UHL Emergency Performance

Author: Richard Mitchell, Chief Operating Officer **paper I**

Executive Summary

Context

We have already seen some improvements this year, including: a slight improvement in January for ambulance handovers following introduction of a new ambulance cohorting policy; Red2Green embedded across the 14 medical wards at the LRI and a clearer picture of why patients are waiting; and GPAU reducing admissions by 20 patients per day.

Despite this, we remain under acute operational pressure. This sustained and unrelenting pressure led us to cancel elective patients from 9-19 February to protect the emergency and cancer capacity. This was not a decision that we took likely, and was not without consideration of the impact on many patients and our staff.

Performance improved by 9% when we provided more beds to the medical pathway and it is essential that we urgently explore all options to balance demand and capacity in 2017/18, noting that current forecasts are for an increasing gap. The three key actions are:

- New actions to separate emergency and elective work
- New actions involving UHL working more effectively downstream (out of UHL) to care for patients in a non UHL setting
- New actions to increase our bed base, if necessary

Questions

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

Conclusion

Staff continue to work tirelessly across the system to improve the experience of patients who come to us. The refreshed RAP will give a fresh impetus to our efforts, and are designed to tackle the fundamental issues that we know need 100% focus but will bring about real, sustainable change if we can get them right. Getting them right is now even more important as we move to a new department, as we know that some of the ways we work need to change; this is our opportunity to do this.

Whilst full delivery of current actions may reduce the imbalance between demand and capacity, it is hoped the recent actions to switch an elective surgical ward to an emergency ward, has proved beyond all reasonable doubt that additional emergency capacity is required to deliver sustainable change. The switch delivered an immediate 9% improvement and I believe far more is achievable if we can embed this changes.

Our key risks remain:

1. Variable clinical engagement

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: EPB 28.3.17 & TB 6.4.17

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

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

REPORT TO: **Trust Board**
REPORT FROM: **Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT: **Emergency Care Performance Report**
REPORT DATE: **2 March 2017**

Four hour performance

2016/17 YTD

- We are treating an average of 650 patients everyday through ED, Eye Casualty and UCC at the Leicester Royal Infirmary
- 16/17 performance YTD is 78.8% and January's performance was 78.1%
- 15/16 performance YTD was 88.6% and January 2016 was 81.2%
- YTD attendances 6% up on the same period last year
- YTD total admissions are 1% higher than last year (noting the impact of GPAU)
- Last week (w/e 19/2/17) was 88.9% - best performance for a week since 27/12/15

Sustainability and Transformation Fund (STF)

January's STF was not achieved and February's will not be achieved. Struggling to deliver the emergency care STF also impacts on our ability to deliver the Cancer and RTT STF. This is impacted further by the decision taken to cancel a significant number of elective cases to protect the emergency and cancer pathways – further details below.

	STF Trajectory 4hr Performance	**Actual 4hr Performance**	STF Achieved?
Apr-16	78%	**81%**	Achieved
May-16	78%	**80%**	Achieved
Jun-16	79%	**81%**	Achieved
Jul-16	79%	**77%**	Not Achieved
Aug-16	80%	**80%**	Achieved
Sep-16	85%	**80%**	Not Achieved
Oct-16	85%	**78%**	Not Achieved
Nov-16	85%	**78%**	Not Achieved
Dec-16	85%	**76%**	Not Achieved
Jan-17	89%	**78%**	Not Achieved
Feb-17	89%		
Mar-17	91.2%		

February 2017

- Month to date – 1-19 February: 84.3%

To date, February has been another tough month up until the decision on 8 February 2017 to reduce elective work, more information below. As a Trust, we have continued to experience high emergency surgical and medical demand across all of our three sites, high ITU activity and delays in stepping patients down, patients waiting for beds longer than we want in ED, high ED and CDU occupancy, and have many patients experiencing external delays for discharge. This is despite us continuing with the red to green work across the acute medical wards at the LRI.

Reduction in elective load February 2017

On 8 February, we took the difficult decision to further reduce elective (RTT) activity across all three sites until 19 February. CMGs with a bed base were asked to:

- Stop elective (RTT) work, which is predominantly day case surgery, going through the Ambulatory Surgical Unit (ASU) at the Royal
- Reduce elective (RTT) work at the Royal, General and Glenfield if the beds could be used to support cancer or emergency flow and/ or the staff could be deployed to staff ASU overnight and at the weekends.

The planned reduction in elective (RTT) daycase work at LRI and the reduction in elective (RTT) orthopaedics work at LGH enabled us to convert the Ambulatory Surgical Unit (ASU) at the LRI to an emergency ward predominantly for medical patients. This change involved all of our CMGs working very collaboratively together and we are very grateful to all involved, especially the nurses who have transferred over from LGH. Since the change was fully embedded on Friday 10/2/17 AM we have:

- Stepped cancer patients down from ITU far quicker, which has supported our 62 day cancer backlog this week being the lowest ever (this partially is coincidence, but does support the cancer improvement)
- Far fewer delays in ED for patients waiting for beds which has contributed to much lower ED occupancy and lower wait to be seen times and lower ambulance handover times
- The team in CDU continues to work wonders and despite high admissions are receiving and caring for patients in a timely way
- On Thursday 9/2/17 we had 83 patients medically fit experiencing external delays and this reduced to 50 on 17/2/17
- Delivered 88.8% four hour performance against 79.4% for the last full week before ASU switched over (see below):

ED, Emergency CCU & Eye Casualty (Excludes pts triaged to UCC)								ED Front Door					
Day	Arrival Date	Total	> 4 Hrs	> 4 Hrs Admitted	> 4 Hrs Non Admitted	< 4 Hrs	%<4 Hrs	Total	ED Front Door >4 Hrs	ED >4Hrs Delay Rsn of ED Front Door	<4 Hrs	%<4Hrs	Total % All UHL <4Hrs
Monday	13/02/2017	421	138	77	61	283	67.22%	191	4	0	187	97.91%	76.80%
Tuesday	14/02/2017	401	106	64	42	295	73.57%	157	0	1	156	99.36%	81.00%
Wednesday	15/02/2017	383	31	16	15	352	91.91%	187	0	0	187	100.00%	94.56%
Thursday	16/02/2017	411	13	11	2	398	96.84%	194	0	0	194	100.00%	97.85%
Friday	17/02/2017	473	59	46	13	414	87.53%	188	0	0	188	100.00%	91.07%
Saturday	18/02/2017	393	68	36	32	325	82.70%	217	3	0	214	98.62%	88.36%
Sunday	19/02/2017	435	51	24	27	384	88.28%	210	1	1	208	99.05%	91.94%
Cumulative	***Mon-Sun***	**2917**	**466**	**274**	**192**	**2451**	84.02%	**1344**	**8**	**2**	**1334**	99.26%	88.83%

ED, Emergency CCU & Eye Casualty (Excludes pts triaged to UCC)								ED Front Door					
Day	Arrival Date	Total	> 4 Hrs	> 4 Hrs Admitted	> 4 Hrs Non Admitted	< 4 Hrs	%<4 Hrs	Total	ED Front Door >4 Hrs	ED >4Hrs Delay Rsn of ED Front Door	<4 Hrs	%<4Hrs	Total % All UHL <4Hrs
Monday	30/01/2017	501	146	74	72	355	70.86%	211	15	0	196	92.89%	77.39%
Tuesday	31/01/2017	456	132	83	49	324	71.05%	205	0	0	205	100.00%	80.03%
Wednesday	01/02/2017	453	106	48	58	347	76.60%	175	0	0	175	100.00%	83.12%
Thursday	02/02/2017	488	132	82	50	356	72.95%	212	1	0	211	99.53%	81.00%
Friday	03/02/2017	499	160	99	61	339	67.94%	222	1	0	221	99.55%	77.67%
Saturday	04/02/2017	423	145	88	57	278	65.72%	209	3	0	206	98.56%	76.58%
Sunday	05/02/2017	423	125	78	47	298	70.45%	217	1	0	216	99.54%	80.31%
Cumulative	***Mon-Sun***	**3243**	**946**	**552**	**394**	**2297**	70.83%	**1451**	**21**	**0**	**1430**	98.55%	79.40%

Within this upturn in performance, there is still a lot of opportunity for further improvement as performance on Monday 13/2/2017 was poor and overnight performance on 17/2- 19/2 inclusive was poor. A verbal update about this will be given in the meeting.

The above are indicators of much better quality of care to cancer and emergency patients. Unfortunately, the dis-benefit of this decision was the volume of elective (RTT) patients cancelled in advance of their day of surgery and we are very sorry to the patients who have experienced a cancellation and to the surgical and support teams who have also been affected. The decision was not an easy one but we do feel it was the right one.

What we now need to do is balance more effectively, than we have been doing recently, the needs of the emergency, cancer and elective flows on all three sites. As of Friday 17/2 we begun the process of reducing the volume of medical patients on ASU and this process will continue over the weekend with only patients with an Estimated Day of Discharge in the next 48 hours, and who meet the carefully selected clinical criteria, admitted onto the ward. On Monday (20/2) we will begin a proportion of elective work through ASU, with more elective work going through on Tuesday (21/2) and ASU will be back entirely to surgery by 0800 on Wednesday. This decision was taken in conjunction with the CMG teams and executive support.

Clearly the risk to the plan is that by reducing the medical bed base down to the number that it was before this temporary change, we will immediately begin to experience the problems detailed in the top paragraph. Whilst this is a risk, we believe the actions below plus the team work and improved morale we have seen this week, can and will enable us to deliver improved emergency and cancer care whilst continuing with elective surgery. The key actions we have committed to deliver from Monday (20/2) are:

- Continue the reduction in patients experiencing delayed transfers of care – in place
- Continue to use the discharge lounge whenever possible at the LRI and GGH and have a list every morning of patients to go to the discharge lounge
- Increased flow coordination at the LRI in medicine with senior members of the site team working with the team – this will ensure effective rapid flow
- We have reviewed our medical staffing this weekend and next week
- We will ensure GPAU is open to midnight every day next week
- We have met this afternoon with senior members of the ED management team and AMU and Specialist Medicine management team to discuss the plan and the importance of us continuing with this heightened level of working
- We have spoken to EMAS about having a HALO on site as much as possible next week

A verbal update on the above will be given in the meeting.

To put it simply, as long as we provide flow next week and the week after, ED occupancy, ambulance handovers and the wait to be seen time in ED will be managed and we believe we will continue to provide flow.

Overall lack of capacity to match demand

One of the things that has really been crystallised in my colleagues' minds and my mind over the last week is that we are so dependent on good flow to effectively care for our elective, cancer and emergency patients. As an executive team working with CMGs, we have committed this week to explore every possible step to balance our capacity and demand in 2017-18. We know we have spoken before about this and have not achieved it but 2017-18 will be different. This will involve UHL taking three key actions:

- New actions to separate emergency and elective work

- New actions involving UHL working more effectively downstream (out of UHL) to care for patients in a non UHL setting
- New actions to increase our bed base, if necessary

Other key actions in February

1. Work with the ED team and the Emergency Improvement Programme (ECIP) to understand how care and performance can be improved between 1800 and 0200

Members of the ECIP team, including an ED consultant from another Trust, undertook an overnight review of our department on 9 February. This was a very useful exercise, and the outcome from ECIP has given us a number of recommendations to take forward, including: reviewing and improving the bed management model across the Trust; working with partners to reduce the number of inappropriate referrals to ED from GPs; embedding new internal professional standards that focus on swift movement to inpatient beds when they become free; and reviewing how UCC works out of hours. We will now work with our clinical teams to develop plans based on the feedback we have received, and provide a further update to the Board in April.

2. Sustainably staff GPAU for extended periods

As discussed previously, the success of the GPAU continues. Following discussions with the medical and nursing teams, we have now agreed a model that will see the hours of the service extended both at the weekend and during the week to 11pm.

3. **Reduce ambulance handovers, including: proactive cohorting in line with the policy, continuation of GP in EMAS Fast Response Vehicle (FRV); and ensuring full usage of discharges lounges at both LRI and GH**

We have seen some improvement in handover times from EMAS. The use of the cohorting process (as outlined above), alongside the actions taken during the System Critical Incident in January will have impacted on this. Handover data (CAD+) is detailed below:

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	YTD
Ambulance Handover >60 Mins (CAD+ from June 15)	6%	6%	6%	9%	7%	9%	9%	11%	17%	13%	9%
Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)	11%	12%	10%	15%	14%	15%	18%	18%	18%	15%	15%

As outlined at the February Board, an ambulance handover improvement action plan is in place with partners, and includes actions to:

- Reduce the attendance and admissions in the Emergency Department (ED)
- Increase the size and speed of take at CDU at Glenfield
- Increase the cohorting capacity of the ED or adjacent areas
- Actions to create a ward or wards on one of our three sites where patients who are medically fit for discharge can be cared for whilst arrangements are made for their discharge
- Immediate actions to reduce external delays to the discharge of individual patients (as opposed to medium-term system improvement actions)

We expect ambulance handover performance to be better for February.

4. **Implement Rapid Flow**

Given its importance, this is now a high impact action for us. We often have unnecessarily long delays in transferring patients from the ED/CDU to a bed, so the principle of rapid flow is that as soon as a patient is discharged from the ward the patient is moved from ED/ CDU to the vacant bed. The multiple moves should occur concurrently to ensure as rapid process as possible. Rapid Flow is part of the national SAFER bundle that implements five clear steps which are proven to reduce blockages in the system and reduce mortality.

Following the initial week trial in January (during the System Critical Incident), the longest wait previously seen was two hours – this was reduced to 30 minutes using Rapid Flow. The trail highlighted the need for additional HCAs to support the process, i.e. a dedicated Rapid Flow Transfer Team led by the AMU Tracker and including some additional HCAs and existing porters. We are currently in the process of recruiting the additional HCAs; a further two week trial will then begin to test the model and implement across the pathway. By creating assessment unit and ward capacity earlier in the day, unnecessary waiting for patients who need to be admitted, will be significantly reduced.

In the meantime, we are using our daily Gold command meetings to monitor Rapid Flow. We have increased portering teams in place to provide consistent flow from ED to AMU.

5. **Red to Green**

The positive impact of Red2Green on our wards remains, despite the on-going pressures across the system, and the growing number of delays that we are seeing on a weekly basis. Complex discharges continue to be a key theme for delays; an audit of all patients waiting on 15 February showed that 77 patients are waiting a total of 512 to leave our medical wards. A significant proportion of these patients are waiting for either a social care package or funding of a Continuing Health Care (CHC) placement. This data will now be presented to the A&E Delivery Group every two weeks.

Coaching of nurses on the wards is in place, alongside daily meetings with external partners. We continue to see an increase in the use of the discharge lounge and discharges before midday, but have more work to do to sustain this across the wards. We know we have lots more to do; we are continuously refining processes as issues arise, and collaborating with our partners to tackle delays on a daily basis.

Workstreams

EQSG updates on all UHL workstreams are attached.

Changes to the Recovery Action Plan (RAP)

The RAP is structured around five key intervention areas, which follow the key interventions contained in the national guidance on A&E improvement plans issued by NHS England in August 2016. Each key intervention area has a senior responsible officer. The RAP has generated 80 actions to date of which 58 are live actions.

The RAP has been reviewed, with the aim of identifying the high impact focus areas that the system believes will, if enacted, lead to sustained improvements in handover delays and A&E performance. These focus areas have emerged from discussion at the regional escalation meetings, discussions with the RAP SROs and a review by John Adler and Tamsin Hooton. The four focus areas are:

Focus area	Key actions	Sponsor	Implementation lead
ED flow and pathways	Optimise streaming and assessment process in ED in preparation for move to new floor	Richard Mitchell	Ffion Davies
	Consistent floor management 24/7	Richard Mitchell	Vivek Pillai
	Extend hours of GPAU	Richard Mitchell	Lee Walker
Reducing ambulance conveyances to LRI	Extend 111 Green triage to 24/7	Stephen Bateman	Pauline Hand
	Explore clinical navigation in EMAS	Tamsin Hooton	Mark Gregory
	Support to onsite crews to prevent care home conveyances to hospital and ensure face to face clinical review of patients before conveyance	Rachana Vyas	Tamsin Hooton/Mark Gregory
Reduce delays within	Embedding Red2Green and tackling systemic	Richard Mitchell	Gill Staton

hospitals	delays, speeding up internal discharge processes within UHL		
	Rapid Flow – embed process using HCAs	Richard Mitchell	Julie Dixon
Improving complex discharges	Improve interface with CHC approval and brokerage	Tamsin Hooton	Noelle Royston/Julie Dixon
	Increase capacity in P2 and P3 to support discharge including discharge to access	Tamsin Hooton	Claire O'Donohue

Sponsors were asked to present how they are planning to take forward their respective actions at the A&E Delivery Board (A&EDB) in February. Presentations on the UHL actions were given at the 15 February EQSG (attached). Further work is on-going to develop a shorter action plan, which will be monitored by the A&EDB, with the original RAP actions forming an improvement plan.

Overall in February

The pressures we saw in January have not lessened in February, leading us to make the difficult decision to cancel a significant number of elective cases early on in the month. We did not make this decision lightly, and recognise the impact this has on our patients and staff. The high impact actions areas that we have agreed with the system will allow us to focus on getting the balance of emergency and planned services back on track, and embed sustainable changes to the way we do things.

There has been national media coverage this month of how some Trusts are avoiding 4-hour breaches by placing their patients on a 'virtual ward', and thereby are 'gaming' the system. Following confirmation from ED Heads of Service, assurance has been provided that this does not take place at UHL.

We must not forget that despite the challenges we face, this is an exciting time for our hospitals, as we move closer to the opening of our new ED on 26 April. As well as dealing with the day-to-day pressures, our teams are working tirelessly to prepare for the move, to ensure that, from day one, we have improved processes and ways of working that are fit for the new environment and ensure patients continue to flow through the emergency care system.

Key actions for March:

Key actions for the next month (noting they are continuing the themes from last month) include:

1. Work with ED team to implement recommendations to improve care and performance between 1800 and 0200, following the recent ECIP review of the department
2. Recruit HCAs to the Rapid Flow team to test the new model before roll-out
3. Develop Red2Green plans with RRCV CMG to roll-out at Glenfield, and continue to embed the approach with wards through coaching sessions.
4. Work with the Heads of Service to confirm plans for improving ED flow and pathways (high impact focus areas).
5. Identifying a plan to rebalance demand and capacity as detailed above.

Risks

The key risk is:

1. **Variable clinical engagement**

Noting that the actions from last week have reconfirmed, beyond reasonable doubt, that we have insufficient capacity, and that we must take every possible action including increasing our bed base, our key risk remains variable clinical engagement across the emergency care pathway.

It is also important to recognise, again, the three other risks which may increase in 2017-18:

1. We already do not have sufficient capacity to care for all our patients and the gap between demand and capacity (beds) will increase next year unless the best case scenario in contract planning occurs. This strengths the point above.
2. The gap between demand and capacity at GGH will increase in the winter 2017-18 because ward 23A will have vascular patients in it from May 2017. We need to; increase ward capacity at GGH, see a reduction in demand, further increase our discharge rate or reduce the elective work on that site.
3. We now have 65 days until the new Emergency Floor (phase one) opens and we need to balance the demand on all staff who are caring for patients on a day to day basis, alongside the need for them to be inducted and familiarised with the new department ready for them to work in it from April.

Conclusion

Staff continue to work tirelessly across the system to improve the experience of patients who need us. The refreshed RAP will give a fresh impetus to our efforts, and are designed to tackle the fundamental issues that we know need 100% focus and will bring about real, sustainable change if we can get them right. Getting them right is now even more important as we move to a new department, as we know that some of the ways we work need to change; this is our opportunity to do this.

Whilst we continue to focus on our internal actions, we are also working with LPT, EMAS and CCGs to ensure we see reductions in attendance and improved discharge processes. It is acknowledged that there is a great deal of work to be done across the system, but there is the desire and commitment to work together for the benefit of our staff and patients.

It is essential that we urgently explore the below:

- New actions to separate emergency and elective work
- New actions involving UHL working more effectively downstream (out of UHL) to care for patients in a non UHL setting
- New actions to increase our bed base, if necessary

Recommendations

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

Project UHL “front door”

November 2015 – November 2017

Dr Ffion Davies, HOS Front Door
Mrs Angie Collins, Matron Front Door
Mr Chris Barbrook, General Manager ED

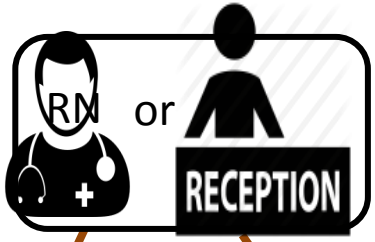
Emergency Department and Urgent Care Centre Facts

- 600 patients/day = 220,000 / year
  - **130 adult primary care = 22%**
  - 120 adult injuries = 20%
  - 220 adult ambulance cases = 35%
  - 130 children (60% ill, 40% injured) = 22%

- UCC refers 40% patients on to ED
- These cause a lot of breaches, especially >7pm
- Not counted in UCC stats, hence 99% 4H performance most of time
- Accounts for an average of 26 “ED” breaches every day

OPTIONS FOR STREAMING MODELS

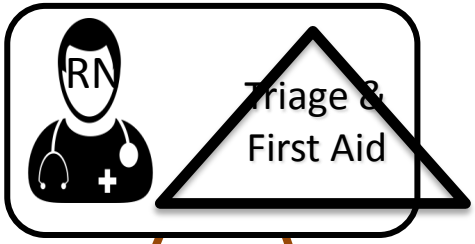
1. STREAMING ONLY



CO-LOCATED PRIMARY CARE

EMERGENCY DEPARTMENT

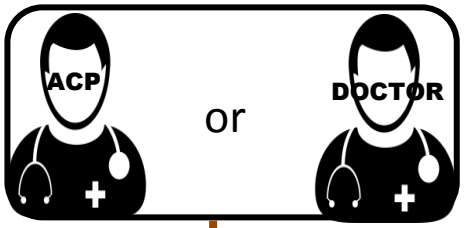
2. STREAM + TRIAGE



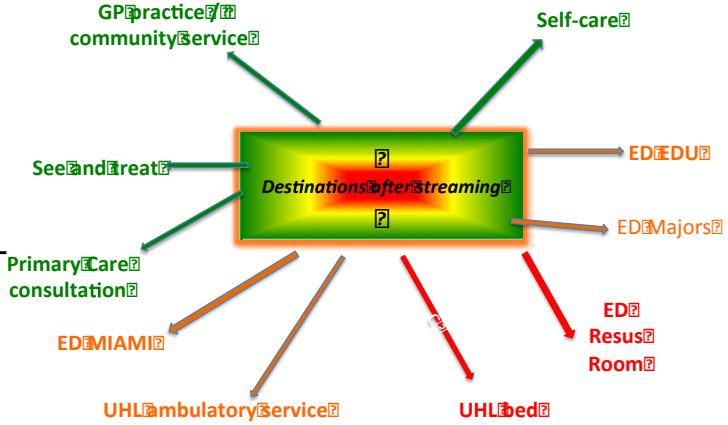
CO-LOCATED PRIMARY CARE

SPECIFIC AREA WITHIN EMERGENCY DEPARTMENT

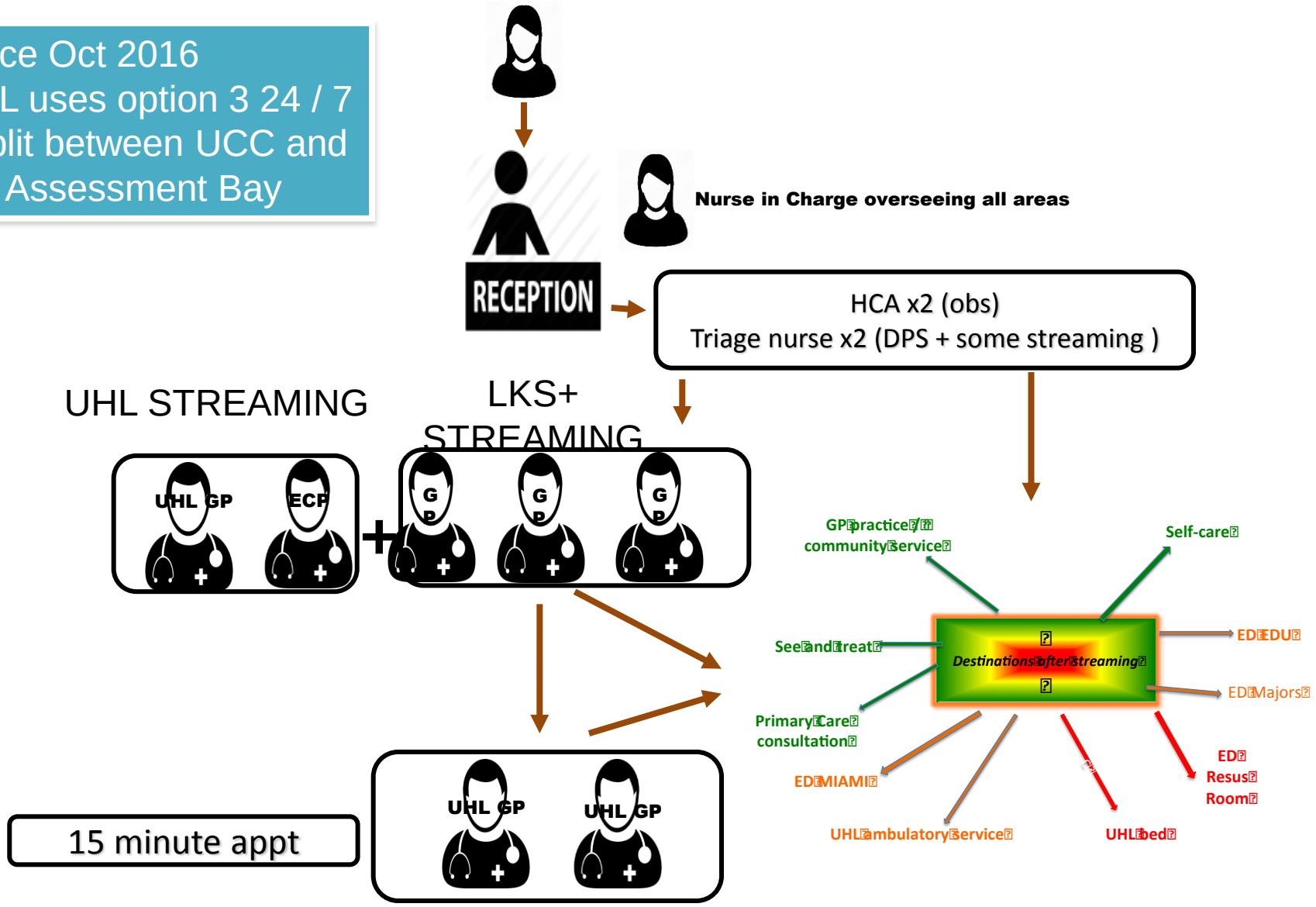
3. STREAM + TREAT OR DEFLECT



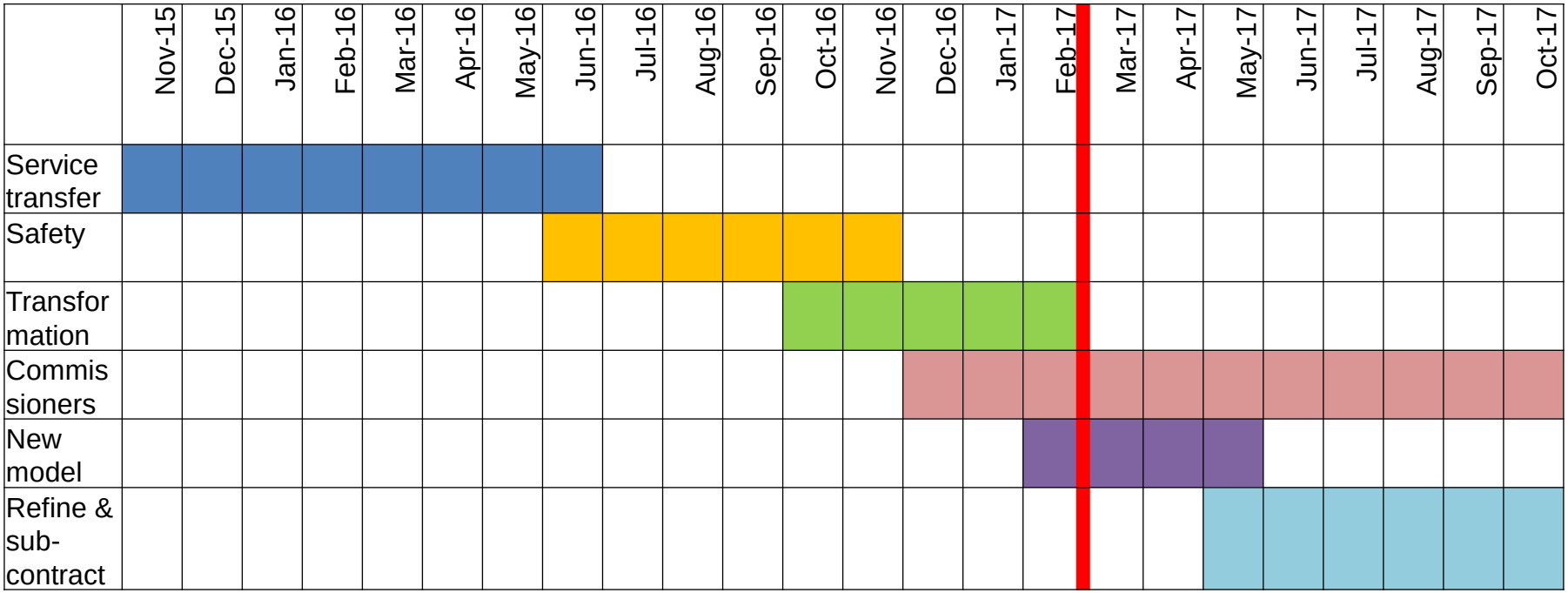
RANGE OF OTHER OPTIONS



Since Oct 2016
UHL uses option 3 24 / 7 - split between UCC and ED Assessment Bay



Project phases



Phase 1 Nov 15-June 16
Service transferred GEH to UHL with minimal preparation

- Inherited GEH staff, contracts, modus operandi
- Major HR issues
- High agency usage
- High numbers of complaints
- Poor reporting culture for incident forms
- Overcrowding, frequently patients waiting to be moved to ED
- Triage DPS scores done late, and not based on any facts
- Very poor morale
- Unsafe and inefficient

Phase 2 June 16-Nov 16
Establishing patient safety

- HOS, Matron and Service Manager appointed
- Senior HR manager to oversee and advise
- Triage moved from behind public desk to formal triage station
- Triage must include proper DPS (pt obs)
- Very proactive recruitment (nursing & medical)
- Co-ordinator and NIC roles established
- Staff trained in Datix
- Clinical governance review set up monthly and 2-monthly team updates
- Background work on new model of care and beginning of commissioner engagement into the vision for the new ED

Phase 3 Oct 16-Feb 17
Service transformation

- SOPs and role cards
- Training in escalation
- Changing culture – escalation/incident reporting as a positive action
- Successful recruitment of substantive staff with reduced agency dependence (support staff, nursing & medical)
- Lead GP post advertised (to support HOS)
- Integration with management structure of ED (included in DIC & NIC walk-arounds, use of ED Tracker, use of Duty Manager)
- Performance management of some individuals
- Support of ACPs to consolidate competencies outside the UCC (in ED Minors/Majors/Assessment Bay)

Phase 4 Dec 16-Oct 17
Defining the commissioned service model

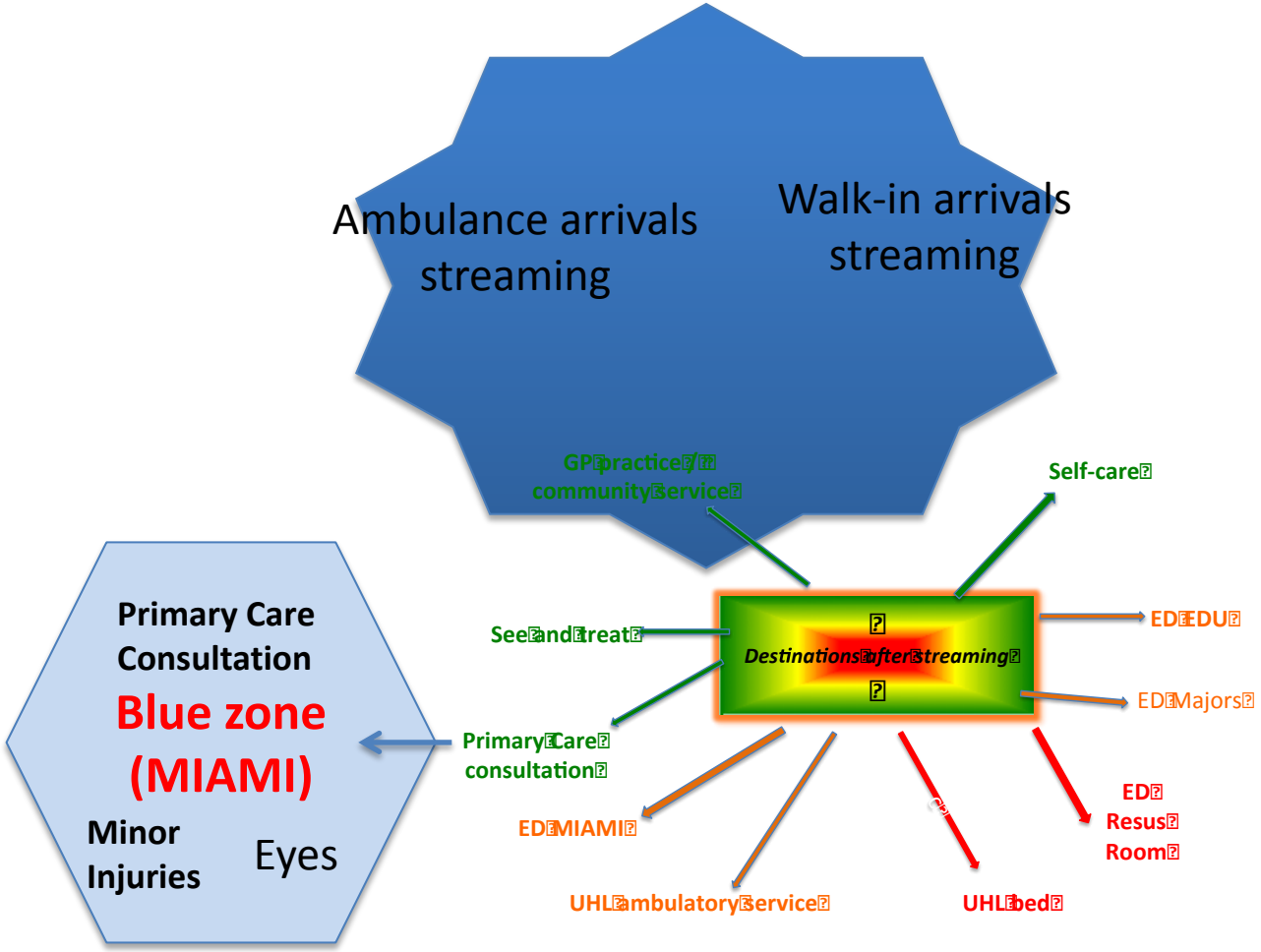
- Demonstration to commissioners of the new model of care
- Lakeside Plus PLC contract extended to support streaming until October 2017
- Role of procured primary care partner defined and agreed bilaterally, service specification finalised Feb 2017, likely implementation November 2017
- Service model for streaming tested nationally and highly regarded as at the forefront of streaming capability (aided by our size which forms a critical mass of front door staff 24/7 and high versatility)

Phase 5 Feb 17-May 17
Move to new service model

- 26th April new ED opens with no defined UCC
- UCC functions split into 3:
  1. Streaming (integrated walk-in and ambulance arrivals in the new Assessment Zone)
  2. Primary care stream of adult ED (within Blue Zone)
  3. Streaming and primary care stream of Paediatric ED
- Requires a high proportion of substantive staff
- Requires re-training of ED nurses to do high-level streaming (skill lost since front door transferred to GEH 4 years ago)
- Will require careful consideration of Lakeside Plus role
- Workforce calculations/rotas being worked up
- Conversion of GP posts to ANP posts

The Front Door in the new Emergency Floor

NB paeds ED similar



Phase 6 May 17-Oct 17
Refining new ED processes & choosing a primary care partner

- Initial Assessment Zone (streaming), Majors and Blue Zone will work flexibly in their roles, depending on patient flow and area occupancy/capacity
- New eye service will need to bed in
- Re-skilling nurses in streaming will take time
- Effective streaming depends on FLOW
- GP OOH service may become integrated?
- Interviews for new primary care partner to be led by UHL, with commissioners participating in the decision

Threats / asks

- Authority to disentangle and set up ED cost codes to clearly identify:
  - ACP staff (mixture of 3 current staff groups amalgamating)
  - GP staff (mixture of 4 current staff groups amalgamating)
- Following this, permission to use medical and nursing budgets as one pool of finance for 6-12 months, and change funded establishment in line with service need (within same total budget)
- Clarification of GP OOH provider and location
- Clear tasking of better metrics provision from IM&T – data held on SystmOne and Nerve Centre, so very difficult to obtain KPI's – no in-house skills or ownership of SystmOne data

ED PROCESS UPDATE- Nights

WHAT IS PERCEIVED

- Increased cycle time
- Delays in being seen
- Decreased process compliance
- Deterioration in the measures of performance

Majors is the holding point for most ED processes at night

- Time to be seen in Majors is the measure of other process that go before it
- All other metrics in Majors follow on sequentially from this
- Current metrics only describe what's happening in Majors in broad terms – “here and now”

Night shift

- Deterioration in performance is predictable
  - At 2300 hours a crowded department with a long wait to be seen usually gets worse.
  - Day shift performance predicts the incoming night
  - Assessment and UCC delays add up
- Staffing is based on having a “good” department at 2300.
- Footprint is designed to shrink
- Escalation plans don’t survive 0300

Challenges/Barriers

- Things we can't change.
  - Ambulance inflow patterns
  - Bed availability patterns are variable and happen at odd hours
- Things we can change
  - UCC flow patterns
  - SOPs don't bed down-why?
    - Change fatigue
    - Drift
    - Ownership
  - Escalation usage
- Historically-ED reacts to external process/pressures
- Metrics-measuring what we actually need in order to improve

Next ED actions

- **SOPs for key roles-**
  - Version 2 of doctor in charge
  - Majors coordinator
  - NIC is complete and awaiting sign off
  - Escalation criteria being modified-owned by majors nursing and medical team members
  - Resus Hot Bed SOP being finalised

- **SOPs written and owned by team members** rather than top down

- **Defining the Normal way of working and embedding it**
  - Monitoring usage of the SOPs for leadership roles
  - ED Red to Green (currently being directed by ECIP)

Long term ED plans

- Decreasing processing/cycle time
  - Availability of clinical information, Resource Directory
  - Interface with specialities- watershed policy, no barriers policy
  - Induction and Handbooks- " This is how we do things here"
  - Education- "Ensuring Right Place First Time"

- Measuring for improvement
  - Measuring the right process
  - Evidence based change for improvement

- Proactive rather than Reactive mindset

External Help outside of ED

- Access to data streams
- Reducing crowding
  - Red to green
  - Watershed and Admissions Policy in general and for specialist areas
  - Flex areas and Swing wards (esp. after new build)
  - Escalation process that accounts for variability
- Closer working with specialities
  - In-reach and patient ownership
  - Professional standards

Threats

- SOPs in ED don’t correlate with DM and SMOC SOPs/role cards
- Data streams
- Senior Decision Maker numbers
- Key staff members not being released

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Caring at its best

Reducing Internal Hospital Delays

Red2Green – Update 10th Feb 2017

One team shared values

Update of Week 9

- We planned:
  - to pilot sustainability model moving to a twice weekly escalation of 'Red' external delays with partners as opposed to daily. With internal delays managed by the Flow Co-ordinators and CMG.
  - Red2Green team to focus on staff coaching and reviewing the stranded patient
- After day two we reverted to daily calls with partners due to:
  - the growing number of delays
  - staffing shortages within the Bed and Flow teams the Red2Green team supported the wards with delays as previous weeks
- Agreed Definitive Metrics that we would Monitor Monthly

Red2Green Metrics

Overview – Period 01/11/2016 – 06/02/2017

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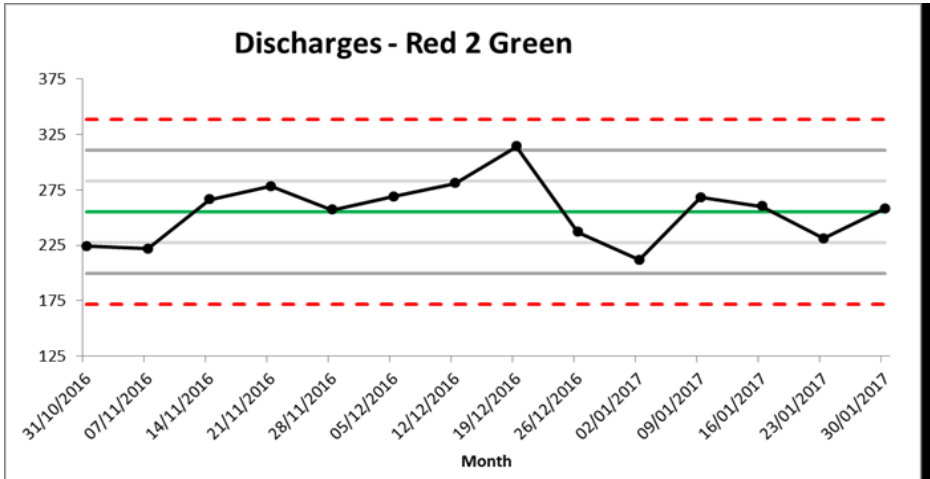

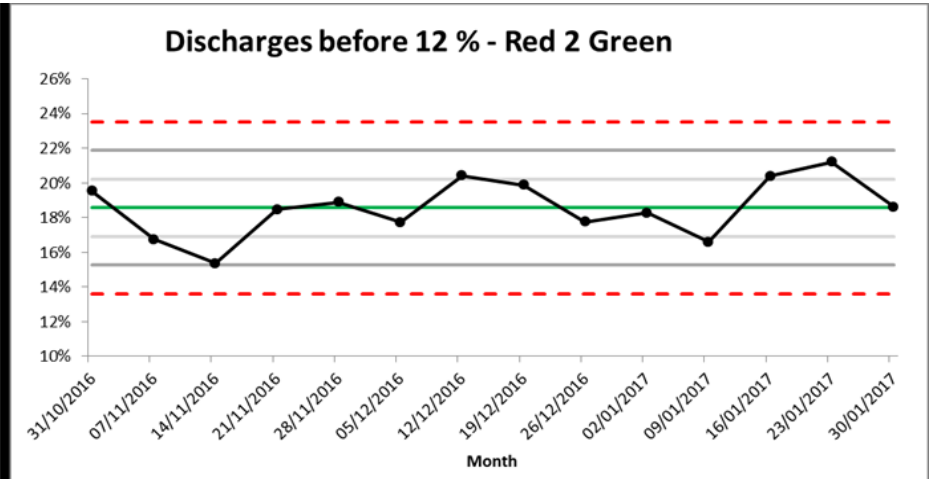

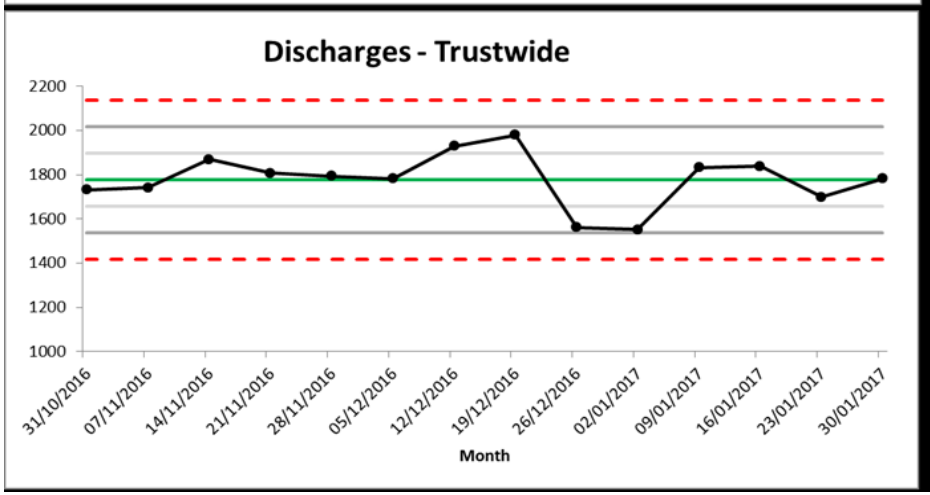

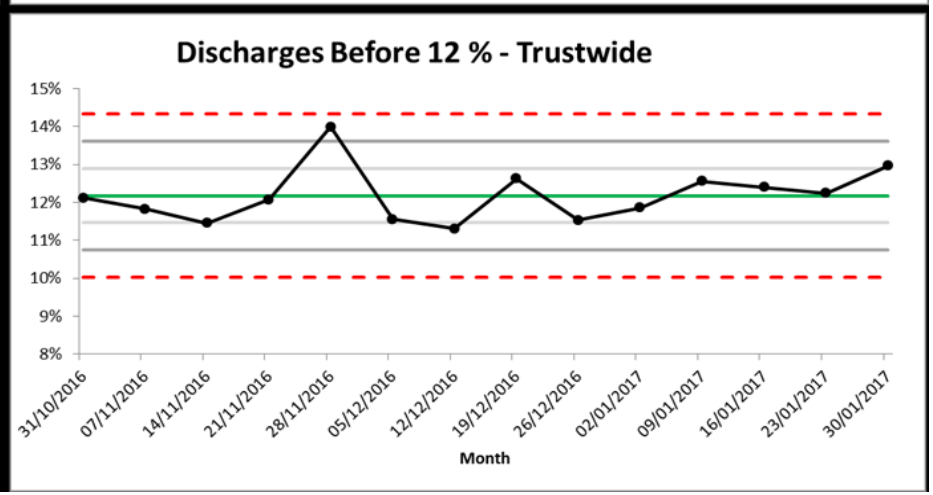

One team shared values

Red2Green Metrics Continued

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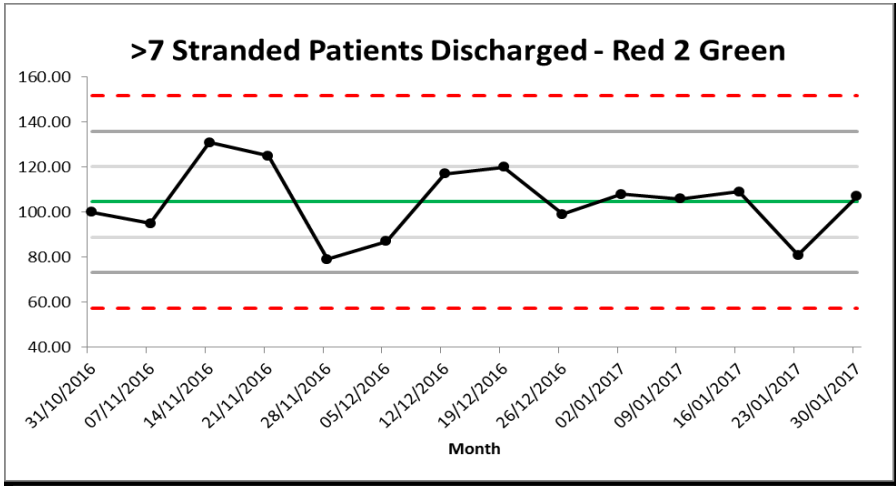

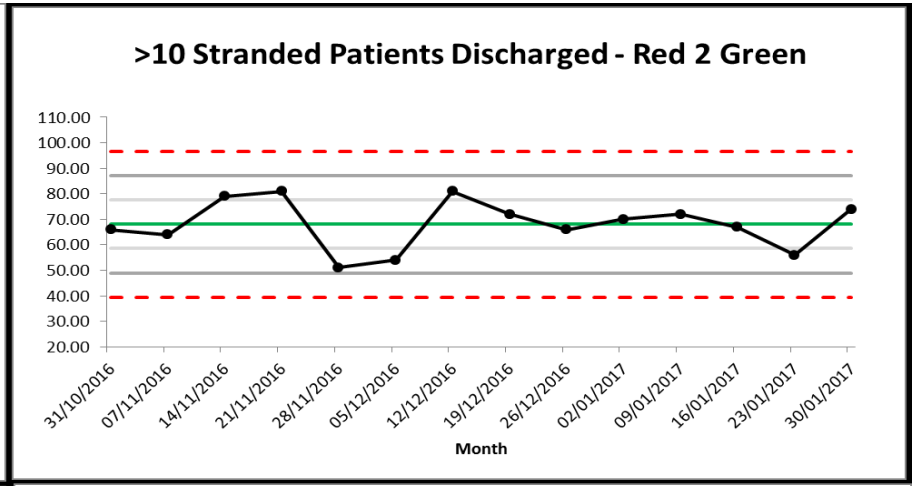

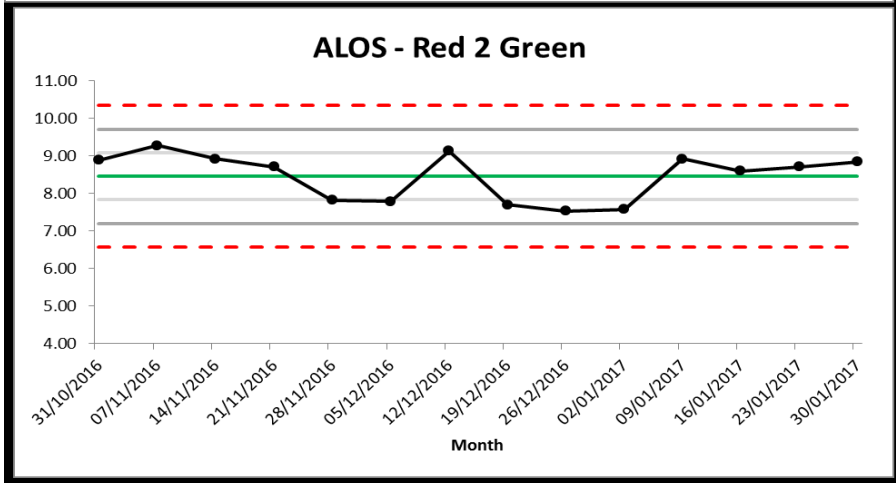

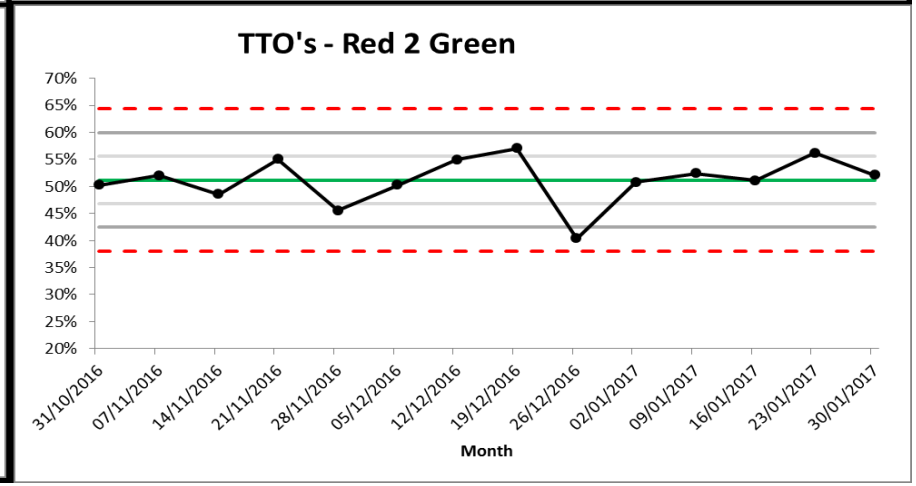

One team shared values

Red2Green

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Caring at its best

WEEK	AM RED	PM RED	PM RED2GREEN
16th - 20th Jan	73%	24%	75%
23rd -27th Jan	73%	21%	79%
3oth Jan- 3rd Feb	79%	25%	74%

One team shared values

TOP 3 Morning ‘RED’ reasons

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10AM REDS 16th -20th January	10AM REDS 23rd - 27th January	10AM REDS 30th Jan- 3rd Feb
Medical review	Medical Review	Medical Review
Complex Discharge	Complex Discharge	Complex Discharge
Specialist Review	OT/PT	Imaging

One team shared values

TOP 3 Afternoon 'RED' reasons

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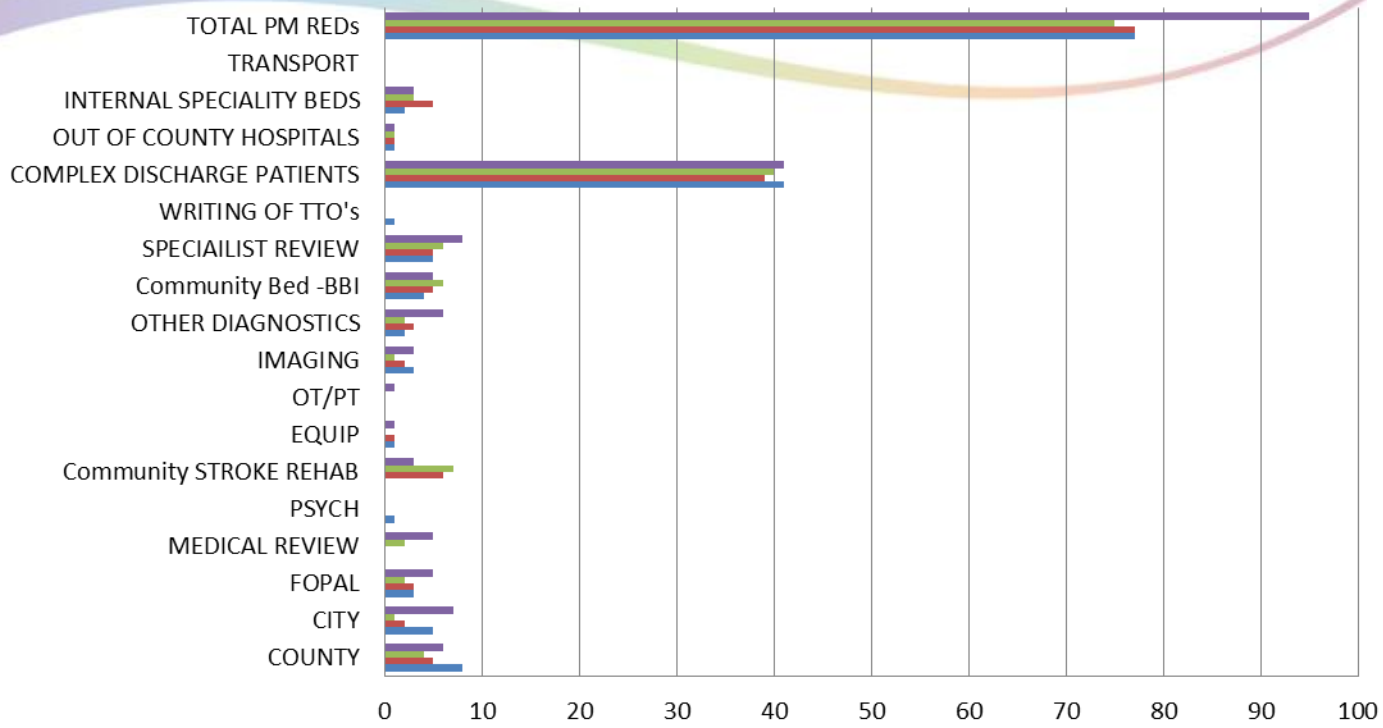
PM REDS 16th -20th January	PM REDS 23rd - 27th January	PMREDS 30th Jan- 3rd Feb
Complex Discharge 32 beds /10%	Complex Discharge 25 beds/ 8%	Complex Discharge 40 beds/13%
Community Hospital BBI 8 beds/3%	County Packages of Care 4 beds/1%	Specialist Review 6 beds/2%
Community Stroke Rehab 6 beds/2%	Specialist Review 4 beds/1%	County Packages of Care 5 beds/2%

- Average number of beds lost per week our of total beds (305)

One team shared values

PM SNAP SHOT OF RED PATIENTS 30th January - 3rd Feb



	COUNTY	CITY	FOPAL	MEDICAL REVIEW	PSYCH	Community STROKE REHAB	EQUIP	OT/PT	IMAGING	OTHER DIAGNOSTICS	Community Bed -BBI	SPECIAILIST REVIEW	WRITING OF TTO's	COMPLEX DISCHARGE PATIENTS	OUT OF COUNTY HOSPITALS	INTERNAL SPECIALITY BEDS	TRANSPORT	TOTAL PM REDs
THUR	6	7	5	5		3	1	1	3	6	5	8	0	41	1	3	0	95
WED	4	1	2	2	0	7	0	0	1	2	6	6	0	40	1	3	0	75
TUES	5	2	3	0	0	6	1	0	2	3	5	5	0	39	1	5	0	77
MON	8	5	3	0	1	0	1	0	3	2	4	5	1	41	1	2	0	77

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Caring at its best

One team shared values

Improved Use of Discharge Lounge

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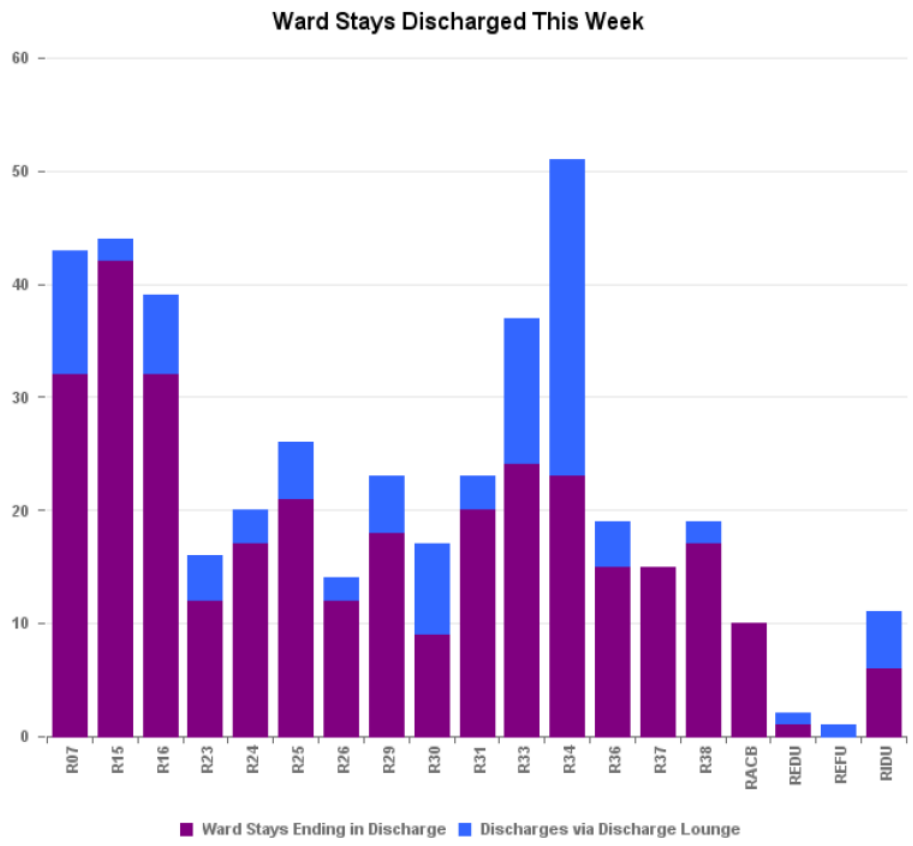
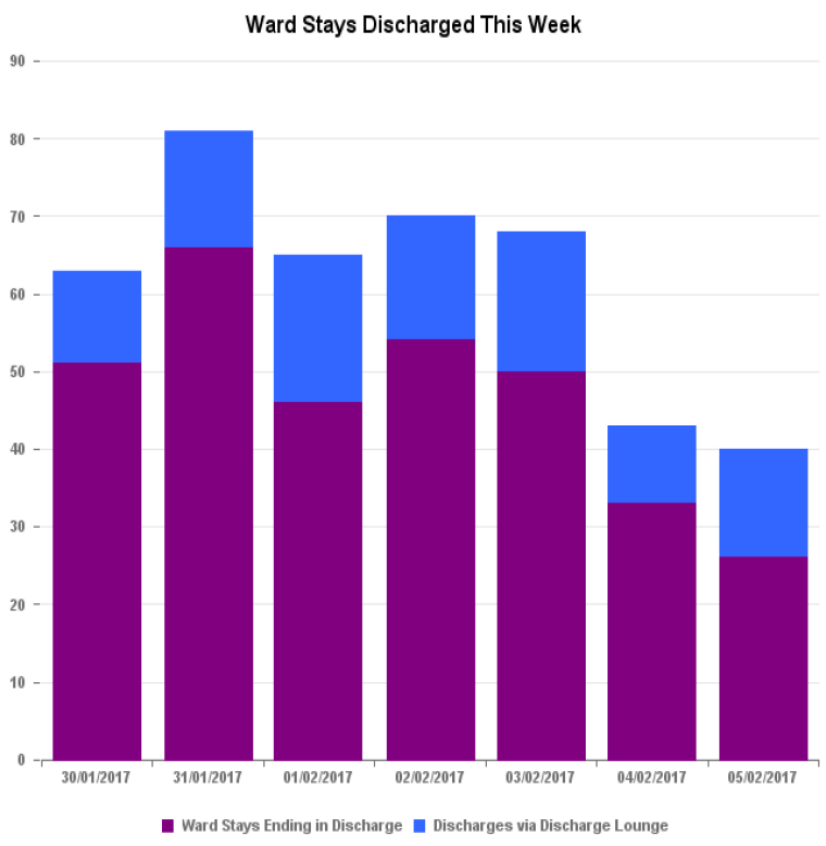
Ward Stays Ending in Discharge

Week Ending Sunday, 5 February 2017



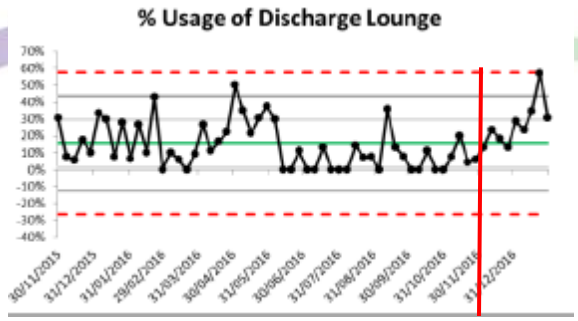
Ward Stays Ending in Discharge

Week Ending Sunday, 5 February 2017

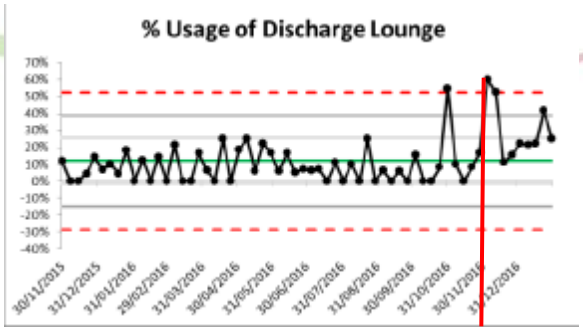


One team shared values

Ward 23



Ward 29



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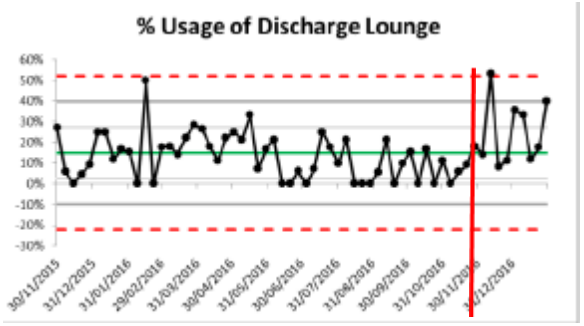
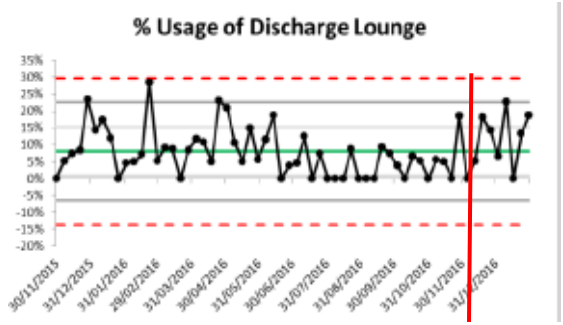
Caring at its best

IDU



Ward 24



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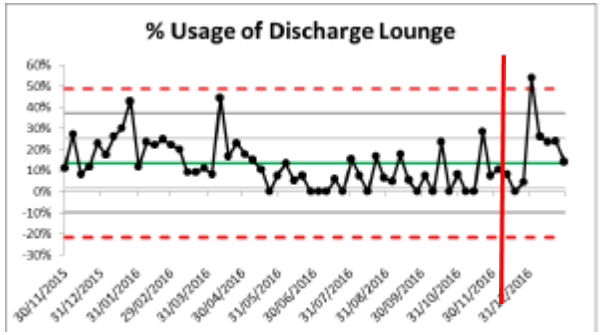
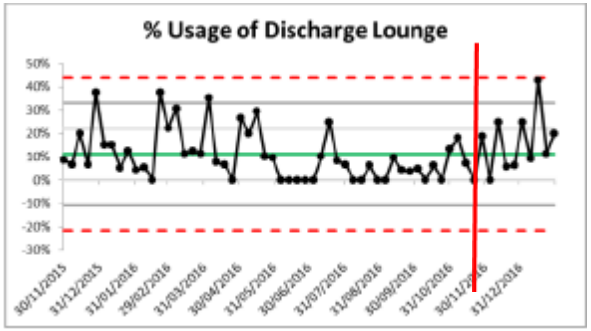
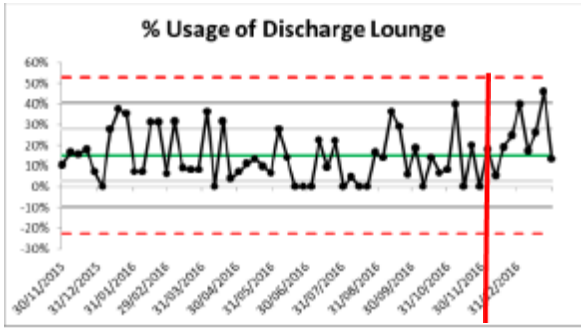


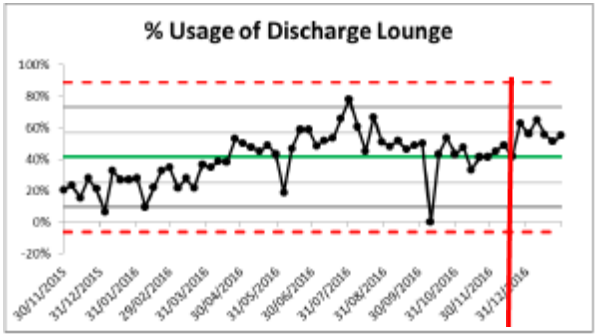
Ward 25



Ward 38



Ward 34



One team shared values

Improved Discharge Before 12

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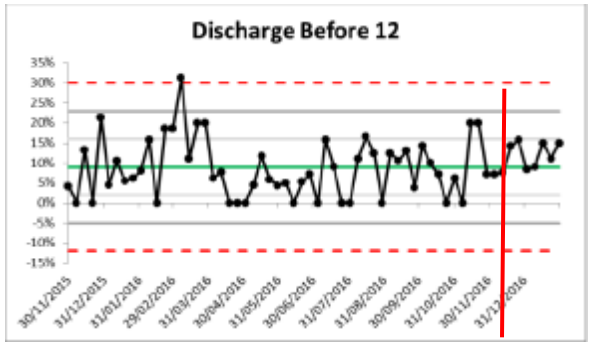
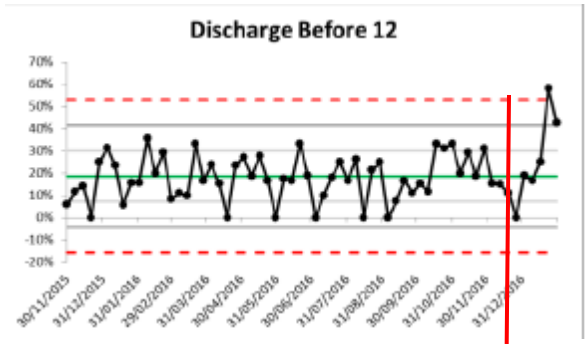
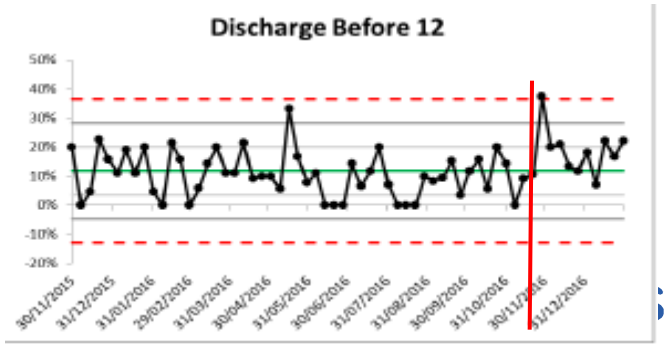
Ward 25



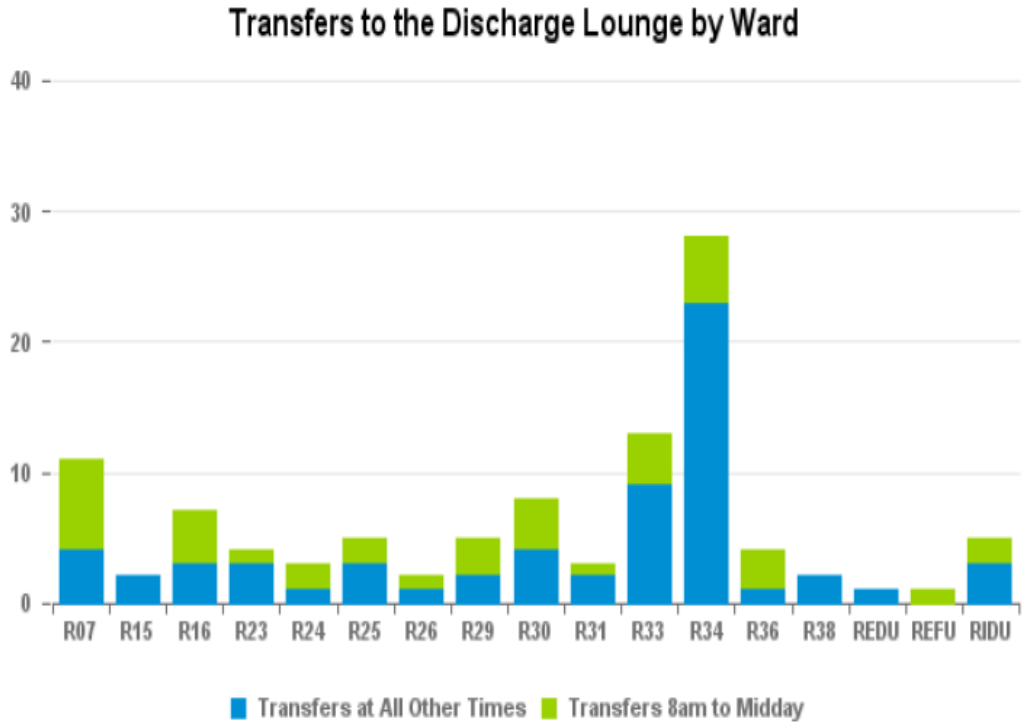
Ward 30



Ward 36



Week Ending Sunday, 5 February 2017



Use of Discharge Lounge

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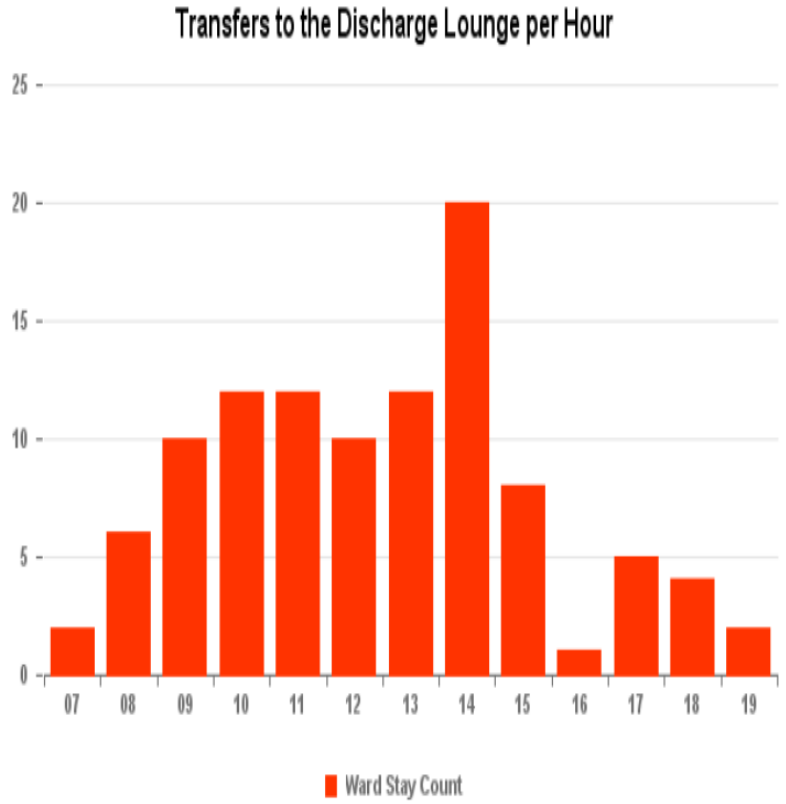

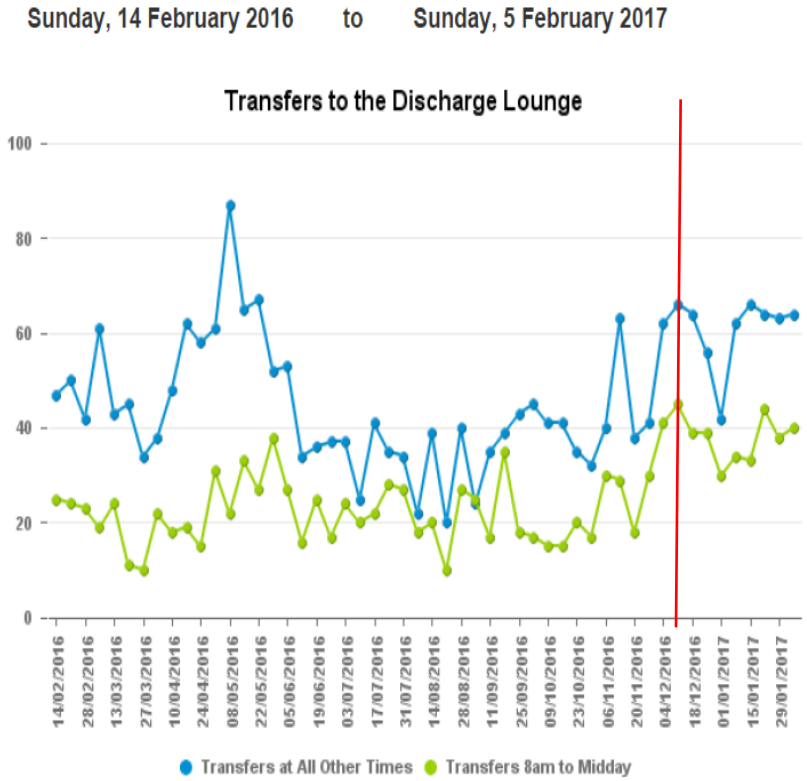

One team shared values

Reduction in Length of Hospital Stay/ Stranded Patients

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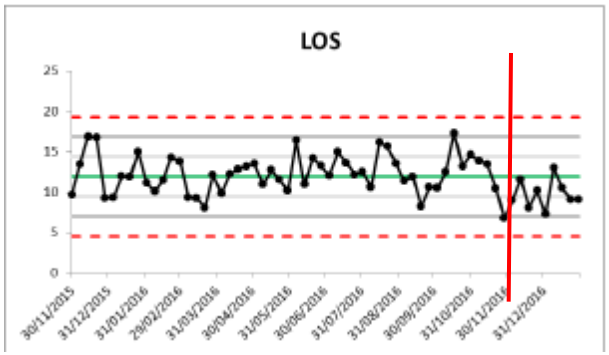
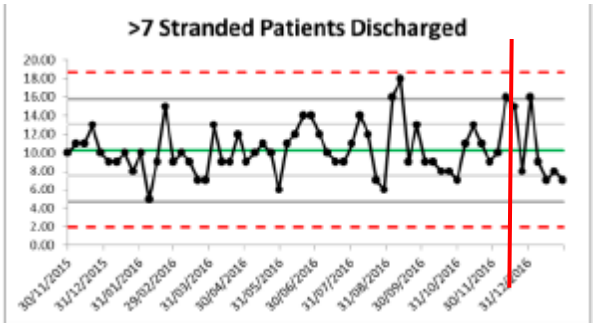
Caring at its best

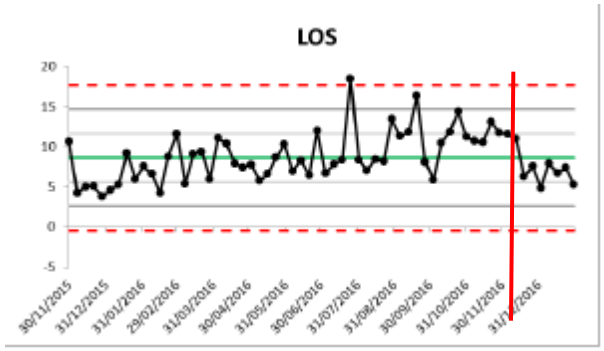
Ward 31



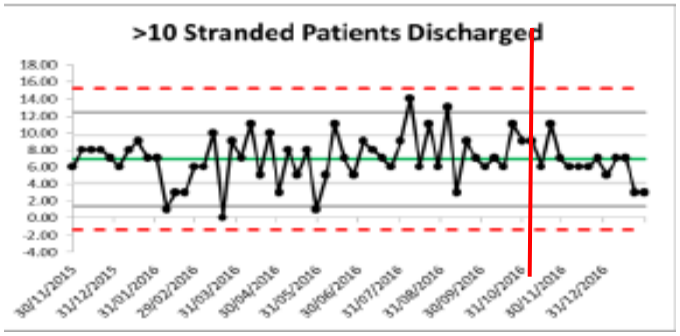
Ward 31



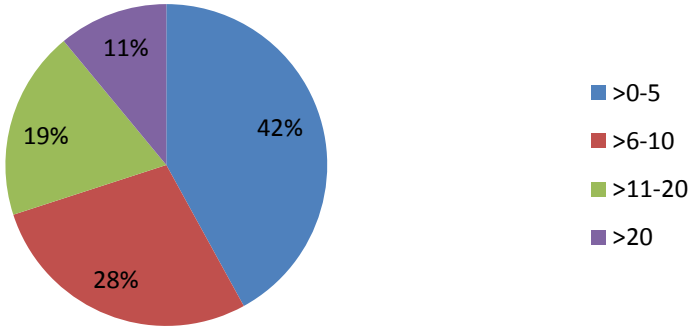
Ward 26



Ward 23



R2G Ward % of Patients LOS - Snap Shot Monday 30th January 2017



30% Patients Stranded

Patient Involvement

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One team shared values

4 Key Questions Audit

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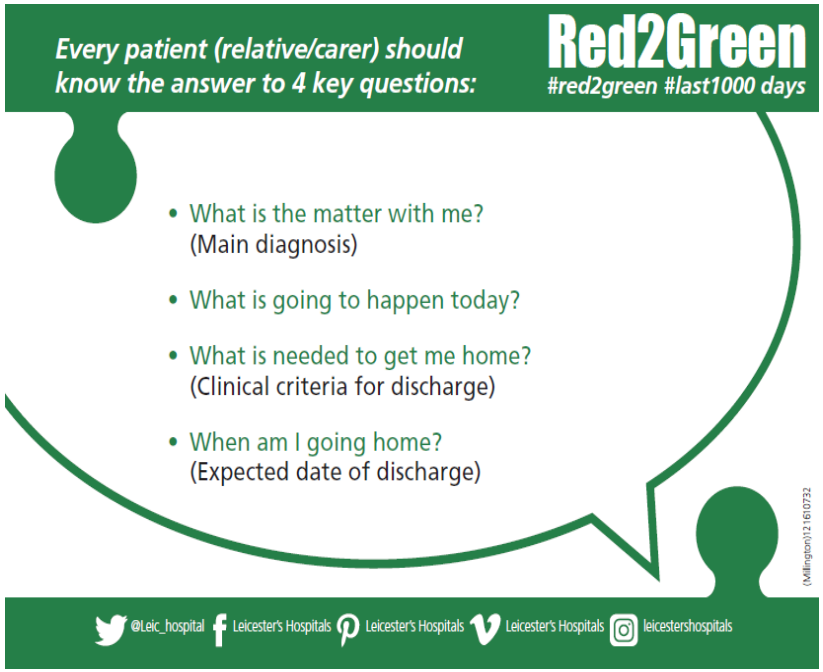
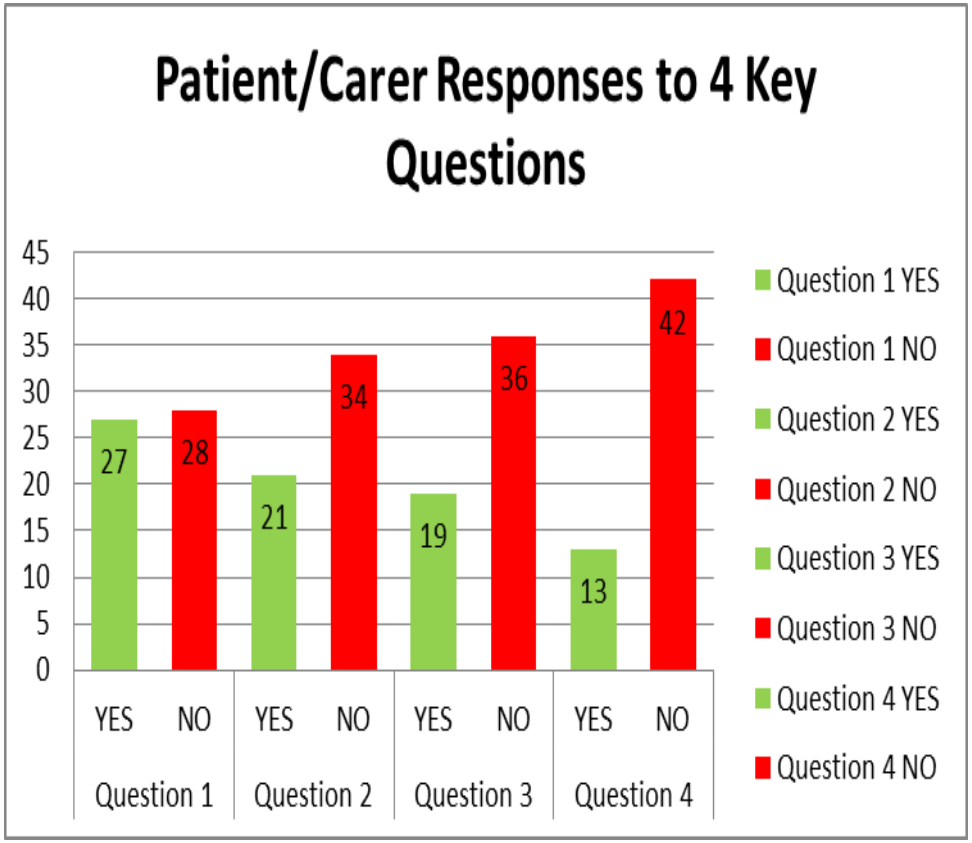
50 Patients/Carers responses to the 4 Key questions





One team shared values

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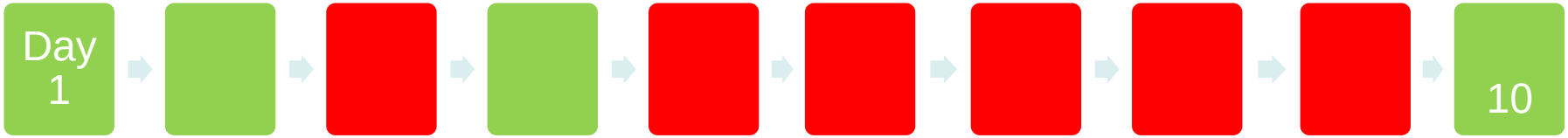
PATIENT STORY
-JOAN's Story



One team shared values

Joan was transferred to UHL from one of our Community Stroke Rehabilitation wards as an elective admission for a Radiologically Inserted Gastrostomy (RIG) that day.

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Joan was admitted to the ward and had pre-procedural bloods taken prior to the procedure. Unfortunately the blood test results showed that Joan had a low blood potassium level, so the RIG procedure could not be undertaken and was cancelled. Treatment was commenced to correct Joan's low potassium level.

The next day Joan continued on her treatment to correct her potassium levels and was prepared for the RIG procedure which had been rescheduled for the following day.

Despite Joan being prepared for the Rig procedure, it did not happen. It is documented in Joan's notes that it was cancelled as either 'the previous case took longer than expected' or it was cancelled by mistake'

Joan was prepared again the next day for the RIG which finally took place in the afternoon. The medical plan was for Joan's bloods to be rechecked in the morning and if satisfactory Joan would be transferred back to the Rehabilitation ward she was transferred from. (Her bed have been saved for her.)

The next morning (Saturday) on checking the site of the RIG the nurse noticed that the suture had become loose and the RIG had been displaced- this was secured with tape and a request was made for a medical review. Joan's discharge was stopped and the plan was to await a gastro review. Discussion was had with the Gastro Registrar on call and it was felt unsafe to feed Joan through the RIG so a nasogastric tube was reinserted to ensure that Joan could be fed. Joan would have to wait until Monday to see the Nutrition Team.

On Monday Joan waited for the nutrition nurse. To come and see her. It is documented that the team tried to bleep the nutrition team twice and left a voicemail. The ward SHO spoke to a Radiologist from the department where the RIG was inserted. It is documented that; 'if the nutrition team have concerns with the RIG then they should come and speak to me in person'

The next morning the nutrition team where chased again to review Joan . At 14.30 hours after discussion with the radiologist a discussion was made that the RIG could be used. Joan was re-referred for a community stroke rehab bed and was transferred back the next morning.
Joan was expected to have a length of stay of 24-48 hours instead her stay was 10 days.

Next steps

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Caring at its best

- Move towards ward based collection of ‘Red’ patients by Flow team - Only monitor Red2Green one week per month.
- Continue to coach and empower staff in the use of nerve centre – update fields twice per day.
- Undertake a deep dive into ‘stranded patients’
- Work with staff to promote morning discharges and earlier usage of the discharge lounge.
- Meetings planned with CMG HON’s end of Feb - mid March re Roll out plans.
- Review/ Update and undertake actions from action plan

Leicester, Leicestershire and Rutland Urgent Care Network

High Impact & Improvement Action Plan

Version: 11 (revised to split HIAs and IAs)
Last updated: 23rd February 2017 **By who:** Tim Slater (updated format)
Approval date: **By who:**

Improvement Plan Programme Structure

Workstream	Sub-workstream	SRO	Medical Lead	Link to National Actions	Link to SAFER bundle	SRO Update	Link to LLR Risk Register
Minimise presentations at LRI campus		Rachana Vyas	Dick Hurwood	2 (111)		13/1/17 S Smith	CL1, CL2
Improve ambulance response and interface		Mark Gregory		3 (Ambulance)		20/2/17 M Gregory	CL2 - reviewed by MG 29/12/16 and no change
Improve the LRI front door	Streaming and Assessment	Lisa Gowan	Ursula Montgomery, Ffion Davies	1 (Streaming)		21/2/17 R Pepper	
	Ambulatory care	Lisa Gowan	Vivek Pillai, Lee Walker	1 (Ambulatory care)		21/2/17 R Pepper	
Improve ED flow	Adults	Julie Taylor	Vivek Pillai	4 (Flow)		21/2/17 R Pepper	
	Children	Julie Taylor	Sam Jones	4 (Flow)		21/2/17 R Pepper	
Improve Ward Flow	Assessment units	Julie Taylor	Lee Walker	4 (Flow)	**S F E**	21/2/17 R Pepper	
	Base wards	Gill Staton	Rachel Marsh	4 (Flow)	**S A F E**	21/2/17 R Pepper	
Improve CDU Flow		Sue Mason	Caroline Baxter	4 (Flow)		21/2/17 R Pepper	
Improve discharge processes		Tamsin Hooton		5 (Discharge)	**R**	20/2/17 C O'Donohue	CL3
Overall lead for UHL-led workstreams		Sam Leak	Ian Lawrence				

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

LLR High Impact Actions **Updated: 21/2/17**

Focus Area	Key Actions	Specific milestones/deliverables	Delivery Date	Link to RAP KIAs	AEDB Sponsor	Implementation Lead	Metric	Status	System Support required
ED flow and pathways	Optimise streaming and assessment process in ED in preparation for move to new floor	• Rapid assessment test needs to be consistent which is variable. • Functionality of departments, GP, UC booking in a timely manner. • Further actions to be developed via EQSG. • Medical leadership deficit is apparent.	26/04/17	KIA1	Richard Mitchell	Ffion Davies			ECIP support, Direct booking into City Hubs, Lakeside, EMAS conveyance to UCC
	Consistent floor management 24/7	• Vivek Pillai presenting proposal to EQSG with a plan to reduce the variance and behaviours however these are very wicked issues. • Ben Owens ED consultant from Sherwood Forest Hospital is current working with medical leaders with a view optimise and align the ED pathways and UCC with other departments as these are currently	31/03/17	KIA 1 and 4	Richard Mitchell	Vivek Pillai			ECIP support
	Extend hours of GPAU	• Increase in consultants SPR and nurses within GPAU until 11pm • Overnight services to be provided by junior doctor and nurse are proposed within the model. • Proposal is being presented at EQSG for sign off however cost pressures are indicated for next year.	31/03/17	KIA 1	Richard Mitchell	Lee Walker			none
Reducing ambulance conveyances to LRI	Extend 111 Green triage to 24/7	1st – 28th February 2017 : DHU to continue with the Phase One Pilot of Green 2 Ambulance Re-triaging by Clinical Advisors 1st March 2017 : Date confirmed when Lincolnshire CAS have agreed to take appropriate clinical calls as per commissioned NHS111 service 1st - 31st March 2017 : DHU 111 to increase the Clinical Advisor resources allocated to the Phase Two Pilot of Green 2 Ambulance Re-triage to cover 7 days a week. 1st April 2017 – East Midlands NHS111 Commissioners contract variation for DHU 111 to undertake Clinical Re-triage of ALL appropriate Green 2 Ambulances (to be confirmed in writing) Evaluation of Green 2 pilot (i.e. Clinical, Operational & Financial) Implement key learnings (e.g. training, UXL, NHS Pathways) Understand and forecast impact on wider urgent care systems, UCC, WIC, MIU, OOHs, GP In-hours	01/03/17	KIA 2	Stephen Bateman	Pauline Hand			Lincolnshire to reduce reliance on DHU staffing, support from Regional commissioners
	Explore scope for further clinical navigation in EMAS of Green ambulances	ORH review of Hear and Treat levels GP/CCG visit to EMAS EOC CCG/Clinical visit to EOC room	Complete initial visit 3/2/17 Further visit planned by 3/3/17	KIA 2	Tamsin Hooton	Mark Gregory			ORH review suggests that LLR levels of hear and treat may be current maximum. If this areas is going to progress, would need sign off of clinical governance and patient safety of further triage of Green calls. Input from GPs and NHS E required to establish pathway. Exploit links between NHS 111 and EMAS to increase activity in clinical navigation hub.
	Support to on site crews to prevent care home conveyances to hospital & ensure face to face clinical review of patients before conveyance	Info requested from UHL, LPT & EMAS regarding no. of referrals w/o a F2F GP review. LPT still reporting only one patient, UHL may be unable to retrospectively report as captured as free text within patient notes, EMAS have not yet reported but may be in the same position as UHL. Dr Hurwood writing a presentation for each of the three CCGs PLT in March 2017 to cover (1) the need for a F2F clinical review in hours (2) the pathway(s) for OOH (3) the use of Consultant Connect (4) the 24/7 home visiting service from April 2017 **Measure of success: UHL, LPT & EMAS to be able to report monthly on the number of patients not receiving an appropriate review and the corresponding registered GP practice**	LC CCG 15/02/2017 ELR CCG Mar 2017 WL CCG Mar 2017	KIA2/3	Rachana Vyas	Tamsin Hooton/Mark Gregory/Sue Jevons			Clinical resource to be identified to be located in EOC, may require funding. Rapid response from GP/OOHs/SSAFA or community teams.
Reduce delays within hospitals	Embedding R2G and tackling systemic delays, speeding up internal discharge process within UHL	This is currently on track and R2G being embedded in key UHL wards. Update provided to AEDB 15/2/17 with KPI data included.	15/03/17	KIA4	Richard Mitchell	Gill Staton			Links to discussions about restructuing UHL discharge team/process incl PCC and CHC. Needs right level of reporting of R2G issues and esp stranded patients to the AEDB and DSG
	Rapid Flow - embed process using HCA	Red2Green is method of reducing delays by days effectively and improving the patient experience this is being conducted by using discharge lounge and becoming reliant on portering and HCA services. A further cohort of HCA's are being trained and an actions plan will be developed to show progress.	31/03/17	KIA4	Richard Mitchell	Julie Dixon			none
Improving Complex Discharges	Improve interface with CHC approval and brokerage	i) Share daily tracker of CHC patients and where they are on the timeline. ii) Reinstate daily conf call at operational level to pick up on individual issues, post R2G meeting. iii) Identify sufficient capacity within UHL assessment process to complete DSTs in timely way up to end of June mobilisation of end to end process. iv) agree interface between UHL discharge and R2G process and new CHC end to end process (for mobilisation from 1st June) v) Discharge 'task force' to take forward this, plus action below, and interface with Home First STP plan	20/2/17 3/3/17 30/3/17 30/3/17 23/2/17	KIA 4 and 5	Tamsin Hooton	Noelle Royston/Julie Dixon/Nikki Beacher/Jon Wilson/Afraf Osman	1. Number of CHC assessments completed in a hospital setting 2. Number of CHC or fast track patients not completed by 28 days/48 hours		Support from ELR CCG, CSU and social care market. Note dependency on sufficient D2A/PoC/P3 capacity
	Increase capacity in P2 and P3 to support discharge including discharge to assess	P2: i) HTLAH in Leicestershire county - increase capacity through additional procurement City procurement for new providers P3: Increase availability of P3 beds (spot purchase plus ? Use of bedded units incl Kingfisher or other sites) Increase case management and therapy capacity	01/4/17 01/6/17 31/3/17	KIA 5	Tamsin Hooton	Claire O'Donohue	1. Number of patients MFFD awaiting POC 2.Reduction in DTOC		Additional therapy resource (staffing and funding). PoC and care home bed capacity to be identified - support from Social Care required Additional case management resources required, could link to development of an integrated discharge team (health and social care), intense engagement with care home market, successful 'patient choice' messages

LLR Improvement Action Plan 23/02/2017

Key Intervention Number	National Guidance reference / detail	Action Detail	Lead Organisation	Accountable Officer	Action number	Planned activity	Expected outcome/Impact	Key milestones	Delivery date	Contribution to ED recovery	Links to Dashboard	Update (All perf. figures are data'd)	Metric: Baseline (month 5)	Metric: Target	Metric: Current position	RAG rating	Comments - RAP review
Key Intervention Area 1: Streaming in A&E ***(Remodel the front door to better manage patient flow - to ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service).***																	
1	NA	Develop ED internal professional standards	UHL	Lisa Gowan	**18a**	Intensive coaching programme to commence 28.11; increased leadership presence on the shopfloor, alongside senior nursing teams.	1. Reduction in non-admitted breaches. 2. Reduced number of patients on ambulances		Ongoing to January 2017	1. Reduction in non-admitted breaches. 2. Reduced number of patients on ambulances 3. Reduce number of 10 minute breaches	non admitted breaches 10 minute breaches	1. Develop action plan 2. Confirm key staff members involvement 3. Develop robust communication plan 4.Develop presentation for 23.11.16 EQSG 5. Confirm medical approach 6. Programme began as planned; initial positive feedback from staff. Impact of increased operational pressures has reduced availability of coaches on shopfloor. 7. Programme methodology embedded into planning for new emergency floor	48% (% patients with decision made within 180mins)	95%	Aug: 45% Sept: 43% Oct: 42% Nov: 45%	**5**	TS: Declared as complete - current performance required to validate
1	NA	Develop ED internal professional standards	UHL	Vivek Pillai	**18b**	Rapid cycle test single queue working w.c 28.11	1. Reduction in non-admitted breaches. 2. Reduced number of patients on ambulances		RCT complete by 2.12.16	1. Reduction in non-admitted breaches. 2. Reduced number of patients on ambulances 3. Reduce number of 10 minute breaches	non admitted breaches 10 minute breaches	1. Updated role cards now in place 2. Nursing teams realigned to support change in process 3. Communication to all A&E teams to be circulated by 25.11.16 4. Debrief and review to take place w.c 5.12.16, ensuring SOPs are up-to-date and relevant 5. Actions completed as planned 6. Ongoing monitoring of impact on metric and performance overall	48% (% patients with decision made within 180mins)	95%	Aug: 45% Sept: 43% Oct: 42% Nov : 45%	**5**	TS: Declared as complete - current performance required to validate
1	NA	Develop and implement tighter protocols for use of ED 'red light' and CDU 'stop'	UHL	Lisa Gowan	**79**	1. Produce CDU operational policy, clearly outlining when a 'stop' can be put in place 2. Review use of ED 'red light'	1. Reduction in stops to CDU		30.01.17			1. CDU operational policy ratified in CDU Operational Group and implemented. 2. 'Red light' review part of revised escalation process and HALO action cards.	Reduction in number of CDU stops			**5**	TS: Declared as complete - does the improvement action need revising to reflect the SOPs required for new ED floor?
1	NA	Implement CDU-EMAS direct streaming protocol, to minimise transfers from ED.	UHL	Lisa Gowan	**80**	1. Develop protocol for direct streaming 2. Engage with clinicians on revised Standard Operating Procedure (SOP) for CDU	1. Reduction in ED transfers to CDU		30.01.17			1. CDU SOP revised, including direct streaming protocol 2. Meeting with clinicians planned for 16 January 2017 3. Review of weekend cardiology and respiratory in-reach to CDU (EQSG 18.1.17)	Reduction in transfers from ED to CDU			**5**	TS: Declared as complete - current performance required to validate
Key Intervention Area 2: No. of 111 calls transferred to Clinicians ***(Minimise presentations from primary and community care to LRI ED assessment services)***																	
2	2.2 2.5 2.6 2.7 3.3	All phone based access points only direct patients to ED when clinically necessary	West CCG	Rachna Vyas	**1a**	1. Introduce alternative pathways for specific clinical cohorts of NHS111/EMAS patients who initially have an ED disposition 2. Introduce alternative pathways for a specific clinical cohort of G2 patients who initially have an ED disposition	Decrease in ED dispositions of 5% Increase in pathway 0 patients being diverted to base visit rather than ED by 5 per day	1. OOH test bed to divert ED dispostions to alternatives launched 2. OOH test bed to divert G2 ambulances to alternatives launched 3. 24/7 test bed to divert ED dispostions to alternatives launched 4. 24/7 test bed to divert G2 ambulances to alternatives launched	1. Dec 2017 2. Dec 2017 3. Feb 2017 4. April 2017	Reduction in Non-admitted breaches in minors/UCC Reduction in admitted breaches	ED attendance Ambulance conveyance	05/12/2016-01/01/2017 shows 41% of total calls referred to the CNH, of which: 18% directed to ED 3% had an ambulance called 8% direct admission to hospital remainder treated within self care / primary care / community care G4 calls now BAU <1y - awaiting NHS E guidance G2 - weekday evenings from mid-Dec 2016 and weekends also from mid-Jan 2017 >80y - awaiting NHS E guidance SPNs - existing format being used pending intro of SCR v2.1 in 2017 (date TBC) w/c 02/01/2017 NHS111 streamed to DHU OOH: 257 interim dispositions 98 potential ED dispositions NHS111 has referred 250 patients to PMAF Hubs in last 3 weeks and is referring 250 patients per week to UCCs ELR GP OOH direct appt booking at all base sites from 16/01/2017 UCC Le - mtg 17/01/2017 UCC Lo - under review in tandem with pilot launch of WL CCG Tier 1 service GP practices in-hours direct appt booking: EMIS Web - testing complete with Husbands Bosworth and SOP now in development SystmOne - Long Lane and Markfield currently in testing phase CRT/AVS landlines still awaiting LPT sign off and installation - SLS liaising with Lisa Phillips (SSAFA)	100% f ED disposiaitons sent to ED	50% of Ed Dispositions directed elsewhere	71% of ED dispositions diverted elsewhere	**3**	TS: Can 1a and 1b be reviewed and merged in to a single action area stating what the outstanding elements are?
2	2.2 2.5 2.6 2.7 3.3	All phone based access points only direct patients to ED when clinically necessary	West CCG	Rachna Vyas	**1b**	Launch of Clinical Navigation Hub (phased implementation with initial restricted offer)	Decrease in ED dispositions of 5% Increase in pathway 0 patients being diverted to base visit rather than ED by 5 per day	4. Phased launch of hub	CN Hub launch 05/12/2016 - note: * phased approach * mainly OOH only until 01/04/2017	Reduction in Non-admitted breaches in minors/UCC Reduction in admitted breaches	ED attendance Ambulance conveyance	Implementation of CN Hub: 05/12/2016: G4 / Dental / MH Richmond Fellowship / ED dispositions (agreed cohort) to go live. Pharmacy calls at peak times for medication enquiries and toxic ingestion CNH access to primary care records - Dec 2016: DHU OOH - 2,563 records accessed via MIG (90% success rate) DHU 111 - 54 records accessed UCC Le - 29 records accessed UCC Lo - 160 records accessed UCCs ELR - 37 records accessed Now encouraging EPR Core access and quality of data for CNH, NHS111 & EMAS. EDSM record sharing access currently under review CN Hub refs to CRT/AVS via EPR Core from Mar 2017 CNH link with LPT SPA via EPR Core - go live date TBC CNH activity information reporting - Dashboard under development *(Note: NHS111 & CN Hub unable to refer directly to SSAFA WIC as functionality not available in TPP in hours unit)*	100% of G2 calls successfully triaged avioded	50% of G2 calls successfully triaged avioded	82% of G2 calls successfully triaged avioded	**3**	TS: Can 1a and 1b be reviewed and merged in to a single action area stating what the outstanding elements are?
2	1.1	Ensure GP's have direct access to a Consultant for clinical discussions prior to acute referral	UHL	Rachna Vyas	**2**	3. Re-launch service to all GP's 4. Evaluate CC activity to agree BAU from 01 Apr 2017	Increase in avoided EAs in specific specialities (from 66% to c.70%) Increase in utilisation rates in Primary care from 74% to 95%	3. Re-launch at PLT using clinical case studies (City) / Lynn Lee writing new comms for dist Dec 2016 4. Ensure connectivity with community services	~~1. Complete~~ ~~2. Paeds live Oct 2016 / Geriatrics due Nov 2016~~ 3. ~~21st Sept 2016~~ / Dec 2016 4. Jan-Feb 2017	Reduction in admitted breaches	ED attendance Emergency admissions Ambulance conveyance	3. Case studies for PLT outstanding 4. Will be undertaken by SQW Vanguard evaluation- particular emphasis on clinical outcomes and ?lack of clinical resources to support the service	Increase in utilisation rates in Primary care Baseline 74%	95%	Oct 2016 70%	**3**	TS: Can this action be revised to reflect the outstanding elements, timescale and metrics?
2	2.1	Instigate direct feedback loop re patients who were referred to acute care via BB but could have accessed other services (interdependency with actions 67 & 69)	ELR CCG	Rachna Vyas	**3**	1. Audit sample of case notes 2. Implement direct and indirect feedback 3. Audit other patient pathways listed in national guidance, starting with EMAS & then NHS111 4. Investigate trial of GP role in Bed Bureau to challenge admissions	As per results of audit	1. Audit GP urgent calls to assess appropriateness 2. Feedback to Primary care at PLT's in Oct/Nov 2016 / establish feedback from GPAU re: appropriateness of refs 3. Plan EMAS GP urgents line audit for LLR	1. Complete 2. Nov 2016 / Dec 2016 3. Oct 2016 4. GP in BB pre-Xmas 2016	Reduction in non-admitted breaches	ED attendance Emergency admissions Ambulance conveyance	1. Audit complete - awaiting BB & GPAU results from UHL (JAD) - still o/s from UHL 2. Slots booked at both Sep 2016 and Nov 2016 PLT / SLS to d/w Dr Ian Lawrence - still o/s from SLS 3. Audit planning started - SLS to track progress post -discussion @ Inflow mtg 31/01 to include Card 35 activity 4. Themers from report to individual CCGs for consideration	NA	NA	NA	**3**	TS: Can this action be revised to reflect the outstanding elements, timescale and metrics?

2	4.6 1.8	CCG led schemes to manage acute demand	City CCG	Rachna Vyas	**4**	1. Maximise utilisation of Hubs, including diverts from ED 2. Ensure all acute access services have embedded pathways to use most appropriate/lowest acuity care setting available including GP urgent referrals	Reduction in the number of City patients referred to UCC/ED by 111 by 5% Increase in utilisation rate at each City hub from c75% to 85% by September Reduction in avoidable admissions from LLR care homes by 10% of 15/16 outturn Reduction in conveyed module 0 patients to ED by EMAS by 5% Reduction in deep emergency admissions to commissioned plan	5. NHS111 direct appt booking to UCC Le GP consults still to be switched back on 6. Clinical Navigation Hub and EMAS to make best use of access to CRT/AVS/LPT SPA/Falls Service/ICS/ICRS/Step Up/UCCs/LRi DVT/LRI TIA/Police MH Triage Car	5. Dec 2016	Reduction in Non-admitted breaches in minors/UCC Reduction in admitted breaches	ED attendance Emergency admissions Ambulance conveyance	1. PMAF Hubs utilisation: w/c 19/12 59% (full Mon-Friday) w/c 26/12 65% (low uptake Christmas eve, day and boxing day) additional staff/appointments w/c 2/1 63% (low uptake on bank holiday) full Tues- Fri – low again during weekend 1. EPAU ambulatory pathway pilot live 05 Dec 2016 1. EPAU utilisation Dec 2016: LC 42 / ELR 18 / WL 31 1. EPAU appts utilisation rate 72.17% 1. EPAU patient satisfaction feedback: 5 star 80.30% / 4 star 18.18% / 3 star 1.52% 1. GAU activity for Dec 2016 not yet available to assess any early impact from EPAU pilot 5. Gaurav Mehta still liaising with Lisa Gowan (UHL), for particular use when PMAF Hubs are closed 5. Appt booked for 17/01/2017 @ UCC Le to activate direct appt bookings from NHS 111 OOH Clinic 4 relocation into UCC Le (was 13/12) delayed by UHL IM&T - awaiting conf from UHL of new date	ED attendances to commissioned plan M4 Baseline: +10% vs plan Emergency admissions to commissioned plan M4 Baseline: +2% vs plan	ED attends: Plan NEL: To plan	ED attends: M8: +10.7% (variance: 4721) NEL: M8: +0.45% (Variance +99)	**3**	TS: Can actions 4, 5, 6 & 7 be merged or at least be streamlined to reflect the outstanding elements?
2	4.6	CCG led schemes to manage acute demand	ELR CCG	Rachna Vyas	**5**	1. Maximise utilisation of UCC's 2. Ensure patients are aware of service provision via NHS NOW app 3. Review of Urgent Care patient flow across ELR CCG to inform re-design of integrated urgent care offer	Reduction in the number of ELR patients referred to UCC/ED by 111 by 5%	1. Maximise the use of the ELR Urgent Care Centres in the four sites providing a seven day evening and weekend service. Oadby profile re-checked on DOS to ensure maximum diversion from 111 2. Focus use of NHS NOW App and continued promotion of service	1. Complete 2. Ongoing rollout programme 3. Clinical leads mtg to review data and proposed model 15/11/2016	Reduction in attendances at ED and Non-admitted breaches in minors/UCC	(SLAM data) ED attendance Emergency admissions Ambulance conveyance	1. Complete 2. App launched 3. Awaiting update on development of live waiting times to integrate with NHS Now Full page service spec of proposed UCC offer to go to locality meetings Dec 2016 Full UCC service spec to go to Governing Body Jan 2017 Service specification needs full review as result of feedback from localities and Board GPs - options to go to Feb 17 GB. Jan 17 GB agreement to retain current service (including Oadby WIC) until 31.3.18	ED attendances to commissioned plan M4 Baseline: +7% vs plan Emergency admissions to commissioned plan M4 Baseline: +5% vs plan	ED attends: Plan NEL: To plan	ED attends: M8: +11.4% (Variance +2462) NEL: M8: +7.5% (Variance +1025)	**4**	TS: Can actions 4, 5, 6 & 7 be merged or at least be streamlined to reflect the outstanding elements?
2	4.6	CCG led schemes to manage acute demand	ELR CCG	Rachna Vyas	**6**	1. Launch Weekend AVS scheme 2. Launch care home service expanded across ELR CCG (provided by AVS)	Reduction in avoidable admissions from LLR care homes by 10% of 15/16 outturn	1. New Weekend AVS scheme to commence in August/ September specifically for complex, elderly, EOL and Care home patients covering 3-4% of the ELR population at greatest risk of admission 2. Go live 03/10/2016	Complete - service live	Reduction in attendances at ED and admitted breaches	ED attendance Emergency admissions Ambulance conveyance	1. Service launched. Activity and impact will be monitored 2. Service expansion complete and in place - impact monitored via care homes SUS data. Recorded a reduction in care homes admissions per month of 51 during the test bed period To discuss viability of LLR Care Homes Dashboard @ Inflow mtg 31/01/2017 3. Plan to extend service to all housebound patients from April 2017	Reduction in avoidable admissions from LLR care homes by 10% of 15/16 outturn Baseline requested	Awaiting data	Awaiting data	**4**	TS: Can actions 4, 5, 6 & 7 be merged or at least be streamlined to reflect the outstanding elements?
2	4.6	CCG led schemes to manage acute demand	West CCG	Rachna Vyas	**7**	1. Ensure adequate capacity in practices for non-urgent clinical presentations 2. Optimise use of AVS service through improved triage and communications to care homes	4 Clinical Pharmacists in place by Q3 2016 Request funding for 8 additional clinical pharmacists by Q4 2016/17 Reduction in avoidable admissions from LLR care homes by 10% of 15/16 outturn	1. Commissioning of Pharmacists in federated groups of practices to provide workforce capacity to focus on cost effectiveness and medicines related admissions 2. Increase AVS response times to care home 3. Increase the number of care homes referring into the service	1. Rolling programme 2. Complete	Reduction in attendances at ED and admitted breaches	ED attendance Emergency admissions Ambulance conveyance	1. Applications to be submitted by 10/02/2017 with an ambition of 1 pharmacist per each 30k population. NHS E decisions due by beg Mar 2017 2&3. Service launched. Activity monitoring indicates 158 care homes patients seen by AVS in Nov 2016. Dec 2016 data not yet available	ED attendances to commissioned plan M4 Baseline: +7% vs plan Emergency admissions to commissioned plan M4 Baseline: +5% vs plan	ED attends: Plan NEL: To plan	ED attends: M8: +8.9% (Variance +1645) NEL: M8: +4.1% (Variance +594)	**4**	TS: Can actions 4, 5, 6 & 7 be merged or at least be streamlined to reflect the outstanding elements?
2		Identify multi-agency solution in high user postcodes across LLR - these are predominantly in East and City	EMAS	Rachana Vyas	**29**	1. Review and Share activity by post code to support a reduction in activity reaching 999 services 2. Review and share H&T/S&T activity by postcode 3. Frequent attenders should be known to the system and managed through a system network 4. (a) Assess Cardiff model/local model in place (b) Formulate plan at CCG level (c) Implement and monitor plan	1. Reduction of 999 activations by 5% per day 2. Reduction in known FA's presenting to 111, EMAS and UHL ED	~~- Baseline activity captured - 14/09/2016~~ ~~- CCG produced postcode analysis report shared - 30/09/2016~~ 1. EMAS provided HVSU post codes for LLR 2. CCGs to identify HDSUs, clinical themes and patient outcomes for those conveyed to hospital 3. Alternative care pathway planning &implementation including comms package for patients and practices - through Nov/Dec 2016	Nov/Dec 2016	Reduction in attendances at ED and non-admitted breaches in Minors/UCC	ED attendance Emergency admissions Ambulance conveyance	Postcode data received - top 34 postcodes by 5 & 6 digits indicates the likely GP practices for the CCGs to work with to identify patients and outcomes ~~Cardiff model reviewed - Braunstone Blues model to be piloted in other areas of Leicester City -~~ ~~Helen Payne (ED FF Nurse) & Deborah Scouthern (EMAS FF Lead) to provide current activity via CTR - RV & SLS will f/u with mtg to discuss pathways and how FF work ties in with Vanguard-funded M/H nurses in UCC & ED 24/7 -~~ ~~FF data triangulation (NHS111/EMAS/UHL Em Attends & UHL Em Admc) mtg 09/11 to identify top 10 postcode areas for LLR - to overlay on current - Police and Fire heat maps to agree next pilot Jan-Mar 2017 as hub & spoke model with Braunstone - Eyres Monsell / Saffron Lane Jan 2017 tbc -~~ A&E Performance Group to re-visit proposed recommendations and associated comms msgs @ Performance Group mtg 25/01 In the meantime CCGs continue to operate their FF SOPS	Reduction of 999 activations by 5% per day. Baseline requested	Awaiting data	Awaiting data	**3**	TS: Given that a large proportion of postcode analysis has been completed, can this be reviewed to confirm what the outstanding improvement action is?
2		All patients referred to UHL by GP should arrive either < 4 hours from time of referral or in a timely manner for a booked appointment/assessment	EMAS	Rachana Vyas	**69**	1. Assess viability of limiting the number of LLR practices using the direct EOC booking function 2. Reiterate to General Practice that all appropriate referrals to UHL must go via Bed Bureau for capacity planning purposes 3. Re-launch criteria for ambulance conveyance to General Practice *Linked to actions 4-6 above - if EMAS refer more CAT-triaged patients to CRT/AVS this should release EMAS capacity to convey patients into UHL earlier*	Reduction in number of GP urgents conveyed to hospital in total All patients conveyed within 4 hours of referral	1. Ability to divert all LLR requests to EOC to BB 2. Re-launch booking criteria and pathway to practices 3. Joint EMAS & LLR CCGs comms to GPs and UHL re: Card 35 SOP	1. 30 Sep 2016 2. PLT, Locality/HNN meetings in Sep 2016 3. Nov-Dec 2016	Reduction in attendances at ED and admitted breaches	ED attendance Emergency admissions Ambulance conveyance	1. ~~In progress - turning EOC line off completely is not viable as the line services the whole region -~~ Superceded by Card 35 protocol for all LLR GP practices 2. Practice-specific Card 35 Comms package disseminated 3. ~~EMAS to advise of impact of Card 35 on demand for GP Urgents and response times - data by CCG and GP practice and whether a clinical review has been undertaken -~~ EMAS R2 activity data @ 18/12/2016 shows a shift from LE2 to LE5 as having the highest no. of calls for last 3w period, but LE2 continues to be highest overall. LE65 consistently highest for no. of calls per 100,000 population. SLS to share with CCGs HNN and locality managers. EMAS to issue letter to GPs reinforcing need for clinical review prior to Card 35 request - awaiting EMAS conf. 4. RV has requested (08/12/) AGCSU for a curve of EMAS to UHL arrival method - trends show no changes	*Card 35 R2 service commenced 05/09/2016* *Baseline requested*	*overall reduction in R2 calls per 100,000 population*	Latest data overall 14 calls per 100,000 population (peaked at 32 calls per 100,000 population)	**4**	TS: Given that Card 35 is embedded and EMAS are providing data, what is the outstanding action, metric and timescale?
2		Frequent attenders should be known to the system and managed through a system network	CCG's	Rachana Vyas	**70**	1. Assess Cardiff model/local model in place 2. Formulate plan at CCG level 3. Implement and monitor plan	Reduction in known FA's presenting to 111, EMAS and ED	Pilot extension to Braunstone Blues initiative	Mar-17	Reduction in attendances at ED and Non-admitted breaches in minors/UCC		~~Cardiff model circulated to CCGs - found to be very similar to Braunstone Blues pilot - Skype call with Cardiff Lead Anna Sussux 29/11 -~~ ~~Helen Payne (ED FF Nurse) & Deborah Scouthern (EMAS FF Lead) to provide current activity via CTR - RV & SLS will f/u with mtg to discuss pathways and how FF work ties in with Vanguard-funded M/H nurses in UCC & ED 24/7 -~~ ~~FF data triangulation (NHS111/EMAS/UHL Em Attends & UHL Em Admc) mtg 09/11 to identify top 10 postcode areas for LLR - to overlay on current - Police and Fire heat maps to agree next pilot Jan-Mar 2017 as hub & spoke model with Braunstone - Eyres Monsell / Saffron Lane Jan 2017 tbc - following Project Board mtg 12/01~~ Police and EMAS current activity has identified the Highfields area of Leicester as a suitable 3m 'pop up' pilot to replicate Braunstone Blues outcomes but with a different appropach. Commitment gained to provide suitable staff, for launch as close to 01/03/2017 as possible EMAS do not currently produce High Volume Service User reports - to discuss further @ Inflow mtg 31/01 UHL Lisa Gowan to advise of current Frequent Attender role and reporting	*See CCG specific metrics for reducing activity to plan*	*See CCG specific metrics for reducing activity to plan*	*See CCG specific metrics for reducing activity to plan*	**4**	TS: Can this action be reviewed and refined to the outstanding elements, metrics and timescales?

2	4.6	Ensure in hours and OOH GPs are consistently seeing care homes residents with do not transfer or do not admit orders	City CCG	Rachna Vyas	**76**	1. EMAS (MG) and UHL (JT) to send recent cases from 13/12/2016 to (DHU) Rob Haines and Dr Hurwood 2. Rob Haines and Dr Hurwood to begin feedback loop	Reduction in inappropriate ED attends and ?Em Adms	1. Dr Hurwood mtg with Julie Taylor 14/12/2016 2. Dr Hurwood to liaise with Rob Haines (case 1) and ELR CCG (case 2) 14/12/2016	14-16 Dec 2016	Reduction in inappropriate ED attends and ?Em Adms	ED attendance Emergency admissions Ambulance conveyance	UHL to develop feedback loop to report on care home residents who have no evidence of a face to face primary care consultation prior to Em Attend / Em Admission EMAS to liaise with GP in hours / OOH where they feel a conveyance could be avoided - paramedics are now contacting GP practices via back office numbers to review status of patient prior to development of action plan OOH GPs now have access to EPR Core to allow enhanced view of patients medical history Initial PHEM GEM mtg Steering Group mtg 30/01/2017 Consultant Connect General & Geriatric Medicine service reporting for Dec 2016 a 74% pick up rate of which 53% are estimated to have avoided an acute intervention	Baseline calc per CCG to be discussed with A&G CSU	Reduction in inappropriate care home acute interventions	Latest performance calc per CCG to be discussed with A&G CSU	**4**	TS: This is now a HIA relating to ambulance conveyance - can this action be removed?
2	4.6	CCG led schemes to manage acute demand	West CCG	Rachna Vyas	**77**	1. Maximise utilisation of ambulatory care patients trated at LUCC 2. Ensure patients are aware of service provision through Winter media campaign 3. Review of Urgent Care patient flow across WLCCG to inform re-design of integrated urgent care offer	Monthly increase of ambulatory care patients referred by general practice and conveyed by EMAS to LUCC Monthly increase of suitable attendances to LUCC following the media campaign Increase appropriate referrals into the Tier 1 offer in Hinckley and Coalville	1. Complete testing of new care model to see treat and discharge ambulatory care patients at LUCC by December 2016 2. Ambulatory care case study to be used in media campaign by end December 2016 3. Completed procurement and contract award by December 2016	1. Complete 2. Due to be completed by end December 2016 3. Anticipated date of contract award 21st December 2016	Reduction in attendances at ED and admitted breaches	ED attendances Emergency admissions Ambulance conveyance	1/2/3. UCC Lo utilisation - Referral to ED has stayed static compared to this time last year, bounce backs have reduced but patients leaving without being seen have increased EMAS (MG) to advise of and lead discussion around entry to UCC Lo @ Inflow mtg 31/01 3. Tier 1 PDSA to commence Feb 2017 *(Note: UHL work to identify patients conveyed by EMAS who have not been seen by a HCP will be included in the KIA1 RAP)* REQUEST TO MERGE ACTIONS 7 & 77	UCC Lo 3,851 pm	UCC Lo N/A	UCC Lo 3,869 pm	**4**	TS: Suggest this is merged with the revised 4, 5, 6 & 7 action?

Key Intervention Area 3: Ambulance Response Programme *(Improve ambulance response and interface)*																		
3		Implement GP Call Back Pilot Scheme	EMAS	Mark Gregory	**32a**	1.Staff idenitfied and developed 2. Work with CCGs to ensure consistency from Primary Care 3. Capture Ealry findings 4. Develop Phase 2 (wider roll out across staff group	Reduced Conveyance to A&E	1. Identify 3 Paramedics (One East, One West, One City) 2. Develop Staff knowledge base in call back system 3. Liaise with CCG re GP Buy in and divert phone Numbers 4. Mobilise Scheme 5. Where success noted, double Paramedic Numbers on a month by month basis 6. Move into monitoring phase and continue roll out.	1. 2/12/16 2. 5/12/16 3. 1/12/16 4. 12/12/16 5. 12/1/17 6. 6/2/17	Reduction in A&E attendances		Update 1/12/16 3 Paramedics identified, Audit sheets in development as is the development plan. CCGs contacted and scheme scope shared. Update 15/12/16 - Scheme Launched, no adverse issues reported. Awaiting first data set. 29-12-16 Good uptake from staff group, some early issues with timely call backs which are escalated through CCG colleagues. Current average call back c30mins 11/1/17 - call back times reducing and failures of delivery being forwarded to CCG lead.	Number of GP Call backs within 10 minutes.	Percentage of Calls attended which are diverted via GP Advice		**4**	**MG: additional monitoring milestone added to ensure action remains current for monitoring**
3		Implement and enhance the use of Mobile Directory of Service	EMAS	Mark Gregory	**33**	1. Ensure registration of all eligible staff to MDoS (50% by March 16) 2. Train Staff in the use of MDoS (50% by March 16) 3. Increase the number of MDoS referrals 4. gain access to mobile SystmOne enabling care plan viewing	Linked across all Non conveyance metric (Reduction of 4% by 31st March 2017)	1. Project lead to be identified 1.1 Project lead to generate project plan to increase points 1 & 2 2. Train the Trainer sessions to be held ensuring MDoS super users can support training schedule 3. Project lead to monitor use and support non compliant staff 4. Work with Commissioners to secure SystmOne access	1. 30 Sept 16 1.1 15 Oct 16 2. 31 Oct 16 3. March 17 4. Feb 17	Reduction in A&E attendances		1. Project Lead identified and in post Update 20 October 2016 Trainning session held for super users to enable train the trainer sessions to be rolled out. 29/12/16 - four week trial commencing on the 23rd December. 35 super users will use MDoS for every patient with feedback driving the launch of cohort two.	50% of staff registered to use MDoS (March 16)	50% staff trained to access and use MDoS (March 16)	TBC	**3**	TS: Suggest this action is refined with revised timescales and metrics **MG: Awaiting revised project plan from scheme owner.**
3		Left shift transportation of Urgent activity into UHL sites **TS: This action isn't progressing and impacts upon flow metrics - status Red?**	EMAS	Mark Gregory	**34a**	1. Review current baseline 2. Scope resource availability 3. draft project and resourcing plan 4. Mobilise additional resources	Earlier attendance of HCP urgent calls	1. Working with PMiT gain average call to arrival time 2. Review current resources within LLR EMAS Pool 3. Liaise with Commissioners to plan additional commissioned resources 4. communicate launch and mobilise additional resources	1. 15 Oct 16 2. 20 Oct 16 3. 1 Nov 16 4. 30 Nov 16	Improved Flow		Update 20 Oct 2016 Operational deployment model of Urgent resources reviewed. Draft plan generated to allow specified resources to undertake Urgent Activity only (Exceptions apply) 07/11/16 - Project plan shared and implemented with EOC colleagues. Urgent resources now working to deliver calls within timescales 1/12/16 - Fall off in project scope dueto handover challenges and trust CMP escalation status	Percentage of patients arriving within their allotted timescale	TBC	TBC	**3**	TS: What action is required to gain traction and progress this? Suggest the improvement action reflects this. **MG: In relation to the left shifting of HCP/Card3S calls, the main thing that would generate traction would be some commissioned resource. As you know, our Urgent resources which are there for this work are routinely pulled in to support front line ops, this is generally more frequent when the hospitals start to slow. I am more than accepting of the fact that this is a contributing factor as it knocks a different pressure later in to the night.** **Ideally if I had some additional resource I could ring fence the resource to ensure the HCP work was delivered in a timely manner. This may be part of breaking the cycle that would be required to ease some of the pressures, albeit a small part of the cycle.**

Key Intervention Area 4: Improved Patient Flow *(Improve CDU, ED and Ward Flow at UHL)*

4	NA	**Impact monitoring action:** UHL to open additional emergency beds at the LRI to decrease bed capacity/demand mismatch	UHL	Gill Staton	**9a**	1. Open and staff 28 beds on ward 7	1. Decrease outlying on non-medical wards (dependent on attendances and admissions remaining constant) 2. Decrease congestion in ED by improving flow 3. Contribute to an improved 4 hour performance 4. Improve staff experience by staffing a consistent ward therefore preventing staff moving from ward to ward	1. Opening of remaining beds, to create 28 bedded-ward 31.12.16 2. Ongoing review of use and impact on performance metrics	Ward fully open 31.12.16 Complete	1. Reduction in breaches linked to poor flow and ED occupancy	Admitted breaches	1. Weekly review of staffing levels and potential for opening additional beds on ward 2. New HCAs begin in December 3. Plan to open ward fully by end of December, HCA recruitment dependent. 4. 18 beds now open 5. Continue to try and staff to 28 beds - ward now able to take 28 patients. 6. Significant decrease in number of medical outliers across the hospital	55% of patients allocated a bed within 60 mins	75%	~~58%~~ ~~Oct: 49%~~ Nov: 46% Dec MTD: 53%	**5**	TS: Declared as complete - current performance required to validate
4	NA	Rapid Flow (formerly - Implement SAFER Patient Placement across UHL)	UHL	Lisa Gowan (Ian Lawrence)	**36**	1. Launch communication throughout UHL 2. Project plan to be developed on how UHL roll-out on wards 3. Roll-out across Medicine 4. Full roll-out across UHL 5. Re-opening of discharge lounge	1. Increase discharges from wards before 1pm 2. Reduce breaches in ED 3. Reduce congestion in ED 4. Improve patient experience 5. Decrease use of escalation areas	1. Launch communication throughout UHL - complete 7th September 2016 2. Project plan to be developed on how UHL roll-out across wards - complete 14th July 2016 3. Roll-out across Medicine - go live 10th October 4. Full roll-out across UHL - phased roll out January to March 2017 5. Re-opening of discharge lounge - 28th November 2016 - COMPLETE	~~Go live of Safer across medicine on 10 October 2016~~ ~~30.11.16~~ March 2017	1. Reduce breaches in ED 2. Reduce time from bed request to allocation	admitted breaches	1. Further work required to develop plans to rapid flow from AMU to base wards. Outline plan developed; meeting planned for 03.01.17 to discuss next steps and implementation. 2. Initial proposals being presented to EQSG 18.01.17 for discussion and approval of next steps. 3. Plan for roll-out of Rapid Flow to Glenfield to be developed post LRI implementation 4. Proposal for dedicated Rapid Flow Transfer Team led by the AMU Tracker and including some additional HCAs and existing porters being worked up; further two week trial to be held to test model 5. Recruitment to HCAs has begun 6. Increased portering teams within ED to provide consistent flow from ED to AMU 7. Consistent review of rapid flow at 4xdaily Gold Command meetings	55% of patients allocated a bed within 60 mins	75%	~~58%~~ ~~Oct 48%~~ ~~Nov: 46%~~ Dec: 64% Jan: 66%	**3**	TS: Suggest that this is revised but remains in place to ensure rapid flow is embedded and consistent? **RP:** IT'S PART OF THE REDUCE DELAYS WITHIN HOSPITAL HIA; I'VE UPDATED THE DETAIL
4	NA	Implement specialty in-reach/ownership of referred patients to ED	UHL	Matt Metcalfe	**40**	1. Review Trust Watershed policy 2. Benchmark against specialty in reach services in other Trusts 3. Work with HOS and CD to communicate policy to all other specialty CDs 4. Re-implement Trust watershed policy	1. Reduced wait times for ED patients by releasing ED medical staff 2. Improve patient experience	1. Review Trust Watershed policy - complete by 17/10/16 2. Benchmark against specialty in reach services in other Trusts - complete by 17/10/16 3. Work with HOS and CD to communicate policy to all other specialty CDs - complete by 17/10/16 4. Re-implement Trust watershed policy - complete by 17/10/16	All actions to be complete by 30.11.16 13.01.17	1. Reduction in breaches 2. Improvement in time to be seen by a doctor and time for a plan 3. Reduction in conversion rate	breaches	1. Deputy medical director to meet with majors HOS to discuss further and agree actions 2. Slippage due to annual leave and operational pressures; meeting being held 16.1.17 to agree approach, support required and next steps 3. Criteria for 30 minute specialty review of ED patients agreed and in place. 4. ED liaison for all consultants being included in job planning reviews as part of ongoing CMG-wide initiative for in-reach structure to ED.	21.2% (ED conversion rate)	TBC	21.30%	**5**	TS: What is the current status of this? Suggest it remains in place at least during the transition to the new ED floor **RP:** THIS CAN BE CLOSED; ITS BAU
4	NA	Implement direct admissions from ED to specialities	UHL	Matt Metcalfe	**68**	1. Develop a CMG wide clinical task and finish group to establish the type of patients that can be direct referred 2. Data analysis to determine impact change will have 3. Agree Patient criteria 4. Write SOP 5. Communicate process to teams 6. Implement 7. Feedback session to ensure the team capture any changes and improvements required	1. Decrease admitted breaches 2. Decrease overcrowding in ED 3. Improved patient experience	1. Develop a CMG wide clinical task and finish group to establish the type of patients that can be direct referred 10th Oct 2. Data analysis 31st Oct 3. Agree Patient criteria 31st Oct 4. Write SOP 11th Nov 5. Communicate process to teams 18th Nov 6. Implement 28th Nov 7. Feedback session to ensure the team capture any changes and improvements required 19th Dec	~~28.11.16~~ 13.01.17	Decrease breaches	admitted breaches	1. Meeting planned with MD, CD to agree implementation plan 2. Electronic system in place for referrals/accepting patients directly onto acute medical wards 3. Discussions begun on directly admitting patients from ED to SSU. Pathway developed and shared with colleagues. 4. GPAU move to yellow majors space 7.11.16, includes active medical in-reach into ED embedded in way of working. 5. Deputy and associate medical directors to agree which pathways/specialities need to be focused on to increase direct referrals 6. Direct admissions to specialties from GPAU rolled out 19.12	80%	77%	TBC following data analysis	**5**	TS: What is the current status of this? Suggest it remains in place at least during the transition to the new ED floor unless evidence of completion and impact is available? **RP:** CLOSED
4	NA	Improve ambulance handovers	UHL	Lisa Gowan	**78**	Reduce delayed ambulance handovers by proactive and continuous use of escalation areas	1. Reduce time patients wait on ambulances 2. Release EMAS crews quicker.	1. Ensure all escalation areas are appropriately staffed and utilised continuously 2. Consider all potential solution for creation of additional cohorting space	Test day 13.16.16 Roll out 19.12.16	Decrease breaches	admitted breaches	1. Relocate vending machines from area to create GPAU waiting space - COMPLETE 2. Issue comms to team - COMPLETE 3. Run concept test day 13.12.16 - COMPLETE 4. Develop robust SOP and circulate to teams -ongoing to reflect revised approach 5. Full roll-out w.c 19.12.16 - COMPLETE (new approach) 6. Cohorting policy and locations to be reviewed by external ED consultant (13.01.17) 7. Review of additional/potential space for cohorting is ongoing; this includes creation of ward for MFFD patients whilst discharge arrangements are confirmed.	Ambulance handover within 30mins of arrival			**5**	TS: Given the ongoing scrutiny of ambulance handover, I suggest this action is revised to reflect move to new ED and remains in place. Suggest a monitoring period of process and metric

Key Intervention Area 5: Improved Discharge

5	5.6, 5.1	Additional packages of care/DRT input will need to be purchased to reduce delayed discharges from the acute trust	UHL	Tamsin Hooton	**48**	Commission extended capacity in DRT to support discharge. £155k = up to 5 beds until the end of March 2016	Increased flow, Reduced delays in discharges	Funding source to be identified. Business Case to EQSG, Discussion at AEDB 5/10	01/01/2017	Reduction in LOS	% discharges before 12pm at UHL, Patients aged 75+ with LOS >10 days at UHL, % of UHL DTOC	Help to Live at Home is now settling into 'business as usual' and hospital discharges have been prioritised. Providers are reporting flow is improveing. **Suggest reviewing this action again in 4 weeks. RAG rate changed to Green 4**	TBC	increase by 5	TBC	**4**	C O'D: Remove from RAP?
5	5.1, 5.4, 5.6	Mobilise 'home first' discharge to assess model from hospital - go live 7th November 2016 for County	CCGs	Tamsin Hooton	**52**	**Referral routes confirmed, UHL staff training, Use of MDS tool on key wards, referral form agreed**	Improve flow at transfer of care stage as no waits for care packages. Improved pathway of care for non weight bearing patients, those requiring further assessment to identify true care needs, reduction in number and complexity of long term care packages. Reduction in number and complexity of CHC packages (including reduction in number of patients eligible for CHC). Reduced LOS in hospital as no eligibility assessments completed during hospital stay (possibly up to 5 days)	Procurement completed. Implement pathway on November 7th 2016. Conversation with City by 30/09/16	07/11/2016	Increased flow, reduced admitted breaches, reduction in LOS	% Discharged before 12pm at UHL, Patients aged 75+ with LOS >10 days at UHL, % UHL DTOC	Hart team is now taking patients from hospital who need a reablement package of care and operating as 'business as usual'. Further procurement required to fill the lots in long term care package provision vacated by TLC. Procurement to take place during Spring 2017. 40 patients in an interim bed awaiting a long term care package. Integrated in-reach discharge team to provide case management and therapy assessment to these patients in January 2017. **RAG remains as amber 3.**	Number of patients using pathway 2. Baseline: 0 cases. November 7th: 5 cases. December 7th: TBA	Number of CHC assessments completed post-transfer of care. Baseline: 0. November 7th: 5 cases. December 7th: TBA.	0	**3**	C O'D: Remove from RAP, service now implemented. Awaiting outcome of new procurement for empty lots.
5	5.1, 5.4	Establish **bed based** pathway for reablement patients (replaces D2A)	CCGs	Tamsin Hooton	**53**	1. Identify homes with spare capacity. 2. Agree referrals into spot placements 3. Agree inreach model 4. Identify in reach resource incl case managers	Improve flow at transfer of care. Improved pathway of care for non weight bearing patients, those requiring further assessment to identify true care needs, reduction in number and complexity of long term care packages. Reduction in number and complexity of CHC packages (including reduction in number of patients eligible for CHC). Reduced LOS in hospital as no eligibility assessments completed during hospital stay (possibly up to 5 days)	Commence mobilisation planning for Peaker park 03.01.17 Meet with Peaker Park team 20.01.17 Therapists in situ 23.01.17 Team meeting w/c 23.01.17 Commence first patient w/c 30.01.17 Commence City spot purchase of beds w/c13.02.17	Pathway running by November	Increased flow, reduced admitted breaches, reduction in LOS	% Discharged before 12pm at UHL, Patients aged 75+ with LOS >10 days at UHL, % UHL DTOC	14 block purchased beds agreed with Peaker Park for County patients. Health and Social Care case managers named. Therapists to commence week commencing 23rd January. Phased implementation to commence 30.01.17 of 3 patients per week up to the total of 14 patients. City social care to spot purchase 10 beds per month to commence wc 13.02.17. Potential additional resource via City CCG being scoped currently	Pathway not in use (existing pathway has 50 patients)	20 cases per week	Existing D2A has 80 patients	**2**	C O'D: To remain on RAP

5	5.2	Design and implement an electronic solution to support a trusted assessment upon transfer of care	CCGs	Tamsin Hooton	**55**	41. Trial of trusted assessment at UHL (using Nervecentre platform) prior to go live of pathway 2.	Reduced number of assessments by multiple people (potential LOS saving), no process delays between assessment and acceptance at onwards community service	Trial go live at UHL during August 2016	November 7th 201	Increased flow, reduced admitted breaches, reduction in LOS	Patients aged 75+ with LOS >10 days at UHL	John Clark reports this trial will be re-prioritised within UHL from 12.01.17. Awaiting further updates as a result of this escalation. RAG remains Red	Number of trusted assessments completed. Baseline: 0. November: 5. December: TBA	Number of accepted trusted assessments. Baseline: 0. November: 5. December: TBA	Reduced DTOC rate. Baseline UHL: 2.43% LPT: 2.85% Target 1.35% and 6.5%	**2**	C O'D: Merge 55 and 56. Keep wording from 55. Update: Rutland model to be considered as an appropriate option fo rbusiness case. Business case in draft form. To be reviewed by group in 4 weeks prior to submission.

5	5.2	Provide electronic means of sharing the trusted assessment with partner organisations at point of transfer of care	UHL	Tamsin Hooton	**56**	42 + 43. Commence a task and finish group to review and agree interoperability across LLR health, social care, and partner agencies. Hospital social care teams to use VPN connection in short term.	Provides initial access to trusted assessment for new pathways (enabler for success of pathways) Agree preferred option via BCT IMT group Progress Options analysis for information sharing, including Everis solution	Initial task and finish group 3rd October 2016 Options analysis to IMT group November ROI	March 31st 2017	Increased flow, reduced admitted breaches, reduction in LOS	Patients aged 75+ with LOS >10 days at UHL	Plan to watch Rutland's trial period in Q4 and merge two working groups to share expereiences and support to review replicability across the rest of LLR. Business case to follow review of trial. Await John Clark's escalation update.	Number of MDS assessments completed by UHL , number TBC at task and finish group	Number of MDS assessments accessed by other agencies. Baseline 0, December TBC	NA	**3**	C O'D: See above
5	5.2	Create trusted assessor roles across health and social care to support transfer of care process	CCGs	Tamsin Hooton	**58**	44. Create trusted assessor roles across health and social care as part of pathway 2 and pathway 3	Appropriate patient flow into the new discharge pathways, and clear management of the journey through the pathways to get the best & timely outcomes for patients	Agree use of existing case manager posts at UHL (October 2016) Agree job role (October 2016)	November for pathway 2 and pathway 3	Increased flow, reduced admitted breaches, reduction in LOS	Patients aged 75+ with LOS >10 days at UHL	Health and Social Care colleagues now working as trusted assessors into pathway 2 (help to live at home). Also to commence with pathway 3 from 30.01.17. Case managers continue to have CHC trusted assessor status for pathway 3.	Number of trusted assessors in post. Baseline: 0. November: 2. March: 6	Number of trusted assessors in post. Baseline: 0. November: 2. March: 6	NA	**3**	C O'D: Remove from RAP, this has gone as far as it can at the current time. Trusted assessor roles in place for pathways 2 and 3.
5	5.1, 5.4	Provide an efficient system wide 'D2A' pathway	UHL	Tamsin Hooton	**59**	45. Switch off existing D2A pathway to coincide with commencement of Pathway 3	Pathway 3 becomes the discharge to assess route out of hospital.	Risk assessment to be undertaken across LLR re: closing down D2A beds	30-Jan-17	Increased flow, reduced admitted breaches, reduction in LOS		Integrated in-reach discharge team to provide support initially to existing D2A cohort in order to close down beds as new pathway 3 beds come online.	Number of open cases. Baseline: 80.	November: 45. January: 30. March: 0	80 open cases	**3**	C O'D: Merge with 53. Keep wording of 53, but add an action to reduce numbers of existing D2A beds
5	5.1, 5.2	Engage with partner organisations to clearly describe the D2A and Trusted Assessor offer	CCGs	Tamsin Hooton	**60**	46. Communications messages being agreed for implementation of new pathways	Clear criteria for which patients are suitable for each pathway, including principles of home first, trusted assessors and single assessment	Messages agreed during October discharge steering group	November 2016-January 2017	Increased flow, reduced admitted breaches, reduction in LOS	LPT and UHL Patients discharged to admitting address	Comms messages are part of pathway 3 mobilisation planning during January.	Communication materials agreed 31/10	NA	NA	**4**	C O'D: Remove from RAP
5	5.1	Design and deliver a pathway to support effective transfer of care for patients with severe dementia	CCGs	Tamsin Hooton	**61**	47. Scope requirements of Severe Dementia Pathway using commissioning intentions. Describe pathway to include specialised care homes for this group of patients. Understand capacity requirements	Patients with severe dementia placed appropriately into the right care setting in a timely manner, follow same principles of 'home first' and 'discharge to assess'	Agree scope, Define patient cohort, Agree current capacity available 31st March 2017	31/03/2017	Increased flow, reduced admitted breaches, reduction in LOS	Patients aged 75+ with LOS >10 days at UHL, % UHL DTOC	Dementia Delivery Group agreed there's a gap in the pathway. Currently setting up a task and finish group to explore the options and capacity issues.	TBA	TBA	TBA	**3**	C O'D: First meeting to be held on 20.02.17, to remain on RAP
5	5.1, 5.3?	Design and deliver short term improvements to capacity for end of life services in order to reduce people dying outside of their place of choice	CCGs	Tamsin Hooton	**62**	48. Scope short term capacity requirements for 'last few days of life' pathway	Patients in the last few days of life have choice about where to die and access the most appropriate care setting in a timely manner	New model to commence in January 2017	31/03/2017	Increased flow, reduced admitted breaches, reduction in LOS	Patients discharged from UHL	Trial of new hub approach has been halted subject to a business case. Review in 3 months. **RAG changed to RED**	TBA	TBA	TBA	**2**	C O'D: To remain on RAP
5	5.1	Monitor Hospital Housing Team offer and review model to support new D2A and TA models where indicated	CCGs	Tamsin Hooton	**63**	49. Continue to review successes and challenges of the expanded Housing team based at UHL and Bradgate Unit	Housing team reduce LOS and delays associated with housing. Currently building team skills and expertise.	Longer term funding agreed 30.01.17 Trial of sheltered housing offer before 31.03.17	Ongoing	Reductions in DTOC, reductions in LOS	Patients discharged from UHL, % UHL DTOC	Team is operational and receiving referrals earlier in the hospital admission process. Remains subject to commissioning support for ongoing funding. External providers willing to discuss sheltered housing options as potential for D2A. WLCCG taking this up as a pilot scheme.	Number of patients supported by team: TBA.	Number of patients supported by team: TBA	Number of patients supported by team: TBA	**4**	Remove, this is business as usual and I attend the hospital housing steering group so it will evolve over time
5	5.1, 5.5, 5.6	Agree and produce a recognised delayed discharge measure across LLR to support operational and improvement work (in addition to DTOC reporting)	CCGs and Local Authorities	Tamsin Hooton	**71**	Create a task and finish group to amalgamate reporting requirements, and agree what will be produced	Improved information on delays and process issues relating to discharge, to support better targeting of actions including improved escalation and surge processes. Supports section 4	Group to meet (October 2016). Presentation to DSG (November 2016). Dummy report produced (January 2017)	March 31st 2017	Improved flow, reduced admitted breaches	% UHL DTOC, % LPT DTOC	Discharge metrics in development to demonstrate flow through new pathways. Dummy report produced for UHL. LPT reviewing data availability and scoping ability to provide same information.	Group to meet 3rd October	First draft report January 2017	0	**4**	C O'D: To remain on RAP (UHL produces info, LPT to provide it)
5	5.3	Agree Policy and procedure to support patient and family choice	CCGs and Local Authorities	Tamsin Hooton	**72**	Discharge Steering Group to lead process to agree policy, with appropriate engagement with stakeholders	Reduced DTOC related to family choice, improved patient/family communication about expectations	Discharge Steering Group to agree action plan COMPLETE DSG to agree policy for approval Approval by CCGs, Las/Integration Execs? Implementation plan incl comms	05/10 1/11/16 23/12/2016 March 2017	Reduction in DTOCs, improved flow, reduced admitted breaches	% UHL DTOC, % LPT DTOC	Initial discussions taken place to support an LLR policy. Key messages for staff in implementing the policy to be drawn up with Healthwatch, UHL, LPT, Social Care teams. No further progress made due to operational pressures, to be reinvigorated w/c 16.01.17	No policy being consistently used	Agreed policy by March 2017	0	**3**	C O'D: To remain on RAP. Next meeting 2nd March
5	4.1, 5.6, 5.5	Adapt acute SAFER flow bundle to address the community hospital service requirements	LPT	Tamsin Hooton	**link to 37**	Benchmark community inpatient wards and identify additional action required Share benchmarking with DSG and confirm required actions	Identify gaps and actions for delivery of SAFER bundle in community hospitals	Completed benchmarking exercise discussed at DSG Agreed action plan	5th October November DSG	Improved flow in CH, improved ability to discharge from acute, improved acute flow,	% LPT DTOC	Red and green work commenced on one ward. Need phased implementation timescales to be shared. **(move to section 4 for FLOW?)**	Benchmarking against 5 SAFER metrics	Agreed actions to address benchmarking gaps Nov 2016	Benchmarking completed. Red Green Day reporting key action	**3**	C O'D: Move to section 4
5		Increased Social Care input to hospital discharge process, particularly at weekends. Social care to step up winter capacity	Social Care City/County /Rutland	Tamsin Hooton	**73**	County/CIty to confirm date of increase to weekend social care input	Improved flow through earlier assessment and continued discharge planning. Increased weekend discharges.	Date agreed. Serivce in place.	28.11.16	Improved flow,improved ability to discharge from hospital		Social Services Assessment staff on site at UHL every weekend				**4**	C O'D: Completed. Remove from RAP
5		Ensure focus on CHC communication and process to reduce delays	Arden and GEM	Tamsin Hooton	**74**	Meeting with Commissioning team to outline key concerns	Improved communication with CHC team and hospital teams, reduced delays in process, reduced escalation	Date of meeting agreed, action plan agreed.	31.12.16	Improved flow,improved ability to discharge from hospital		CHC business Manager has attended red to green and forwarded suggestions to 'improve' the process. Suggestions under review.				**4**	C O'D: Merge 74 and 74a. Keep wording of 74a. Update is that mobilisation meetings are progressing with key stakeholders engaged.
5		Ensure all providers engaged with CHC new model mobilisation meetings	ELR CCG	Tamsin Hooton	**74a**	Gain initial dates from ELR CCG after standstill period, ensure circulated to providers	Improved communication with CHC team and hospital teams, reduced delays in process, reduced escalation	Date of meeting agreed, action plan agreed.	31.01.17	Improved flow,improved ability to discharge from hospital		Mobilisation meetings being set up with key operational staff, due to meet end of Janaury 2017.				**4**	
5		Implement an Integrated in-reach discharge team to support D2A pathways	ELR CCG	Tamsin Hooton	**75**	Business Case for integrated team agreed (Nov 16), Team funding agreed (Dec 16), personnel identified (Dec 16), team in situ (by 5th Jan 2017)	Enhanced ability to identify correct patients for pathways, provude trusted assessment, provide case management, provide therapy assessment	See planned activity	05.01.17	Improved flow,improved ability to discharge from hospital, reduced delays		Team to commence w/c 23.01.17 to support existing D2A plus new block purchased beds				**4**	C O'D: To remain on RAP. Update: Therapists and case managers working side by side in pathway 3. Further integrated approach to be set out and implemented
5		**Moved from KIA2 21/12/16:** To ensure that patients discharged from the Acute Trust with a Nerve Centre PARR+ score of +5 are provided with adequate community support to prevent readmission within 30 days	UHL	**TBC**	**66**	1. Roll out use of PARR30 tool 2. Update Nerve Centre with PARR score for at risk patients 3. Identify and implement community/primary care support within 48 hours of discharge	Reduction in readmissions for patients leaving the Trust with a PARR score of +5 by 10%	1. Nerve Centre being updated by 30/11/2016 2. Primary/community care support secured and implemented 3. CTR liaising with Jane Bulman for conf. that ICRS can undertake all LLR calls daily (anticipated volume 10 daily)	1. November 2016 2. November 2016 3. November 2016	Reduction in attendances at ED and admitted breaches	Reduction in readmissions	**No named lead yet:** Patient needs to be f/u by UHL staff Establish what ICRS are currently offering Establish what HART are currently offering Call handlers could be non-clinical but need access to the UHL clinical record Need to agree an LLR offer	Reduction in readmissions for patients leaving the Trust with a PARR score of +5 by 10%	10% reduction	Awaiting data	**2**	C O'D: No idea about this one, not heard anything since I sent it to Rhiannon Pepper

Actions declared as completed:

Key Intervention Number	National Guidance reference / detail	Action Detail	Lead Organisation	Accountable Officer	Action number	Planned activity	Expected outcome/Impact	Key milestones	Delivery date	Contribution to ED recovery	Links to Dashboard	Update (All perf. Figures are dated)	Metric			RAG rating
4	NA	Reduce time from bed allocation to departure from ED	UHL	Julie Taylor	**14**	1. Establish baseline 2. Identify themes for delay 3. Allocate Rapid Flow team to ED 4. Communicate and promote change in process 5. Rapid cycle test the new process 6. Implement	1. When beds are available, patient will leave within 15mins	1. Establish baseline - complete 18th July 2. All other actions were completed in August	All actions complete 1 September 2016	1. Improve flow from ED 2. Decrease congestion in ED	admitted breaches	1. Work with the rapid flow team has shown an reduction in the average time from 30 mins to 19 mins. 2. Delay themes identified: * Photocopying issues - resolved * Patient status issues -resolved 3. Currently looking at issues around bulking of bed availability and transport issues. 4. Data requested on % of patients with bed request outside of LRI as impacting on 15min performance. Data will then be cleansed to provide a true reflection of improvement made.	26% (patients leaving dept within 15mins of bed allocation)	50%	31%	**5**
4	NA	Reduce handover times for nursing team	UHL	Julie Taylor	**15**	1. OD facilitated workshop with medical and nursing teams on handovers 2. Trial of suggested new format of handover 3. Embedding of newly agreed process in the department	1. Reduce handover times to maximum of 20 mins and reduce number of handovers.	1. Baseline current handover process & times - complete 27th July 2016 2. Implement bedside handover - will be complete 7 November 2016 3. Reduce number of doctors handovers - review 7 November 2016	All actions to be complete 7 November 2016	1. Reduction in wait to be seen in ED	breaches	Handover time : 20mins	Handover time: 15 mins	Maximum 15 mins	20 mins	**5**
4	NA	Reduce delays in diagnostics for patients in ED	UHL	Julie Taylor	**20**	1. Baseline audit to be completed 2. Identify reasons for delay from audit 3. Complete trial of dedicated porter for 3 days in ED	1. Decrease congestion in ED 2. Improved efficiency of diagnostics	1. Baseline audit - complete 18th July 2. Reasons for delays identified 25th July 3. Trial of dedicated porter - delayed due to availability of porters	All actions to be complete 17 October 2016	1. Reduction in patient wait times 2. Reduction in breaches	Breaches	1. Baseline audit - complete 18th July 2. Reasons for delays identified 25th July 3. Trial of dedicated porter - delayed due to availability of porters 4. Porter trial took place on 13-15 September; further meeting planned this week to discuss and review the data gathered and look at potential service improvements. Being picked up in workstream.	Transfer time from ED to imaging metric is being reviewed	TBC	TBC	**5**
1		NHS Improvement recommended presentation from South Warwick on how they improved system performance.	UHL	Lisa Gowan	**25**	-CD to make contact with South Warwickshire Trust - Invite to present to senior leadership team to identify any further actions for UHL to implement	Unable to comment on expected outcome until contact has been made	Unable to comment on expected outcome until contact has been made	Exchange visit to be complete by 1 November 2016	Unable to comment on expected outcome until contact has been made	Breaches	1. Clinical Director made contact with South Warks Director of Ops and Medical Director to confirm next steps. 2. Contact made; South Warwickshire to provide dates for UHL visit. 3. Action to be picked up by workstream	Unable to comment on expected outcome until contact has been made	TBC	TBC	**5**
4	NA	Improve discharge from UHL by decreasing transport delays	UHL	Gill Staton	**45**	1. Meet Arriva and CCGs to establish reasons for delays 2. Implement actions to address delays 3. Implement a weekly meeting to review patients that were re-bedded and identify themes and develop actions to resolve 4. Establish process of prospectively booking discharges 5. CCG to complete procurement of NEPTS	1. Increase early discharge 2. Decrease failed discharge	1. Set up meeting with Arriva & CCGs by 1st October 2016 2. Set up weekly review to start w/c 26th September	All actions complete by end of October	1) Reduction in breaches 2) Improved flow out of ED	admitted breaches	1. CCG UHL meeting 29.9.16 to discuss contract arrangements and overbooking processes to manage demand until new contract confirmed 2. Arriva UHL meeting 30.9.16 to jointly improve processes 3. Meeting took place with Arriva; new way of working agreed, including focus on discharge from assessment areas and increase ambulance utilisation.	4.5% (discharges pre 11am) 13% (discharges pre 1pm)	33% before 12.00	4.2% (discharges pre 11am) 12.9% (discharges pre 1pm)	**5**
4	NA	Implement low risk ambulatory service on CDU	UHL	Sue Mason	**26**	1. Business case to be written for EQSG 2. Meeting with CCGs to discuss commissioning 3. Implement if commissioned	1. Maintain LOS on CDU achieved during pilot (July/August) 2. Average LOS in low risk ambulatory service 2 hours 3. Improve quality for patients by decreasing time in CDU	1. Business case went to EQSG on 31st August 2. Met with CCGs to discuss commissioning 6th September 3. Implement if commissioned 1st December	If commissioned, 01/12/2016	1. Decrease in frequency of CDU going on a 'stop' therefore decreasing congestion in ED and number of breaches	breaches in ED	1. Funding agreed; service begins on 1.11, four days a week. Clinical lead actively seeking GP cover to provide five day service.	13 (Length of stay in CDU)	13 (target to achieve length of stay achieved during the pilot)	13.3	**5**
1	1.2	Increase the streaming/ treating and redirection of patients from ED front door.	UHL	Lisa Gowan (Ffion Davies)	**8**	1. Model streaming service integrating Lakeside with primary care team & UHL. 2. Develop staffing model to allow increased streaming. 3. Develop clinical model to enable increased treat and redirect.	1. Reduction in late referrals to ED 2. Increase in the number of patients streamed. 3. Increase in the volume of patients treated/redirected.	1. Paper to JA confirming the service integration plans 23/9/16. 2. Continuation of the streaming service 1/11/16 3. Remodelling of the streaming service 1/12/16 4. Monthly review of the service - on-going 5. Opening of new service 1/4/17	Continuation of service 1/11/16	1. Decrease attendance in ED 2. Ensuring referrals from UCC to ED occur in a timely fashion 3. Reduction in non-admitted breaches in UCC & ED	Treat and redirect	1. Contract with Lakeside extended from November 2016 to 1st April 2017 2. Integrated model of care agreed 3.New integrated workforce model implemented from 10/10 4. Paper outlining the clinical model for procurement from April 2017 being drafted for discussion. 5. Regular KPI monitoring meetings with Lakeside in place from 1.11.16.	44% (% pts treated and redirected)	55%	44%	**5**

1	NA	Review short stay capacity & demand and determine if we are going to increase the short stay capacity and reduce base ward capacity	UHL	Lisa Gowan (Lee Walker)	**13**	1. Review literature on how many AMU beds are required to match demand and capacity 2. Visit other Trusts to compare the size of their AMU capacity to ours 3. Determine if we are going to increase our short stay capacity or not	1. Improvement in flow from ED 2. Improvement in patient experience 3. More efficient way of working, leading we hope to a reduction in LOS	1. Review literature on how many AMU beds are required to match demand and capacity - 9/9/16 2. Visit HEFT to compare the size of their AMU capacity to ours - 2/9/16 3. Determine if we are going to increase our short stay capacity or not - 28/9/16	Agree on whether we will increase AMU capacity or not ~~28/9/16~~ 30.11.16	1. Improvement in flow from ED resulting in a reduction in non admitted breaches	Admitted breaches	1. ECIP suggested we are 28 to 50 beds short. 2. Contact being made with HEFT to discuss their capacity and clarify numbers. 3. Agreed to move GPAU to yellow zone 7.11.16 until March 2017; vacated capacity to be used as four additional AMU beds (opening dependent on safe staffing). This will provide insight into future short stay capacity requirements. 4. Nursing and medical staffing pressures and space potentially restrict further increase in bed numbers. 5. Fire, health and safety and infection control reviews of vacated space to be carried out to determine number of bed spaces available: UPDATE: 3 bed spaces available in vacated area. 6. GPAU capacity extended from 6 to 9 spaces. 7. Ward 7 open as transitional ward/discharge area. 8. No other space to add additional beds currently.	106 short stay beds	134	106	**5**
4	NA	Trial senior acute physician in ED to challenge admissions	UHL	Julie Taylor (Lee Walker, Ian Lawrence)	**10**	1. Three day trial in September 2. Two further trials to take place to confirm results 3. Collate results and review outcome of trials 4. If results positive review medical job plans to check if it can be staffed within existing resource. 5. Implement (if outcome positive)	1. Reduced conversion rate to admission 2. Increase bed capacity 3. Decrease congestion in ED 4. Improve patient experience with 'home-first' mentality	1. 15th August complete 1st trial 2. 29th August completed 2nd trail 3. 26th September complete 3rd trial 4. 3rd October review outcomes and confirm benefits and decision to progress	Decide by ~~14/10/2016~~ 11/10/16 if this will be fully implemented COMPLETE	1. Decrease congestion in ED 2. Decrease breaches 3. Improve patient experience 4. Reduction in volume and % of patients admitted	Decrease admission	1. First two trials complete-provisional data showing decreased conversion to admission 2. CHKS data to be used to benchmark target against peers, and develop key further actions for UHL. 3. Acute physician in ED not sustainable long term due to resource constraints. 4. GPAU to move to yellow zone space from 7.11.16 for GPAU patients, UCC referrals from ED, and pull from majors. This will allow challenge of admissions and appropriate pts to be pulled from ED to ambulatory stream by acute physicians. 5. Weekly review of model of working with GPAU next to ED	21.2% (ED conversion rate)	18.70%	21.30%	**5**
4	NA	Increase utilisation of yellow zone (ambulatory majors)	UHL	Julie Taylor (Lee Walker, Ian Lawrence)	**16**	1. Determine different staffing models to test 2. RCT models 3. Review outcomes 4. Develop model 5. Implement change	1. Reduce non-admitted breaches 2. Improve patient experience	1. 29.6.16 RCT an Acute physician model running this area 2. Collate results 3. If positive see if this model is viable (resources)	30.11.16	1. Reduction in breaches	breaches	1. Initial day trial (RCT) went well; needs longer trial to prove concept and collect meaningful data to support approach. LW to action. 2. Obtain data from Leeds Hospitals via ECIP re their model and criteria. 3. HOS to review criteria for local use 4. Daily reminder to clinical matrons to be responsible for ensuring patients are identified for yellow zone. 5. Yellow zone area to become ambulatory area for GPAU patients, UCC referrals to ED, and pull from majors beginning 7.11.16. This is in line with model that will be used in new Emergency Floor. 6. Weekly review of new model of care, including pull of ambulatory patients from ED, to take place following relocation of GPAU. 7. Monitoring as part of action 10a. 8. Yellow majors no longer exists; GPAU in ED now in place	68% (Majors yellow area 4hr performance)	95%	61%	**5**
4	NA	Develop hospital internal professional standards (incl speciality in-reach to ED)	UHL	Sue Mason	**43**	1. Implement UHL Better Change project to decrease Cardiology inpatient LOS pre Cath Lab 2. Implement daily review of patients on monitored beds 3. Review capacity and demand of monitors available	1. Improved LOS in Cardiology 2. Decreased delay of transfer of patients from ED to CDU	1. Baseline data collection of cath lab waits - complete 2. Implement electronic referrals for Cath lab - complete 3. Implement Hot lab Cath lab sessions - complete 4. Reaudit Cath lab waits 11th November - this has been brought forward to October	All actions to be complete by 11 November 2016	1) Reduce delay of transfer of patients from ED to CDU	ED breaches	1. Baseline data collection of cath lab waits complete 2. Implement electronic referrals for Cath lab complete 3. Implement Hot lab Cath lab sessions complete 4. Reaudit of Cath lab waits taking place w/c 24.10 to confirm if changes have had necessary impact. 5. Post-change audit complete; shows decreased wait time for patients and decreased LOS. Contributing factors include improved communication between ward and lab; increase in timely referrals	-	3.5	3.4	**5**
4	NA	Decrease conveyance of Cardiorespiratory patients between LRI and Glenfield to increase EMAS capacity	UHL	Lisa Gowan	**27**	1. Establish baseline activity 2. Review the criteria 3. Case note review to determine if the patient was conveyed to the right location 4. Develop action plan 5. Implement any required changes	1. Decrease conveyance of cardiorespiratory patients from LRI to Glenfield 2. Improve quality to ensure that patient gets to the right specialty first time	3. Case note review to determine if the patient was conveyed to the right location 30 September 4. Develop action plan 31st October 5. Implement high impact and short term rapid interventions 30th November	Full implementation 30 November 2016	1. Reduce attendances at ED 2. Reduce overall breach rate	breaches	1. Audit to be completed for all those patients sent direct the LRI to ascertain reasons by end of September 2. 2 FY2's have been identified to carry out audit on those patients transferred from LRI to gather evidence on process and define next steps. 3. Audit complete - shows 34% conveyance due to lack of available beds. Actions to follow include: clear comms to CDU that all stops to be agree via	Oct	96 (10% reduction)	50 to date in Sept (ED LRI to GGH)	**5**
5	5.6, 5.1	Increase OPAT provision (up to 2 beds) to provide a service that delivers IV antibiotics in the patient's own home, in order to reduce LOS	UHL	Tamsin Hooton	**49**	Expansion of the current process that will allow patients who require IV antibiotics to be treated at home rather than in a hospital bed.	Increased flow, reduced LOS	MRET funding to be utilised to March (£100K) Advertise for 3 nurses (Sept 16) Identify consultant Pas (complete)	Expansion scheduled for 1/12	Reduction in admitted breaches, reduction in LOS,	Patients discharged from UHL	3 nurses in post with another due to start soon. Providing a 7 day service. Now need to work up a business case for longer term funding (funding agreed for 9 months). **Suggest closing this action. RAG changed to Green 5.**	current numbers of patients supported	2 bed expansion up and running (can be phased if recruitment requires)	TBC	**5**
5	5.5	ICS to provide a programme of education to hospital ward teams in order to increase the usage of ICS.	UHL/LPT	Tamsin Hooton	**50**	Share referral criteria for ICS - 10/09 Clinical ward rounds to identify suitable people (joint with LPT)	More appropriate referrals, increased utilisation of ICS	Circulate ICS criteria Communication exercise internally and on wards Ward rounds weekly - senior LPT and UHL staff - agree frequency and put in place	30/09/2016	Increased flow, reduced admitted breaches, reduction in LOS, ICS Capacity utilisation (baseline 80%, increase to 90%)	% of LPT ICS Beds used by patients	**Suggest closing this action**. ICS utilisation has improved (although it is more step up capacity being used than step down). **Rag changed to Green 5**	Number of referrals to ICS from UHL wards. Baseline TBC	TBC	TBC	**5**
5	5.1, 5.5	Review model of ICS for opportunities to increase usage, focus on County pathways	LPT	Tamsin Hooton	**51**	Integration of ICS with county POC provision/HTLAH model	More appropriate referrals, increased utilisation of ICS	Initial paper to Integration Exec 5/10 Full Cusiness Cases 5/11 Decision on further integration to go to Integration Executive Pilot in Loughborough of inreach/joint working with ICS	**Business case 2nd November to IE**	Reduced LOS/Reduced discharge delays, also supports 'step -up' and reduced ED admissions	% of LPT ICS Beds used by patients, % UHL DTOC	**Suggest closing this action.** ICS model to be reviewed as part of 'Home First' workstream within the STP. Loughborough pilot is in place. **RAG changed to Green 5**	Business case for social care input to work alongside ICS agreed	Business case agreed	Implementation commenced	**5**
5	5.1, 5.5	Review future model of ICS to support discharge to assess and 'Home First' model	UHL/LPT	Tamsin Hooton	**51a**	Discharge Steering Group to agree strategic direction for **Discharge to assess,**	Better integrated discharge to assess approach across LLR, increased use of ICS	Agree future integrated discharge to assess short term model by November 2016 Trial changes to ICS model by November - March 2017 Agree Business Case with commissioners/BCT - Jan 2017	31/03/2017	Reduced admissions, reduced admitted breaches, reduced LOS, improved flow	UHL DTOC %	**Suggest closing this action.** ICS model to be reviewed as part of 'Home First' workstream within the STP. Integrated in-reach discharge team is now planned to support discharge to assess model. Discharge steering group has agreed short term vision of D2A, further planning required for medium/long term strategy. **RAG changed to Green 5**	Discharge to Assess model agreed.	Reduction in numbers of patients assessed for CHC in acute setting (baseline TBC) but target only 10%	Business case for social care input to work alongside ICS agreed	**5**

4	NA	UHL to open additional emergency beds at the LRI to decrease bed capacity/demand mismatch	UHL	Gill Staton	**9**	1. Open and staff 28 beds on ward 7	1. Decrease outlying on non-medical wards (dependent on attendances and admissions remaining constant) 2. Decrease congestion in ED by improving flow 3. Contribute to an improved 4 hour performance 4. Improve staff experience by staffing a consistent ward therefore preventing staff moving from ward to ward	1. 10th October 2016 identified staffing to be confirmed 2. Equipment to be ordered and delivered by 22nd October 3. Planned opening 1st November 2016 4. Fortnightly progress update meeting in place with COO	Ward open 1 November 2016	1. Reduction in breaches linked to poor flow and ED occupancy	admitted breaches	1. Estates work on ward 7 started on 14/9/16 2. Communications have gone out to all staff in September 3. Equipment ordered on 25/8/16 4. Nurse staffing rosters set up and shifts sent out agency on 08/08/16 5. There is a fortnightly meeting in place chaired by COO to progress 6. On Track to open November 1st (The main risk to opening remains staffing) 7. Ward 7 delayed opening as a 28 bedded ward as unable to staff safely, continue to monitor weekly to establish if we can open a bay at a time 8. Ward to be used as discharge and transitional care ward (6-10 beds overnight) to support increase in morning discharges; appropriate staffing being secured	0%	28 beds open on the ward	0%	**5**	
4	4.1 4.3 4.4	Implement SAFER patient flow bundle Trust wide **TS: When will Red2Green be Trustwide?**	UHL	Gill Staton (Ian Lawrence)	**37**	1. Baseline audit of wards to be completed on utilisation of the SAFER flow bundle 2. Develop actions to address gaps identified in audit 3. Re-audit once actions put in place 4. Phased roll-out across UHL	1. Increase in the number of patients discharged before 1100 2. Increase in the number of patients with EDD 3. Consistent board rounds on all wards 4. Decrease number of 'stranded' patients 5. Improve ward ownership 6. Increase patient experience by ensuring patient is part of the decision making process 7. (Percentages to be confirmed once baseline audit complete)	1. 29th August 2016 audit of 5 wards completed 2. 19th September 2016 baseline audit of 2 further wards to identify areas for improvement 3. Collation of results and feedback w/c 1st October 4. Action plan developed by 10th October 5. Implementation of plan to start 17th October on key wards 6. Start of baseline audit of remaining wards on 14th November 7. Action plan and full roll-out by mid-December	SAFER patient flow will be rolled out on two key wards by 01/11/2016 COMPLETE	1. Improve base ward capacity for admissions from ED.	admitted breaches	1. 29th August 2016 audit of 5 wards completed 2. Week of 19th September:2 further wards audited and data being collated for baseline 3. Resource for implementation of actions being identified 4. Re roll-out of professional standards 5. Increase rigour of board rounds to create consistency 6. Internal professional standards updated and will be re-launched with team throughout November. 7. Roll out across medical wards complete. 8. Trust wide roll-out - Area of focused support from ECIP; to be discussed further at UHL Beds Programme Board 3.11.16 9. Now being rolled out as part of Red/Green Trust wide initiative	5.82 (average length of stay for Medicine)	4.67	5.82	**5**	
4	NA	Glenfield to open additional beds to decrease bed capacity/demand mismatch	UHL	Sue Mason	**39**	Open 28 beds on ward 23a	1. Decrease outlying on non-medical wards (dependent on attendances and admissions remaining constant) 2. Decrease congestion in CDU 3. Contribute to an improved LOS on CDU 4. Improve staff experience by staffing a consistent ward therefore preventing staff moving from ward to ward 5. Reduced frequency of CDU going on a 'stop' **TS: review of stop protocol required - see streaming action**	1. 18th November 2016 staffing to be confirmed 2. Equipment to be ordered and delivered by 31st October 3. Planned opening 1st December 2016	Ward is due to open on Monday 5 December 2016	1. Decrease breaches linked to better flow to GGH	admitted breaches	1. Communication to staff started 15th August 2016 2. Compiled list of equipment requirements - ordered w/c 18th Sept 3. Out to recruit for staff 4. Discussed with medical staff to provide cover 5. Funding agreed and phasing needs finalising - now complete 6. Rota now agreed; ward sister position filled; ward kit etc being ordered for 5.12.16 opening. 7. Ward opened ahead of schedule	0	28 beds open on the ward	0	**5**	
2	1.8	Increase utilisation of step up capacity to prevent acute activity (interdependency with action 3)	LPT	Rachana Vyas	**67**	1. Develop additional guidance with GP's and circulate. This should include medical management template with pre-populated prescribing guidance and parameters 2. Improve engagement and understanding of service across General Practice through use of case studies 3. Consider viability of Bed Bureau referring to Step Up	Increase utilisation of step up capacity by > 2 patients per day by CCG	1. Guidance, template and Comms complete 2. Rolling programme of case studies and direct feedback to GP's to be implemented using Board GP's 3. GP review of clinical referrals into Bed Bureau to assess viability of proposing alternative pathway of care	1. 31 Oct 2016 2. 31 Oct 2016 3. 23 Nov 2016	Reduction in attendances at ED and admitted breaches	ED attendance Emergency admissions Ambulance conveyance	Team identified at City CCG to lead development of template and guidance in partnership with LPT. Includes LPT team, nursing & quality, Medicines optimisation, IT leads and lead clinician - template complete and in operation REOMMEND CLOSE THIS ACTION AND OPEN A NEW ACTION PETAINING TO MENTAL HEALTH EMAS M/H Triage Car 16:00-23:59 7/7 from 06/01/2017. LLR trend in M/H Em Attends @ UHL ED down by 3.4% since July 2016 vs a total UHL Em Attends increase of 7.6% for the same period. 70 Em Attends avoided in Dec 2016 vs a target of 60. GW review of the ambulance M/H triage car pilot for decision at MH Clinical Forum Jan 2017	Increase utilisation of step up capacity by > 2 patients per day Baseline: City CCG: 1 per day West: 3 per day East: 2 perday Total: 6 pts/day	> 8 pts/day	w/e 13.01.17: City CCG: 1 per day West: 2 per day East: 2 perday Total: 5 pts/day	**5**	
3		Implementation of Dispatch on Disposition	EMAS	Mark Gregory	**34**	1. Trust identified as adopter site 2. Timescales for implementation Negotiated with NHSE 3. NHSE assurance review and sign off 4. Mobilisation 5. Secure exec lead for ARP/DoD at the delivery board 6. Map Nature of Call list against current keyword flows	Reduction of Resources to scene by 0.2 from 1.4 baseline Linked to above non conveyance trajectory	1. Work with NHSE to register as implementer site 2. negotiate and agree timescales for mobilisation 3. Assurance review to be arranged and undertaken 4. Mobilise scheme	1. September 16 2. September 16 3. 10th Oct 16 4. 31st October 16	Reduction in A&E attendances		1. Trust approved as implementer site 2. Timescales agreed Update 20 Oct 2016 DoD live as at the 3rd October. Further review of call codes being undertaken as progress is made towards ARP. Current RPI rate of 1.34 07/11/16 - DoD implemented succesfully. RPI rate currently @1.32 1/12/16 - Current RPI @ 1.36	1.4	Oct 16 - 1.4 Nov 16 - 1.36 Dec 16 - 1.32 Jan 17 - 1.28 Feb 17 - 1.24 Mar 17 - 1.2	TBC	**5**	
3		Monitor and increase the use of CAD+ at the Leicester Royal Infirmary	EMAS	Mark Gregory	**30**	1.Set Current baseline 2. Working with UHL arrange for notify screen move 3. Working with EMAS PMIT, generate individual compliance report 4. Ensure consistent use by Amvale resources	90% of crews using CAD+	1. Baseline generated from UHL handover report 2. link UHL & EMAS IM&T teams re the move of the notify screen 3. PIN number report to be generated and shared with divisional managers 4. Liaise with Amvale and feedback non-compliance	1. 1st October 16 2 31st October 16 3. 31st October 16 4. 30th September 16	Accurately monitor handover times and track trends		Update 20 Oct 2016 1. Baseline taken from report dated 10-10-16. Baseline set at 65% 07/11/16 - Meetings held to outline IT issues and reporting metric. Current performance @ 69% 01/12/2016 - Non Comliance tool now in use to ensure supportive conversations at staff level. Current performance - @69% 15/12 - focussed push to staff and supportive discussions assisting delivery. Current Performance @ 85%	Oct 16 - 75% Nov 16 - 77.5% Dec 16 - 82% Jan 17 - 85% Feb 17 - 87.5% Mar 17 - 90%	90% of crews using CAD plus	*TBC*	**5**	Remove to completed 20/2/17
3		Sustain Current High levels of Hear and Treat rates for LLR 999 calls	EMAS	Mark Gregory	**35**	1. Assess workforce capabilities to ensure robust 24/7 cover 2. Assess access for Clinical Advice Teams to the DoS 3. Communicate new access routes to Clinical Advice Hub once mobilised	Maintenance of the current baseline of 20% hear & Treat Rates for LLR generated calls	1. Workforce review undertaken and WFP generated 2. DoS access reviewed and available to CAT 3. Communication to be shared when CAH PID received	1. September 16 2. September 16 3. Nov 16			07/11/16 - on target and delivering 1/12/16 - H&T @20% 15/12/16 - H&T @18.2% 19/12/16 - H&T @ 19.1% Continued strong performance. Move to completion list	20%	20%	TBC	**5**	Remove to completed 20/2/17

Actions removed as part of RAP refresh February 2017:

3		Implement A&E Front door Clinical Navigator	EMAS	Mark Gregory	**32**	1. Identify individuals to undertake navigator role 2. Provide Supportive development with navigators to ensure appropriate challenge etc. 3. Monitor and report against findings 4. Look towards extension to hours via Vanguard Funding	Linked across all Non conveyance metric (Reduction of 4% by 31st March 2017)	1. Clinical team Mentors identified as navigators 2. Jay Banerjee to deliver training 3. Monthly reports to be fed into the appropriate meeting structure 4. Business Case to be submitted for extension to coverage	1. 1st Sept 2016 2. 1st Nov 2016 (Complete) 3. 10th of Each Month 4. 10th Oct 2016	Reduction in A&E attendances		1. Team identified and Briefed 1. Soft launch of confirm and challenge commenced 2. Dr Jay Banerjee contacted and dates for trailing being developed 20 Oct 2016 update Discussion and detail shared with commissioners to understand finance available. 07/11/16 - Paper submitted by J.Banerjee outlining project scope. Meeting held with CCG colleagues and BC to be drafted for upstream navigation. 1/12/16 - Dr Banerjee held development session for CTMs. Plans for initial Frail Elderly upstream navigator being developed. Plans also being developed for Paramedic Call Back pilot Non Life threatened patients 29/12/16 - from the 13th January Dr Banerjee will be rolling out education sessions to front line staff via CPD days. 11/1/17 - Education sessions escalated and delivered ahead of trajectory. first trial of scheme to launch on a consultant connect basis during the weekend of the 14th & 15th January.	Number of Calls to Geriatric navigator	Percentage of EMAS attendances where an alternative should have been used not to exceed 15% per month (Nov 16 Onwards)		**3**	Can this action be superceded by either the HIA or PH GEM? **This can be superseded by the HIA so please move to closed, but closed due to replication.**
1	1.2	**Impact monitoring action:** increase the streaming/treating and redirection of patients from ED front door	UHL	Lisa Gowan (Ffion Davies)	**8a**	1. Ongoing monitoring of new model of care and impact on performance metrics	1. Reduction in late referrals to ED 2. Increase in the number of patients streamed. 3. Increase in the volume of patients treated/redirected.	1. Fortnightly review of the service - on-going, to inform opening of new service, 1.4.17	Continuation of effective service 1.4.17	1. Decrease attendance in ED 2. Ensuring referrals from UCC to ED occur in a timely fashion 3. Reduction in non-admitted breaches in UCC & ED	Treat and redirect	1. First of fortnightly review meetings with Lakeside commenced; metrics for the new clinical model of care agreed. 2. Nurse in Charge role started 1.11.16 to have overview of department 3. Interviews for additional GPs and ECPs to take place in December 4. In-reach ENP for see and treat to begin 3.12.16	44% (% pts treated and redirected)	55%	~~Sept 44%~~ ~~Oct 46%~~ Nov 48%	**4**	This is now part of the HIA action relating to streaming
1	1.4	Maximise use of ambulatory pathways across the front for, ED and CDU	UHL	Lisa Gowan (Ursula Montgomery/ Ffion Davies)	**11**	1. ED on the day review of utilisation of ambulatory pathways planned. 2. Develop action plan to address any gaps 3. Implement change 4. Reaudit 5. Embed a process for continual education and up skilling of all ED staff in available ambulatory pathways and how to access them.	1. Increase number of patients accessing ambulatory pathways	1. ED on the day review of utilisation of ambulatory pathways planned 28/9/16 2. Develop action plan to address any gaps 14/10/16 3. Implement change 4/11/16 4. Reaudit 25/11/16 5. Embed a process for continual education and up skilling of all ED staff in available ambulatory pathways and how to access them 7/12/16	Complete by 07/12/2016	1. Decreased ED attendances 2. Decreased non-admitted breaches 3. Decrease late referrals to ED	ED attendance	1. Work underway to forward plan for ways of working within new front door of new build 2. Review current list of ambulatory pathways, and sense-check for ease of use and explanation about services to ensure pathways are clear and meaningful for use by clinical teams. 3. Update at 1 March EQSG on ongoing pilot of ambulatory unit at CDU	% late referrals to ED	5% (Revised to reflect late referrals)	Oct 18% Nov 15%	**3**	This is now part of the HIA action relating to streaming
1	NA	Develop ED internal professional standards	UHL	Lisa Gowan (Vivek Pillai)	**18**	Implement Rapid Assessment and Triage (RAT): 1. On the day observation to identify areas of improvement 2. Develop improvement plan 3. Implement improvement plan Patients to be seen by senior decision maker in 90mins & have decision made within 180 mins: 1. Two hourly huddles implemented with senior nurse, doctor and manager; from 1 September there will be a focus on time to be seen by doctor. 2. Implement process to ensure appropriate use of escalation areas 3. Revise SOP for Majors - COMPLETE 4. Reduce medical handover times to maximum of 20 mins	1. Reduction in non-admitted breaches. 2. Reduced number of patients on ambulances	Implement rapid assessment: 1.Observation and plan - complete 31 Oct 2016 2. Implementation - complete 30 Nov 2016 Patients seen within 90mins/decision within 180mins: 1. Huddles began 1/9/16. 2. Implement process to ensure appropriate use of escalation areas - in place 3. Revise SOP for Majors - 30 October 4. Rapid cycle test new medical model - 30 October	All actions to be complete by ~~30 October 2016~~ 28.11.16 (actions now picked up in 18a, 18b and 18c below)	1. Reduction in non-admitted breaches. 2. Reduced number of patients on ambulances 3. Reduce number of 10 minute breaches	non admitted breaches 10 minute breaches	1. Internal escalation process updated and in place, to improve timely ambulance handovers 2. Doctor in Charge role card updated and circulated 3. Role card for majors leader finalised 4. External support for implementation of RAT is required; contact has been made with Sherwood Forest Hospitals FT, via NHS Improvement. 5. ECIP visit to Trust 12 and 13 January 2017, including external ED consultant input. 6. ECIP feedback following 2 days 13.1.17 - awaiting report	48% (% patients with decision made within 180mins)	95%	~~Aug: 45%~~ ~~Sept: 43%~~ ~~Oct: 42%~~ Nov: 45%	**2**	This is now part of the HIA foucs on streaming and 24/7 ED leadership, including outcome of ECIP and peer review
4	NA	Impact monitoring action: Impact of GPAU model of care into ED	UHL	Lee Walker, Ian Lawrence	**10a**	Ongoing monitoring of impact of change of model for GPAU pull of patients from ED and UCC by senior acute physicians	1. Reduced conversion rate to admission 2. Increase bed capacity 3. Decrease congestion in ED 4. Improve patient experience with 'home-first' mentality	1. Monthly review of impact	Ongoing	1. Decrease congestion in ED 2. Decrease breaches 3. Improve patient experience 4. Reduction in volume and % of patients admitted	Decrease admission	1. Weekly meetings in place to review impact 2. Update to EQSG 23.11.16 3. Initial 2 week data is positive, showing marked reduction in admissions to AMU and increase in patients being seen directly in GPAU, rather than ED. 4. Options appraisal on extending opening hours on sustainable basis, to be completed by 4.1.17 5. Discussion at EQSG 18.01.17 on extended hours of GPAU and financial impact. Next steps agreed for securing additional resource for extended opening.	% with GPAU or AAU as first location	33%	Oct: 25% Nov: 36% Dec MTD: 38%	**4**	This is now part of HIA relating to streaming
4	NA	Reduce handover times for medical team in ED	UHL	Matt Metcalfe	**18c (Was 15)**	1. OD facilitated workshop with medical and nursing teams on handovers 2. Trial of suggested new format of handover 3. Embedding of newly agreed process in the department	1. Reduce handover times to maximum of 20 mins and reduce number of handovers.	1. Baseline current handover process & times - complete 27th July 2016 2. Implement bedside handover - will be complete 7 November 2016 3. Reduce number of doctors handovers - review 7 November 2016	All actions to be complete ~~27 November 2016~~ 13 January 2017	1. Reduction in wait to be seen in ED	breaches	1. Deputy Medical Director now supporting diagnostic and development of key actions, hence change in timeline. 2. Slippage due to annual leave and operational pressures; meeting being held 16.1.17 to agree approach and next steps 3. To be included as part of observation provided by external ED consultant support - awaiting report.	Handover time: Medical: 3 hours (out of 24)	Maximum 1 hour (out of 24)	3 hours	**2**	This is now part of the HIA foucs on streaming and 24/7 ED leadership, including outcome of ECIP and peer review

Comments - RAP review

4	NA	Improve leadership and behaviours in ED.	UHL	Ian Lawrence	**21**	1. Appoint OD consultant 2. Sept - Nov: delivering leadership interventions; delivering sessions with leaders and teams on behavioural competencies; integrating OD, comms, SOPS and IT. 3. Delivering coaching for key leaders within ED	Improved staff morale	1. OD consultant in post May 2016 2. Sept - Nov: delivering leadership interventions; delivering sessions with leaders and teams on behavioural competencies; integrating OD, comms, SOPS and IT. - on-going 3. Delivering coaching for key leaders (Heads of Service & Key managers) within ED - complete August 2016 4. Agreement with Exec colleagues on tackling challenging behaviour and reducing variation. 5. Implement consistent daily action learning	This is on-going work until 31 March 2017	Non specific	Breaches	1. Pulse check baseline complete July 2016 (174 responses) 2. Follow up taking place September 2016 (20 responses) 3. LiA recruitment & retention event planned Oct 16 4. NHS Elect (coaching leaders) began on 24.10; next session in January 5. OD sessions complete - outcome and next steps discussed at 26.10 EQSG; multi-media alternatives being developed to increase uptake. 6.UHL change programme developed to focus on 30,60,90 day high impact actions. To be aligned with updated OD focus and plan (8 below) 7. Area of ECIP focus. 8. Following presentation at EQSG on findings from OD Sept-Nov actions, OD plan to be refreshed and refocused on delivering interventions and support to the team 'in situ' to support cultural change in ED. 9. Link to action 18: Intensive coaching programme, supported by OD team, Associate Medical Director, and senior leadership team. 10. Plan presented to EQSG 23.11.16 11. NHS Elect resilience training for band 7 nursing staff and service managers, taking place in December 12. Actions linked with RAP action 18 - internal	Sickness rate: 3.9% Turnover: 9.7% Vacancies: 30%	Sickness rate:3% Turnover: 9.5% Vacancies: 10%	Sickness rate: 3.8% Turnover: 9.7% Vacancies: 28%	**4**	This is now part of the HIA foucs on streaming and 24/7 ED leadership, including outcome of ECIP and peer review
4	NA	Reduce overnight breaches	UHL	Lisa Gowan	**22**	1. Senior leadership shift change (2pm - 10pm) over winter 2. Pro-active use of escalation areas to allow space in ED for decisions to continue to be made 3. Ensure consistent huddles over the night period 4. Open additional beds (as per previous action re ward 7)	1. Reduction in breaches 2. Improved patient experience	1. Implementation of the late shift rota (senior management 2pm - 10pm) 3rd October - COMPLETE 2. Increased clinical matron presence 7 days per week including evening 3rd October 3. Ensure safety huddles are completed during the night (SMOC or duty manager to lead) 5th September 4. Open additional ward capacity 1st November 2016 - Complete	All actions to be complete ~~1 November 2016~~ ~~16 December 2016~~ March 2017	1. Reduction in breaches overnight	Breaches	1. Intensive coaching programme to include overnight in ED in January. 2. Actions to be progressed following completion of overnight diagnostics: - Review of medical rota versus demand overnight - New escalation process agreed and in place - COMPLETE - Review approach and capacity to processing patients in the evening/overnight 3. Included as part of external request for medical leadership support 4. ECIP to run a red2green style diagnostic between 6pm-2am, to support team understanding of key problems and potential solutions	Currently 29% of patients arriving between 7pm and midnight are treated within 4hrs	70%	~~22%~~ ~~Oct: 30%~~ ~~Nov: 31%~~ Dec: 29%	**2**	This is now part of the HIA foucs on streaming and 24/7 ED leadership, including outcome of ECIP and peer review
4	4.2 4.5	Implement Red Day / Green Day as part of SAFER	UHL	Gill Staton (Ian Lawrence)	**47**	1. Investigate feasibility of method of capture of Red and Green Days (white boards or electronic) - complete 2. Develop Red and Green Day Criteria for implementation - complete 3. Develop launch pack - complete 4. Communicate to and educate staff - complete and ongoing 5. Roll out across ESM -audit following roll-out - complete	1. Decrease LOS for ESM	1. Agree Nerve Centre feasibility of recording of R&G days by 1st October 2. Agree R&G Day Criteria by 29th September 3. Roll-out of launch packs on 10th October 4. Audit 14th November 2016	All actions complete by 14 November	1) Improve base ward capacity for admissions from ED.	Admitted breaches	1. Red to Green being rolled out in all wards in ESM from 12 December. Resource identified and planning commenced week commencing 28.11.16. ECIP are supporting the start of the project - COMPLETE AND ONGOING 2. Director leads identified for each ward as part of roll-out. 3.Full R2G action plan in place, plan for phased roll out plan to the whole Trust by end March 2017 4. Key themes being identified for escalation and solutions to embed and sustain new ways of working	5.82 (average length of stay for Medicine)	4.67	5.82	**3**	This is now a HIA relating to flow - remove? **IT'S PART OF THE REDUCE DELAYS WITHIN HOSPITAL HIA; AGREE IT CAN BE REMOVED**

LLR A&E Delivery Board

Risk Register - February 2017

		Potential Risk Description	Initial risk level			Mitigating actions in place	Assurance	Further mitigating Actions	Expected date of completion	Reduced Risk Score			Comments
Risk Owner	Risk Ref	Should be high-level potential risks that are unlikely to be fully resolved and require on-going control	Impact	Likelihood	Rag Status	Systems and processes in place and operating that mitigate this risk	Evidence that this risk is being effectively managed	Additional actions required to mitigate this risk further	For further mitigating actions	Impact	Likelihood	Rag Status	
Tim Sacks	CL1	**RISK:** Keeping a patient in their usual place of residence with a treatable condition, managed by primary care and the patient dies. **CAUSE:** Capacity & confidence in primary care, OOH GPs adherence to pathways, availability of community staff to support primary care management, inconsistency across City & County. **Impact:** potential adverse outcome for patient	4	4	16	RAP - Area 2 Actions (link) Development of support services in community: - AVS/CRS, NHS 111, EMAS, OOH Workforce planning for primary care Consultant connect	Implementation of actions in RAP Area 2 by AEDB **KPIs:** ED attendance Unexpected deaths in the community	Undertake work to understand the variability across City & County Implement actions to change the culture of staff and patients regarding end of life care at home Support more GPs to take appropriate risk management in the community	TBC	4	3	12	
Rachana Vyas Mark Gregory	CL2	**Risk:** Too many people with a perceived need for emergency ambulance response **Cause:** Inappropriate assessment and or Access **Impact:** Patients waiting 'unsighted' in the community for a first response following initial telephone triage - EMAS crews unable to attend urgent cases in the community	5	5	25	RAP - Areas 2 and 3 (Links)	Implementation of actions in RAP Areas 2 & 3 by AEDB **KPIs:** SIs relating to patients waiting for ambulance response Red conversion rates Ambulance handover delays	Review actions relating to NHS 111 warm transfers Review interfacility transfers (UHL originated) Review Primary Care Access Rates	TBC	5	3	15	
Tamsin Hooton	CL3	**Risk:** Discharge breakdown **Cause:** Limited community capacity in health and social care, inappropriate early discharge, poor post discharge follow up, failure to plan discharge at the point of admission. CHC capacity, avaiability of HTLAH packages **Impact:** Patients not being discharged or patients being readmitted	4	5	20	RAP area 5 (Link)	Implementation of actions in RAP Area 5 by AEDB **KPIs:** DTOC Medically Fit for Discharge (MFFD) rates Stranded patient data Readmission data Discharges before 12pm	Review actions for post discharge follow up DTOC - data being drawn together to show delays, allows analysis during discharge working group CHC mobilisation plan taking place (Jan-March) for new provider HTLAH operational plan in place with vacant lots out to procurement (Jan 17) Pathway 3 County beds (14) online from 30.01.17	TBC	4	4	16	
Caroline Trevithick	CL4	**Risk:** Management of a dying patient in the community results in hospital admission **Cause:** Lack of Advanced Care plan, failure to follow advanced care plan, lack of DNACPR, failure to follow DNACPR, pressure from families and carers **Impact:** Patients being admitted inappropriately at end of life.	3	4	12	End of life BCT plan	**KPIs:** Reports from UHL/EMAS regarding inappropriate admission			3	3	9	
Pete Miller	CL5	**Risk:** There is a risk that sufficient staff cannot be recruited or retained to fulfil the needs of the new operating models **Impact:** service changes the changes will either be delayed, or not made, or delivered at too high a cost, resulting in a failure to achieve the overall goals of the programme **Cause:** Insufficient staff	4	5	20	Workforce strategy complete Action plan in place to address known capacity risk areas (eg primary care, nursing)	BCT workforce group review	Develop approach to strategic workforce planning to assess new capacity risks as they arise - Ongoing Link with clinical workstreams to provide Ongoing workforce planning support - Ongoing Develop joint attraction strategy		3	5	15	