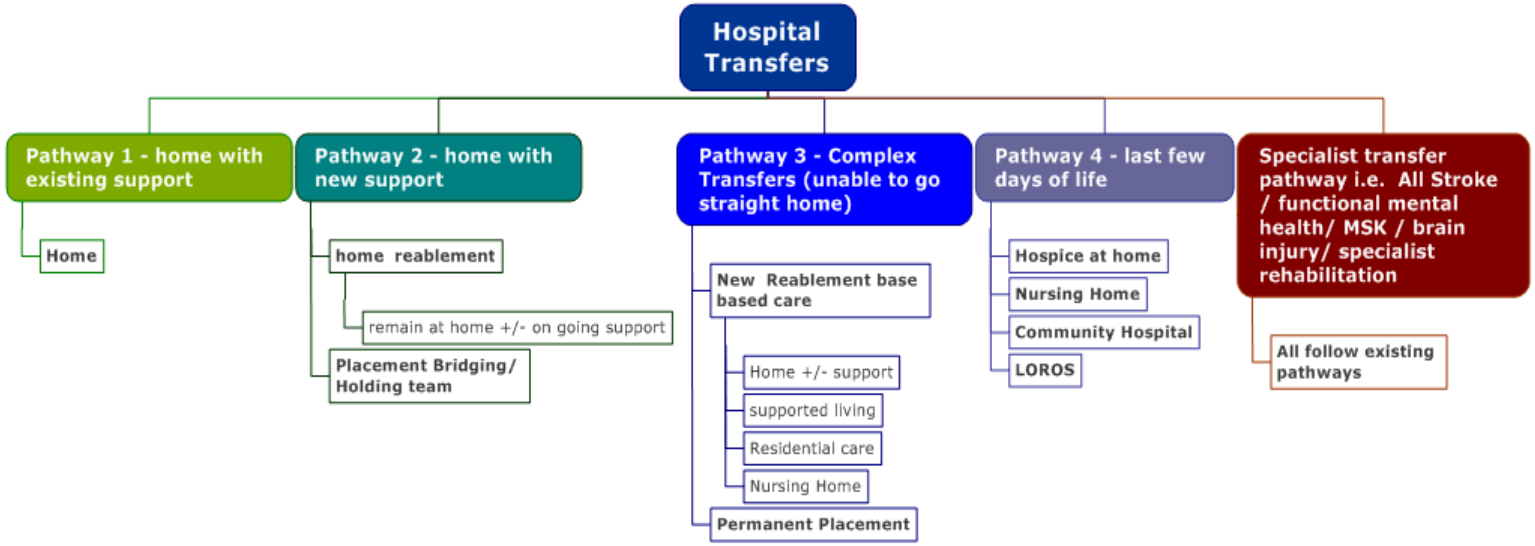
8: Discharge:

Improving community support for people who have had a stay in an acute hospital is one of the key elements of our Urgent Care Improvement Plan. The aim of this workstream is to develop a simple, responsive and comprehensive package of discharge support services which enable people to return to their normal place of residence after a period of hospital stay, or to move to a specialist placement in a timely way if that is needed. The objective is to ensure that people can return home as soon as they are medically fit to do so, and that they receive the right level of support in the community to regain independence and prevent readmission.

Following a thorough review of discharge pathways in LLR, we have agreed a simplified set of discharge pathways which we are now putting in place. The diagram below shows the five new discharge pathways. The work to put the new pathways in place includes a number of new procurements and service changes, which will continue throughout 2016/2017. For instance pathway 3, which involves the procurement of rehabilitation support and placements, will be in place by October 2016. The discharge work is linked to work within the Better Care Fund such as Help to Live at Home, and the development of the Intensive Community Support service (ICS), which provides home based nursing to prevent admission and facilitate earlier discharge. These projects will enable the transformation of the current state and delivery of the 'post transformation' system. A number of these projects have mapped dependencies or represent a development from the 2015/16 Urgent Care Improvement plan. The links are highlighted in the "other mapped projects" section of the table.

In addition, at a Discharge Summit held in May 2016 and which was attended by more than 50 representatives from across the LLR health and care system, the successes and difficulties within the present system were assessed and five additional priority projects identified. Together these will address the main remaining barriers to effective discharge. These projects are (pending approval):

- Responsiveness and timeliness of the discharge process (UHL internal processes)
- Staff training and support
- Step up / step down navigation hub
- Shared risk
- Single assessment



Dependencies

It is noted that work within the urgent and emergency care System has impacts across the wider health and social care sector. Some of the main dependencies within Better Care Together and the Better Care Fund have been mapped across in the table below. This will reviewed and revised at the programme of work develops. Further details of the BCT dependencies and the Vanguard Programme (Strands 1-6) is covered in Appendix 2.

Project	Purpose	Key dependencies/ Other Mapped projects (from former Urgent Care Improvement Plan and Vanguard Programme)
NHS111 Clinical Triage and Navigation Hub	Development of single clinical triage and navigation hub for Health and Social Care with ability to book direct into services and provide support to front line clinical staff. Service will also include bed bureau function and Consultant Connect service with UHL.	Inflow: Alternatives to admission, Access to GP Practice, clinical triage, UCC/WiC relationship with EMAS, LC PMCF Hubs, UHL Bed Bureau, UHL Consultant Connect Flow: Ambulatory Pathways, Strand 1 Vanguard Programme
Integrated Community Care **SRO: Tamsin Hooton (WLCCG)**	Development of an integrated urgent care service removing duplication within the system and development of the urgent care community offer. Integrated urgent care offers to be developed by each CCG.	Inflow: Access to GP Practice, care planning Mutual Aid, CNS OOH Test beds – working with Federations on services offered in Loughborough UCC (alignment work to be carried out) Links with GP hubs in City (alignment work to be carried out)
LRI Front Door **SRO: Sam Leak (UHL)**	Development of a single front door at LRI merging streaming, UCC, Minors, OOH, ambulatory care and assessment bays. Focus is on development of a reduced cost service to manage 56% of patients who could be more appropriately seen within a primary care environment.	Inflow: UHL EDSS, UHL GGH CDU Pilot (linked to BTC LTC) Flow: Ambulance Handovers Long Term Strategy: Future model of LLR front door, future model of UCCs Consider inclusion of flow: Ambulance Handovers

Mental Health Crisis Pathways **SRO: Jim Bosworth (ELCCG)**	Development of an improved crisis support pathway for patients open to all age groups, covering 999, ED, NHS111 and POSAU	Inflow: Vulnerable people, Police, Fire, Ambulance, Health & Social Care
7 Day Services in UHL **SRO: John Jameson (UHL)**	Development of 7 days services, including access to diagnostics and interventions within the urgent and emergency services at UHL. Project will also include review of impact on social services to ensure no bottlenecks are created through this work.	Inflow: Improve 7 day services To include outflow: 7 day care home discharges
Contracting For Transformation **SRO: Spencer Gay (WLCCG)**	Contract development to be reviewed in line with the whole system approach being taken.	Long term strategy: Longer term strategic view of urgent and emergency care
Predictive Modelling **SRO: Will Monaghan (UHL)** **(Joint) Will Legge (EMAS)**	Development of a predictive modelling tool to show capacity and demand and patient flows through the LLR UEC system.	Flow: Understanding variability in Emergency Department performance Consideration of inclusion of other work e.g. EY
ED Pathways (Flow) **ED Flow** **New ED Floor** **SRO: Sam Leak**	Delivery of the RAP. Covered under ORG meetings, but will report in on progress to ensure interdependencies are managed. To redesign and rebuild the ED service at LRI, redesigning pathways to maximise flow and improve patient experience.	Dependencies to be managed via ORG Programme is managed by UHL with updates to UCPB to enable dependencies to be managed
Discharge: **Transfer to Access** **Patient Transport**	To implement and test five new transfer pathways to support patients in reaching their optimum levels and ability to self-care. Piloting of a TTO car which will enable medicines to follow the patient, and on wards to ensure that patients are booked and made ready earlier in the day to ensure there is not a surge for transport later in the day. Expected outcomes to reduce DToCs and rebeds.	BCF and BCT dependencies and links to S4

Supporting Family Decision Making	Develop information for patients and families that explains the patient's journey from admission to their final placement (i.e. home or a care home placement which may involve an interim placement whilst a permanent placement is found). It will also set out reasonable expectations on the timeliness of family decision making. Work with Healthwatch will develop this with patients and families.
Improving Flow Through Community Services	To review the transfer process between UHL and community hospitals to enable early allocation and transfer of patients. In addition, a process of standardisation across all community hospitals will be introduced to ensure transfers are being consistently managed.
MDS – Health and social care data	Development of a minimum data set across health and social care to enable better care planning and discharge co-ordination.
SRO: Tamsin Hooton (WLCCG)	

Measuring Success

Impact and Outcomes

We have identified five key outcomes/domains that we will improve through the Vanguard work. We are in the process of defining detailed measures and baselines for these outcomes and agreeing improvement trajectories, with support from public health. The key outcomes we will measure are:

- Improved Patient Experience
- Sustainable Models
- Health Inequalities (Safety/Quality Check)
- Parity of Care in UEC
- Personalised Co-ordinated Care
- UEC Health Outcomes

The below table shows the outcomes/domains and the outputs associated with each. Please note that these are still under development and are contained for illustration purposes at this point. Further work will be undertaken with clinicians and public health to develop challenging yet realistic trajectories to improve performance in all these areas. These trajectories will be aligned with the BCT, STP and CCG operational plans.

Outcomes/Domains	Outputs
Improved Patient Experience	Friends and Family Test
	ED and UCC wait
	Re-admissions
	Ambulance handover time
	Average length of stay
	Access to diagnostics??
Sustainable models (volumes=V, system usage=S)	% of HRG codes 9 & 11 as ED attendances (S)
	Ratio of UCC/ED attendances (S)
	Avoidable admissions (S)
	Emergency admissions 0-6hrs (V)
	% of ambulance conveyances (S)

	Number of 999 calls (V)
	Number of NHS111 calls (V)
	% of NHS111 to ED (S)
	% of NHS111 to 999 (S)
	Emergency admissions (V)
	UCC attendances (V)
	UHL bed capacity - medical & non elective surgical (S)
	0 day length of stay (V)
Health inequalities - quality check - annual presentation to UCPB & review of impacts/EIA/QIA	PH outcomes framework - annual report
	Achievement of 4 hour wait target for MH patients
	Use of Section 135/136/POSAU
	Use of police cells as a POS
	Use of ED as a POS
	Calls from NHS111 to Richmond Fellowship
	% of MH patients conveyed to ED by EMAS
Parity of care in UEC	% ED MH assessments within 1 hour
	(Pi tool) Number of patient handovers
	Patients with a SCR/care plan
	Patients directly booked into service by CTNS
	Referrals between NHS111 and CNTS
	Patients referred between LLR SPA and "111"
	Patients - see and treat
Personalised co-ordinated care	Clinicians accessing CTNS
UEC health outcomes	30 day mortality

	Re-attendance at ED
	Re-attendance at UCC
	Variation in mortality by day of week
	UCC to ED referrals

In addition to these high level outcomes, each of the workstreams has agreed a more detailed set of metrics to measure the impact of the work. The Urgent Care Programme Board also reviews a dashboard of indicators that track levels of demand and performance of urgent care providers at each meeting. We are exploring how to use the Health and Care Trak tool (Pi) to support evaluation of the impact of the Vanguard changes.

Evaluation and monitoring

The National Vanguard team have issues guidance on how local sites should commissioning evaluation of their work. We are in the process of identifying evaluation partners to help us evaluate the Vanguard, over the course of 2016/2017.

We will work with the national Vanguard team to trial a set of urgent care 'system measures' which have been selected to help SRGs to develop a rounded picture of the performance of the urgent care system. The system measures cover three domains: Clinical Outcomes, Patient Experience and Staff Satisfaction, with a number of indicators in each domain. We have received a data set covering the system measures from the National Vanguard team and will be presenting this to the Urgent Care Programme Board and SRG in April, once the data has been analysed for LLR.

Communications

DRAFT
Communications and

A communications strategy will be develop to link all the projects together into one cohesive approach. The draft communications strategy of the Vanguard is included here as a reference document and will be expanded to include all of the UEC projects. This will be shared with the UCPB for approval once completed and will also act as the reference for the Urgent Care strand of the BCT Programme.

Consultation

The Urgent Care Programme, including the Vanguard is part of Better Care Together and therefore will be reflected in the forthcoming BCT consultation. There is no specific consultation questions relating to urgent care envisaged at the present time as the proposals are not considered to warrant formal public consultation.

Engagement with the public, patients and carers is important within the Vanguard work. We have drafted a consultation and engagement strategy which sets out how we will approach this, which included in the Value Proposition. Our approach will be to start with using the wealth of intelligence we have on the views of local people, including recent Healthwatch reports and the outcome of a number of public engagement events across LLR, to inform the development of the Vanguard plans.

Each workstream is currently reviewing its own engagement plan in the light of the project plan for the workstream, to ensure that where we need to do further engagement on aspects of our plans, we identify this need and make arrangements for the relevant level of engagement.

Appendix 1: Project Work Plans

Strand 1: Integrated Urgent and Emergency Care

Milestone (What)	Responsible Officer (Who)	Timescales (When)
To confirm the aims and objectives with key stakeholders	Project Team	27.5.16
1. Test Beds		
111/OOH ED Liaison desk pilot (9 day pilot)	Leah Chilengwe	29.4.16
Evaluation of ED Liaison Desk pilot	Leah Chilengwe	27.5.16
Secure funding for enhanced triage trial	Tamsin Hooton/Gill Killbery	20.5.16
Next stage clinical trial - NHS 111 G2/G4 ambulance outcomes to commence Whitsun: Week 1 : Medics only Week 2: Medics and ANPs a) Baseline data for Green 2&4 to be defined b) Meeting with Gayle Anderson to look at warm transfer/green 2 & 4 data c) Tim Hargreaves to discuss with Neil Spencer the mapping of DHU G4 calls to S&T rather than H&T	Leah Chilengwe	27.5.16
To agree the DX codes for the G2/G4 enhanced triage trial at DHU	Pauline Hand/Gayle Anderson/Sarah Smith	20.5.16
Agree a GP resource for the enhanced trial at DHU + Days/Times required	Pauline Hand/Tracy Yole/SS	20.5.16
Agree ANP resource for the enhanced trial at DHU + Days/Times required	Pauline Hand/TY/SS	27.5.16
Clinical triage pilot of Green 2&4 ambulance dispositions from NHS111 (Medics only)	Leah Chilengwe/SS	03.6.16
Gayle Anderson to receive activity data (14.06.16)	Gayle Anderson	17.6.16
Analysis of activity data (16.06.16)	Gayle Anderson/SS	17.6.16

Clinical triage pilot of Green 2&4 ambulance dispositions from NHS111 (Medics & Nurses)	Gayle Anderson/SS	10.6.16
Gayle Anderson to receive activity data (21.06.16)	Gayle Anderson	24.6.16
Analysis of activity data (23.06.16)	Gayle Anderson/SS	24.6.16
Comparison of Week 1 and Week 2 outcomes (23.06.16)	Gayle Anderson/SS	24.6.16
Evaluation and review of all test bed pilots involved in the enhanced triage trials	Clinical Triage Implementation Group (CTIG)	1.7.16
2) Volume Modelling		
Identify the current call volume for 111 by month/by day of the week/by hour of the day for 2015/16: Green calls Under 1's Over 75's Special Patient Notes	Pauline Hand/Gayle Anderson	27.5.16
To identify patient tracking process for patients with SPN through the 111/OOH service	Pauline Hand	27.5.16
Identify the current call volume for OOH by month/by day of the week/by hour of the day for 2015/16: Green calls Under 1's Over 75's Special Patient Notes	Rob Haines/Kerry Rainford	27.5.16
Identify the following pathway costs: 111 call - non-clinical call handler only 111 call - non-clinical call handler plus nurse intervention 111 call - non-clinical call handler plus GP intervention 111 call - non-clinical call handler plus Mental Health intervention 111 call - non-clinical call handler plus Dental intervention 111 call - non-clinical call handler plus Pharmacy intervention 111 call - warm transfer to OOH	Kerry Rainford/Gill Killbery	20.5.16

OOH - H&T only OOH - H&T plus base visit OOH - H&T plus home visit Ambulance - S&T and non-conveyance Ambulance - S&T and conveyance to Acute care		
Identify the current call volume for Mental Health	Pauline Hand	20.5.16
Visit to Peterborough Clinical Triage Hub (City Care Centre)	Project Team	20.5.16
Map out the call duration requirements: By role type per hour/by day of the week Utilisation calculations e.g. comfort breaks Anomalies e.g. mental health calls Percentage of calls to be answered within 'x' seconds Abandonment rates	BI Resource	20.5.16
To assess the impact of the proposed navigation service on existing services i.e. the percentage of increase/decrease of referrals. These need to include 111 and OOH.	Project Team	3.6.16
People Approach		
Complete an organisational impact assessment including all key stakeholders (see Project documentation)	Project Team	13.6.16
Gain HR advice re possible TUPE arrangements for any new model of care	Project Team/Sarah Young	20.5.16
Develop the organisational structure for the new service including: Roles and responsibilities	Project Team	27.5.16
Develop the organisational structure for the new service including: Skill mix	Project Team	27.5.16
Develop the organisational structure for the new service including: Contractor provisions	Project Team	27.5.16
To define and agree the recruitment approach for any new staff required	Project Team/Contracts	27.5.16

Training needs analysis for new service	Peter Lacey/Lisa Sharples	27.5.16
Identify and secure funding for any identified training needs	Tamsin Hooton/Gill Killbery	20.5.16
Development of Training & Development plan	Peter Lacey/Lisa Sharples	1.7.16
Implementation of Training & Development plan	Peter Lacey/Lisa Sharples	5.8.16
Design & Process		
Agree structure for patient and public engagement for Strand 1	Sue Venables /LL	27.5.16
Gain agreement that all patients will complete Module 0 before any early exit to triage	Project Group	10.6.16
Agree the groups of patients that will exit after Module 0 and go straight to triage, this will include under 1's, over 75's, SPNs and the rest to be confirmed	Project Group /Clinical Ref Group	10.6.16
Agree the groups of patients that will complete Pathways and then be transferred to the clinical triage	Project Group/ Clinical Ref Group	10.6.16
Agree the groups of ambulance dispatch patients from a 999 call that will be diverted to the Clinical Triage Hub and at what point	Project Group/Will Legge	27.5.16
Agree the skill mix for the Clinical Navigation Hub	Project Group/ Clinical Ref Group	22.7.16
Cost modelling for the proposed skill mix	Project Group/ Clinical Ref Group	22.7.16
Agree the Operational Model for the Clinical Navigation Hub i.e. number of physical locations, any remote working etc	Project Group/ Clinical Ref Group	22.7.16
Co-design Workshop to look at: Patient flow into Navigation and out into Integrated Community Services Call routing process (warm transfers) Patient information recording system(s) Direct booking processes (need to include GP Federations/Dentistry/Mental Health) SOPs Governance processes	Project Team (Mandatory stakeholder attendance will be required)	1.7.16

Physical/Virtual locations		
Out of the Workshop, CTIG to formally design and agree the following: Patient Pathways Agreements SOPs Information Governance Clinical Governance Reporting Governance	CTIG	26.8.16
EMAS to create and obtain approval of new SOP to reflect the transfer of agreed 999 Green calls to Clinical Triage Hub with all associated governance processes	Will Legge	29.7.16
The CCGs Clinical Groups to review the Project Plan and outline model. (City 2nd June) Required dates for ELR and WL.	Project Team	1.7.16
Map out the requirements for information sharing across the patient pathways. Consider interface with police and fire service.	CTIG	10.6.16
To develop the Information Sharing Agreement that spans across the patient pathways i.e. Pan-LLR Multi-Agency	CTIG	TBC
To develop the Information Governance Agreement that spans across the patient pathways i.e. Pan-LLR Multi-Agency	CTIG	TBC
To develop the Reporting Agreement that spans across the patient pathways i.e. Pan-LLR Multi-Agency	CTIG	TBC
Develop Service Specifications for each aspect of the new service	CTIG	19.8.16
Service Specification approval and sign-off by DHU	Board Date TBC after 19.8.16?	30.9.16
Service Specification approval and sign-off by EMAS	Board Date TBC after 19.8.16?	30.9.16
Service Specification approval and sign-off by Vanguard Programme Board	Board Date TBC after 19.8.16?	30.9.16
Service Specification approval and sign-off by WLCCG	Board Date TBC after 19.8.16?	30.9.16
Service Specification approval and sign-off by ELRCCG	Board Date TBC after 19.8.16?	30.9.16

Service Specification approval and sign-off by LCCCG	Board Date TBC after 19.8.16?	30.9.16
Service Specification approval and sign-off by the County Local Authority		30.9.16
Service Specification approval and sign-off by the City Local Authority		30.9.16
Service Specification approval and sign-off by the Rutland Local Authority		30.9.16
Service Specification approval and sign-off by the WL CCG		30.9.16
Service Specification approval and sign-off by LCCCG		30.9.16
Service Specification approval and sign-off by ELRCCG		30.9.16
Any detailed project modelling to go to CCG Clinical Commissioning Committees (City 18th August) Required dates for ELR and WL.	Project Team	19.8.16
Quality Impact Assessment to be completed	Project Team	26.8.16
Equality Impact Assessment to be completed	Project Team/Haseeb Ahmad	26.8.16
Development of the full financial modelling	Gill Killbery	24.6.16
Pre-sign-off financial modelling with CCG CFOs	Tamsin Hooton/ Gill Killbery/CCG CFOs	8.7.16
Develop full Business Case	Project Team	26.8.16
Sign-off full Business Case WLCCG		26.8.16
Sign-off full Business Case LCCCG		26.8.16
Sign-off full Business Case ELRCCG		26.8.16
Ensure Escalation Plans are updated in the LLR Surge & Resilience Plan	Project Team	26.8.16
Start Project phasing	Project Team	16.9.16
Technology		
Map out technology and telephony interfaces for Clinical Triage Hub / SPA(s)	TBC	24.6.16
ED Liaison Pilot outcome: to check that ED alternatives are profiled on DoS to accept these	Gaurav Mehta/Gail	20.5.16

patients	Anderson	
To identify the provider for the next phased trial which is end of NHS 111 Pathways patients with an Ambulance (G2/G4) Disposition Trial.	Pauline Hand/Leah Chilengwe	20.5.16
Review manual ambulance despatch option for G2/G4 dispositions trial for LLR contract with DHU. Stream cases to OOH. Modify allowable disposition codes to be streamed from NHS 111 non-DOS button.	Leah Chilengwe/ Pauline Hand	20.5.16
Map G2/G4 disposition codes within OOH Adastra instance for trial	Gaurav Mehta	20.5.16
Clinical triage tool (TAS Odyssey?) for use by ANPs involved in trial	Rob Haines/ SS/LL	20.5.16
To map EMAS AMPDS G2/G4 codes to agreed priorities within the Clinical Hub for Braunstone.	Neil Spencer/SS	20.5.16
Installation and go live of EMAS Adastra in CAT	Will Legge	29.7.16
EMAS CAT Adastra system testing and confirmation of fit for purpose	Will Legge	26.8.16
Order 999 to NHS 111/OOH ITK link within MIS to Adastra	Neil Spencer	TBC
For Ambulance Disposition Trial an SOP for manual ambulance despatch will need to be developed from NHS 111.	Pauline Hand	TBC
Activity reporting for trial both from NHS 111/EMAS/OOH using the same outcomes as ED Liaison Desk trial.	Pauline Hand/ Neil Spencer/Rob Haines	TBC
Agree and map out the formal interdependencies with the SPA project	Tracy Yole/Gemma Whysall	27.5.16
Explore whether we can do NHS Pathways triage cut-off for just the LLR contract area. Cut after ambulance/police response. Map DX000 to the Clinical Hub. Assumption attempt warm transfer otherwise 10 minute call-back from the Clinical Hub.	Pauline Hand/Jenny Doxey	2.9.16
Pilot of the new NHS Pathways early exit with clinical staff using agreed clinical triage tool.	Pauline Hand/Jenny Doxey	9.9.16
Develop the warm transfer telephony SOPs to include business continuity, escalation and calls lost.	Pauline Hand/Jenny Doxey	2.9.16
Develop DHU contract variation and revised suite of KPIs.	Leah Chilengwe	TBC
Direct appointment booking with GP OOH base visits.	Leah Chilengwe/ Pauline Hand	27.5.16

To explore the options of direct booking with: LRI UCC SSAFA WIC Loughborough UCC Mental Health Crisis		TBC
Identify the patient case record information required by the clinicians over and above the Summary Care Record (SCR).	Clinical Reference Group	27.5.16
An options appraisal of any required clinical record for the navigation.	Gaurav Mehta	24.6.16
Installation of SystmOne OOH Call Centre module into UHL Bed Bureau (13/06)	Julie Dixon	17.6.16
Agree the technology and telephony interfaces from the Clinical Triage Hub into SPAs: Community Health Services (CHS) Mental Health MSOP (Mental Health Services Older People) Local Authorities: City Local Authorities: County Local Authorities: Rutland	Integrating LLR Points of Access Board	29.7.16
Implement the technology and telephony interfaces from the Clinical Triage Hub into SPAs: Community Health Services (CHS) Mental Health MSOP (Mental Health Services Older People) Local Authorities: City Local Authorities: County Local Authorities: Rutland	Project Team	30.9.16
8pm - 8am LLR OOH Service		
Confirm NHS111 to OOH direct appointment booking live & functional	LL/Gaurav Mehta	TBC
Review of existing service provision - staff resources, activity and outcomes - for:		
(a) Home visiting service		TBC
(b) Each of the primary care centres (base visits by appointment)		TBC

(c) Consider shift of Leicester PCC activity to UCC @ LRI		TBC
(d) Consider shift of Loughborough PCC activity to UCC @ Loughborough		TBC
(e) Assess need for change to staffing configuration for UCC Loughborough (to deliver above)		TBC
Agree revised Service Specification		TBC
Authorisation and sign off of revised Service Specification		TBC
Integrated Community Urgent Care Offer (Test Beds)		
Agree the reporting system for each CCG this will include updated Project Plans, Risk & Issue Logs, Exception Reporting, Finance, Governance, IT, Telephony interdependencies		27.5.16
8am - 8pm Services WL CCG		
Weekends Access ("Passport") Pilot:		TBC
Does each Passport also have a current SPN generated and logged with NHS111/OOH	Soyuz Shrestha	TBC
Evaluation of pilot to date	Soyuz Shrestha	TBC
Charnwood test Bed:		TBC
Project Plan for Charnwood Test Bed	Cathrina Tierney-Reed	TBC
8am - 8pm Services LC CCG		TBC
Understand revised Hubs offer within Leicester City	Rachna Vyas	TBC
Understand plans for Leicester Walk In Centre	Rachna Vyas	TBC
Understand vision for UCC Leicester	Rachna Vyas	TBC
8am - 8pm Services ELR CCG		
Project plan for EL&R ED Liaison Desk provided by NDUC via UCC Oadby	Tim Sacks	TBC
Procurement & Contracts		
Clinical Hub Finalised	TY/HOCPP	7.4.17
Draft of Service Specification for new models of care	TY	7.4.17

Development of sustainability and finance modelling	Spencer G	7.4.17
Development of new pay mechanisms	Spencer G	7.4.17
Commissioner sign-off		2.6.17
Conduct if required formal consultation	Sue V/ TY/HOCPP	1.9.17
Formal procurement approach for some aspects	Tamsin Hooton/ HOCPP	6.10.17
Possible new provider arrangements - possible multiple contracts (July 2018)	Tamsin Hooton/ HOCPP	
Suitable mobilisation period to ensure delivery during possible period of change (Oct 2018)	Tamsin Hooton/ HOCPP	
Year 1 of new contract arrangements (Nov 2018)	Tamsin Hooton/ HOCPP	
Consolidation of delivery and management model	Tamsin Hooton/ HOCPP	
Additional year of transition for some elements of service delivery	Tamsin Hooton/ HOCPP	

Strand 2: LRI Front Door

Milestone (What)	**Responsible Officer (Who)**	**Timescales (When)**
Confirmation of Project SRO	Sam Leak	April 2016
Confirmation of Project Lead	Sam Leak	April 2016
Development of Project Group	(Project Lead)	April / May 2016
Development of Terms of Reference	(Project Lead)	May 2016

Development of Project Group (membership and meeting dates confirmed)	(Project Lead)	May 2016
Development of Project Initiation Document	(Project Lead)	May 2016
Development of service specification, to include IM&T proposal	Sam Leak / (Project Lead)	End May 2016
Development of IM&T proposal and workforce proposal	Sam Leak/Project Lead	End June 2016
Development of Action Plan, Risk Register, Issues Log (Excel workbook)	Sam Leak / (Project Lead)	End May 2016
Sign off of service specification by UHL, 3 x LLR CCGs, LLR BCT IM&T Steering Group, UCPB approval	Sam Leak / (Project Lead)	June 2016
Tests and evaluation of key elements of new service model and development of model	(Project Lead)	June – August 2016
Development / approval of business case for new models of care	Sam Leak / (Project Lead)	July - August 2016
Full service mobilisation	(Project Lead)	TBC
Service Live	Sam Leak	In line with new ED floor opening (March 2017)

Strand 3: Mental Health

Milestone (What)	**Responsible Officer (Who)**	**Timescales (When)**
All Age Liaison Psychiatry (Core 24 service by Jan 2018)		
Confirm Vanguard funding	NHS E	May
Review and confirm staffing following funding decisions	Paula Vaughan	April
Develop all age model on a reduced funding of £430K while awaiting national decision	All	May

14 hr In-Patient assessment performance data available	Sue Scarborough	May
Staff Recruitment	Paula Vaughan	TBC
Phased Service Commencement	Paula Vaughan	TBC
999 Community Triage Car		
Confirm Vanguard funding	NHS E	May
Pursue alternative funding streams while awaiting outcome of Vanguard	Gary Wainwright	May
Purchase Mental Health Triage Car	Subject to funding- Terry Simpson.	30th June 2016
staff Recruitment	Subject to funding- Terry Simpson.	30th June 2016
Purchase IT equipment	Subject to funding- Terry Simpson.	30th June 2016
Move into co-located office with Police Colleagues	Subject to funding- Terry Simpson.	TBC
Go live	Subject to funding- Terry Simpson.	TBC- subject to funding
CAMHS Community Crisis (Go live December 2016)		
Richmond Fellowship on DoS	Gaurav Mehta/Louise Keran	May
Discuss Pilot with 111 / Richmond Fellowship	Gary Wainwright/Pauline Hand/Christine Lawrence	May
Pilot starts	TBC	May/June
Agree next steps	TBC	June

All Age Place of Safety Assessment Unit		
Commence building work		w/c 29th April 2016
Interim arrangements in place during building work	Paula Vaughan	w/c 29th April 2016
All age POSAU opens	TBC	
Achieving Integrated Business Reporting		
Discuss next steps	Brenda Howard	w/c 29th April 2016

Strand 4: 7 Day Services

Milestone (What)	Responsible Officer (Who)	Timescales (When)
Phase 1 set up		
Validate 7DS work planned completed and gaps	Vicki Hing	May
Phase 2 analysis		
Agree outcomes at speciality level	Vicki Hing	April/May
Planned work for 2016 analysis	Vicki Hing/Head of Operations/Head of Service	April/May
Develop a diagnostic pack for each CMG	Vicki Hing	May
Agree workforce assumptions	John Jameson	May
Agree financial assumptions	John Jameson	May
Determine current status Clinical Standard 5	Vicki Hing	May
Determine current status Clinical Standard 6	Vicki Hing	May
Define gap against standards	Vicki Hing	May
Phase 3 Communication and Engagement		
Relaunch 7 day services on intranet	Vicki Hing	May
Set up comms with Vanguard	Vicki Hing	May
Phase 4 New Models for 7 day services		

Surgery Plan CS 02. 08 Develop Plans to meet gaps (including business plans)	G Garcia	May
ESM Plan CS 02. 08 Develop Plans to meet gaps (including business plans)	Ian Lawrence	May
RRCV Plan CS 02. 08 Develop Plans to meet gaps (including business plans)	Caroline Baxter	May
Womens Plan CS 02. 08 Develop Plans to meet gaps (including business plans)	A Curry	May
Childrens Plan CS 02. 08 Develop Plans to meet gaps (including business plans)	A Curry	May
CSI Plans CS05 Develop Plans to meet gaps (including business plans)	S Khalid	May
MSS Plan CS 02. 08 Develop Plans to meet gaps (including business plans)	I Davies	May
CS 06 Plan Develop Plans to meet gaps (including business plans)	TBC	May
Workforce planning complete		June
Surgery Plan CS 02. 08 Trail / Test Changes as applicable (TBC)	G Garcia	September
ESM Plan CS 02. 08 Trail / Test Changes as applicable (TBC)	Ian Lawrence	September
RRCV Plan CS 02. 08 Trail / Test Changes as applicable (TBC)	Caroline Baxter	September
Womens Plan CS 02. 08 Trail / Test Changes as applicable (TBC)	A Curry	September
Childrens Plan CS 02. 08 Trail / Test Changes as applicable (TBC)	A Curry	September
CSI Plans CS05 Trail / Test Changes as applicable (TBC)	S Khalid	September
MSS Plan CS 02. 08 Trail / Test Changes as applicable (TBC)	I Davies	September
CS 06 Plan Trail / Test Changes as applicable (TBC)	TBC	September
Surgery Plan CS 02. 08 Implement agreed plans	G Garcia	September
ESM Plan CS 02. 08 Implement agreed plans	Ian Lawrence	October
RRCV Plan CS 02. 08 Implement agreed plans	Caroline Baxter	October
Womens Plan CS 02. 08 Implement agreed plans	A Curry	October
Childrens Plan CS 02. 08 Implement agreed plans	A Curry	October
CSI Plans CS05 Implement agreed plans	S Khalid	October

MSS Plan CS 02. 08 Implement agreed plans	I Davies	October
CS 06 Plan Implement agreed plans	TBC	October
Phase 5 Monitor and Evaluate		
Handover / EWS Data Nerve Centre analyse data	Vicki Hing	February 2017
NHS IQ Audit	Vicki Hing	November

Strand 5: Contracting For Transformation

Milestone (What)	Responsible Officer (Who)	Timescales (When)
Procurement of suitable NHS111 provision sustained ahead of formal agreement of longer term approach to Integrated Care.	Tamsin/HOCPP	April 2016
Negotiations with current providers as development of trial and final clinical hub.	Tamsin/HOCPP	July 2016
Management of co design of models of care and transition into the trial clinical hub model with providers	Tamsin/HOCPP	July 2016
Phased transition of elements of Vanguard Programmes into trial clinical Hub	Tracy/ HOCPP	Nov 2016
Clinical hub finalised	Tracy/ HOCPP	April 2017
Draft of service specification for New models of care	Tracy Y	April 2017
Development of sustainability and finance modelling	Spencer G	April 2017
Development of new payment mechanisms	Spencer G	April 2017
Commissioner sign off		June 2017
Conduct formal consultation if required	Sue V/Tracy/ HOCPP	Sept 2017
Formal procurement approach for some aspects	Tamsin/HOCPP	Oct 2017
Possible new provider arrangements- Possible multiple contracts	Tamsin/HOCPP	July 2018
Suitable mobilisation period to ensure delivery during possible period of change	Tamsin/HOCPP	Oct 2018
Year 1 of new contract arrangements	Tamsin/HOCPP	Nov 2018
Consolidation of delivery and management model	Tamsin/HOCPP	
Additional year of transition for some elements of service delivery	Tamsin/HOCPP	

Strand 6: Predictive Modelling

Milestone (What)	Responsible Officer (Who)	Timescales (When)
System design		
Workshop to scope the system required	Matthew Davies	7th April
Meeting SROs/Tamsin/James/Project Lead to finalise scope	Matthew Davies/SROs/Tamsin Hooton/James Wray	June
Identify IT lead	Matthew Davies/SROs/Tamsin Hooton/James Wray	May/June
Write PID	Matthew Davies	May/June
Write project plan	Matthew Davies	May
Identify key system leaders and champions	Matthew Davies	May
Establish project group(s)	Matthew Davies	June
Develop system costs	Matthew Davies/IT lead	June
Develop system benefits - financial	Matthew Davies	June
Write business case	Project Lead	August
Business case submitted	Project Lead	September
Data		
Identify all data sets required	IT lead	May/June

Meet system data leads to discuss IG and quality issues	IT lead	May/June
Data sharing agreements in place	IT lead	July
Interoperability	IT lead	May/June
Develop business requirements	IT lead	June/July
Map data flow	IT lead	June/July
Plan interoperability works required	It lead	June/July
Triggers Developed		
Develop 3 playbook scenarios for test	Project Lead	June/July
Develop whole system escalation plans and triggers	SRG	June/July
Sign off and approval		August
Trials and embedding		
Dashboard of Strand 1 data created using Pi tool, to test usefulness of data	Brenda Howard/Tracy Yole	TBC
S1 dashboard evaluated	Tracy Yole	TBC
Development of initial model	Project Lead	July
Small test developed using live data	Project Lead	July
Small test of live data evaluated	Project Lead	August
Redevelopment of model	Project Lead	September
Workforce		

Develop links with BCT workforce	Matthew Davies	May
Enable cross system working and workforce solutions in line with escalation plans	Project Lead	June/July
System live		December

Discharge

Milestone (What)	**Responsible Officer (Who)**	**Timescales (When)**
Housing Officer		
Expand the Housing Enablement Officer role to provide support to LGH, GGH and LPT.	Tracy Yole/Quin Quinney	April 2016
Relaunch of Team	Tracy Yole	June 2016
Pathway 1		
Launch Pathway 1 including patient information on all the support available.	Sue Venables/Tracy Yole	August
Pathway 2		
Complete County full business case 2016. LA to explore if HART to take all hospital discharge early	Peter Davis/Yasmin Sidyot/Cathrina Tierney-Reed	October 2016
City to work up pathway 2 full offer	Rachana Vyas	Awaiting information from LC CCG

Develop new patient/family information leaflets on transfer/discharge into Pathway 2	Tracy Yole	October
Pathway 3 – procurement		October
ITT bid deadline	Chris Davies	May 2016
ITT clarification interviews	Chris Davies	June 2016
Recommended Bidders informed and standstill period	Chris Davies	July 2016
Develop and implement a communications plan for the introduction the 'Home First Work Plan, including the implementation of the 'Principles of Good Practice for Transfer from Hospital' for staff, patients and carers. For patients – explaining the patient journey while setting out patients role and family engagement	Sue Venables	August 2016
Develop new patient/family information leaflets on transfer/discharge into Pathway 2/3.	Tracy Yole	October 2016
Service commences	Chris Davies	November 2016
Pathway 4 - End of Life		
Identify Project Lead	TBC	TBC
Write business case	Project Lead	TBC
Pathway 5 – Severe dementia/head injury		
Initial scoping meeting to agree outline pathway	Arlene Neville	TBC
Identify Project Lead	Arlene Neville	TBC
Write business case	Project Lead	TBC
UHL Discharge		

Monitor and review the 11am Conference call to ensure that TTO's are being picked up	Julie Dixon	Ongoing awaiting UHL
UHL to undertake a review of the time taken from discharge decision to actual time of discharge	Julie Dixon	TBC Awaiting UHL
Continue to work with the wards and the medical staff to enable the 'made ready' times to be brought forward to earlier in the day	Julie Dixon/Maria McAuley	Ongoing Awaiting UHL
Scope out the 'Trusted Assessor Role' with the care home association and UHL.	Julie Dixon	March 2015 awaiting confirmation from UHL
Minimum Data Set		
Confirm Cloud MDS template	Tracy Yole/Julia Ball	April 2016
Test cloud MDS template	Tracy Yole/Julia Ball	May 2016
Complete proof of concept for cloud MDS	Tracy Yole/Julia Ball	May 2016
Upload MDS app on Nerve Centre	Tracy Yole/Julia Ball	Oct 2016
Roll out across medicine then the rest of UHL	Tracy Yole/Julia Ball	Oct 2016
Responsiveness and Timeliness (Awaiting approval)	**Julie Dixon/Ian Lawrence**	
Discuss and agree project plan	June	
Reference other work in this area		
Explore issue of access (IT) to nerve centre		
Staff Training and Support (Awaiting approval)	**Mandy Gillespie/Julie Dixon**	
Discuss and agree project plan		June
Identify gaps and establish scope and risks, what training is mandatory		
Identify where training is available and whether there is funding available		

Design (including terminology)		
Write business case	Julie Dixon/Sam M	
Training rolled out		July – October
Evaluation available		March
Shared Risk (Awaiting Approval)	**Mandy Gillespie/Nikki Beacher**	
Discuss and agree project plan		June
Establish teleconference group	Sam Merridale	
Piloted transfer to assess joint health/social care built trust ? expand to single assessment (double output)		
Establish robust procurement and commissioning process to include patient assessment (contractual)		
System monitoring		
Step up / Step Down Care Navigation Hub (Awaiting Approval)	**Tamsin Hooton/Sam Merridale**	
Meeting to develop modelling		May
Discuss and agree project plan`		June
Single Assessment process – shared care and management plan. Patient owned record (Awaiting Approval)	**Mandy Gillespie, Tracy Yole/Jackie W**	
Discuss and agree project plan		June
Explore SystmOne		
Tie down discharge summary		

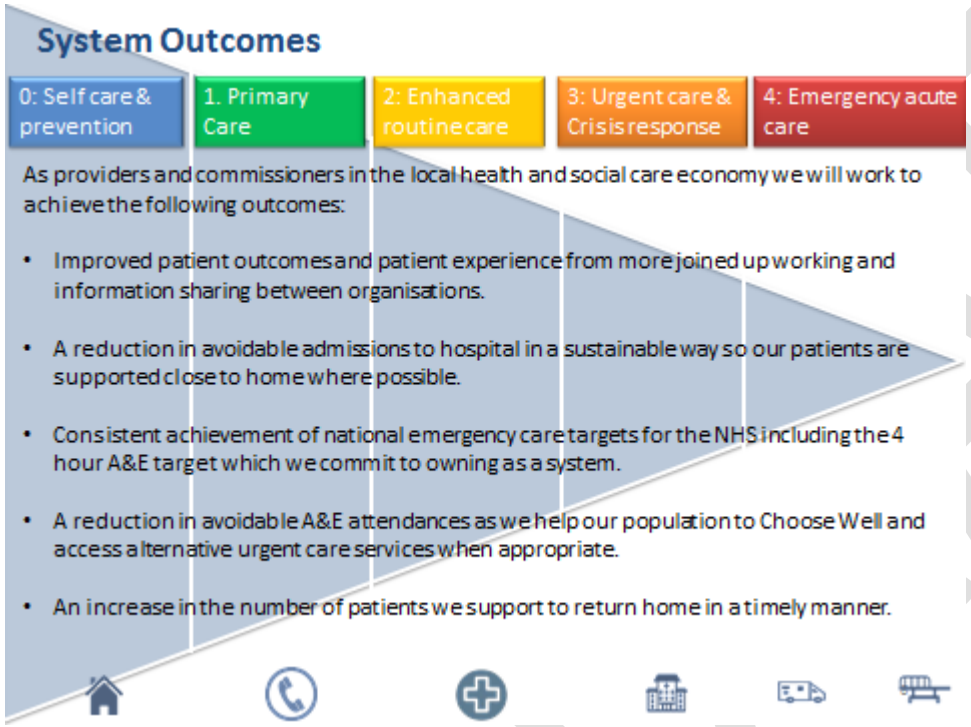
Access to summary care records		

Appendix2: Vanguard Dependencies with BCT

	Children's Service, Maternity and Neonatal	LDs	Planned Care	Long Term Conditions	Mental Health	Community Hospital Recon-figuration	Frail Older People and Dementia	Urgent Care	End of Life
Strand 1: Integrated Urgent Community Care				Reducing ED attendance by targeting patients with LTC, using technology to create a unique protocol for each patient.	Clinical triage and local navigation hubs provide early, senior clinical input involving GPs, Mental Health and crisis practitioners and pharmacists.		Building on the Frail Older People's Assessment and Liaison Service, providing consultant psychiatrist input and enabling initial treatment & prescribing	Pathway development (receiving referrals and diverting patient flow)	Using technology to create a unique protocol for each patient, incorporating end of life wishes.
Strand 2: LRI Front Door				Reducing ED attendance by targeting patients with LTC, using technology to create a unique protocol for each patient.	Additional workforce recruitment and refinements, building on the existing ED Mental Health triage nurse service.			Pathway development (receiving referrals and diverting patient flow)	
Strand 3: Mental Health	Improved access to Mental Health crisis support, for children and young people. .				Improving access to care through:-(1) Increased clinical triage, crisis response and improved community support. (2) Providing consultant psychiatrist input and enabling initial treatment & prescribing. (3).An all age liaison psychiatry service.		Build on the Frail Older People's Assessment and Liaison Service, and integrate into the all age service.	Improved access to Mental Health crisis support via NHS11, for All ages. All age Place of Safety assessment unit.	
Strand 4: 7 Day Services	Improved access to Mental Health crisis support via NHS11, for children and young people, 7 days a week.			Hospital inpatients will have scheduled 7day access to diagnostic services. Consultant-directed diagnostic tests & completed reporting available 7 days a week.	Enabling achievement of clinical standards 7 & 9, providing patients with assessment by psychiatric liaison 24 hours a day seven days a week.		Increased consultant psychiatrist input, allowing initial treatment and prescribing to take place 7 days a week.	Improved access to assessment, diagnostics and treatment days a week.	
Strand 5: Contracting for Transformation	Contract Development of new contracts and to incentivise transformational change in existing contracts.			Contract Development of new contracts and to incentivise transformational change in existing contracts.	Contract Development of new contracts and to incentivise transformational change in existing contracts.		Contract Development of new contracts and to incentivise transformational change in existing contracts.	Contract Development of new contracts and to incentivise transformational change in existing contracts.	Contract Development of new contracts and to incentivise transformational change in existing contracts.
Strand 6: Predictive	Provide data on capacity, resources to manage flow			Provide data on capacity, resources to manage flow	Development of an algorithm to ensure correct dispatch of vehicles for		Provide data on capacity, resources to manage flow	Provide data on capacity, resources to manage flow	

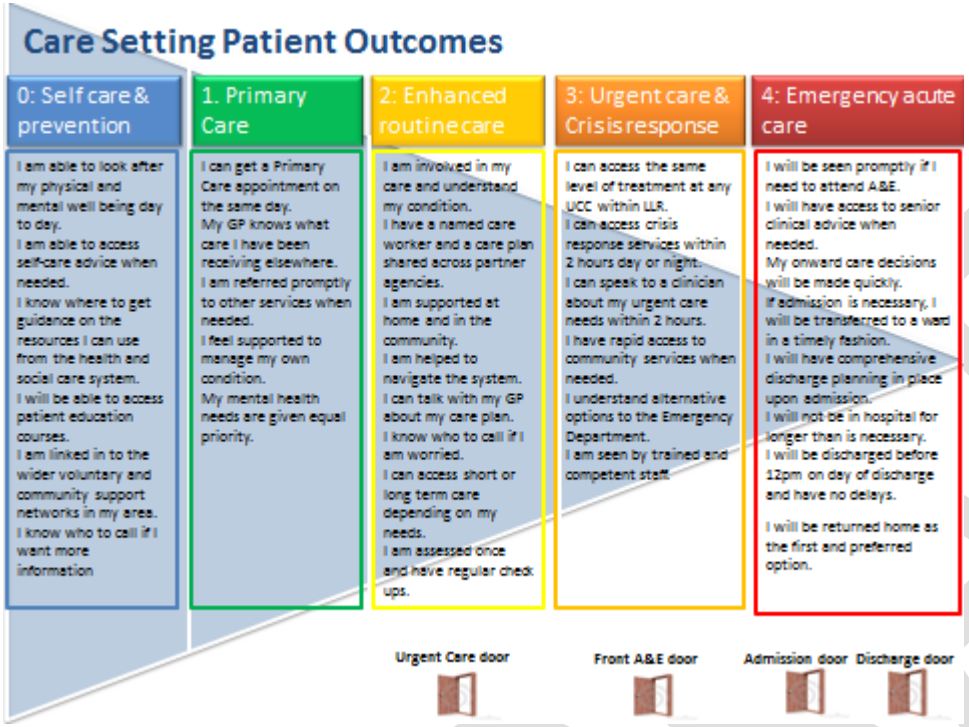
Modelling	Receives data on demand.			Receives data on demand.	ambulance services and Mental Health expertise available to NHS111 call centres.		Receives data on demand.	Receives data on demand.	

Appendix 3: System Principles (Keogh)



Care Setting Principles

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


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