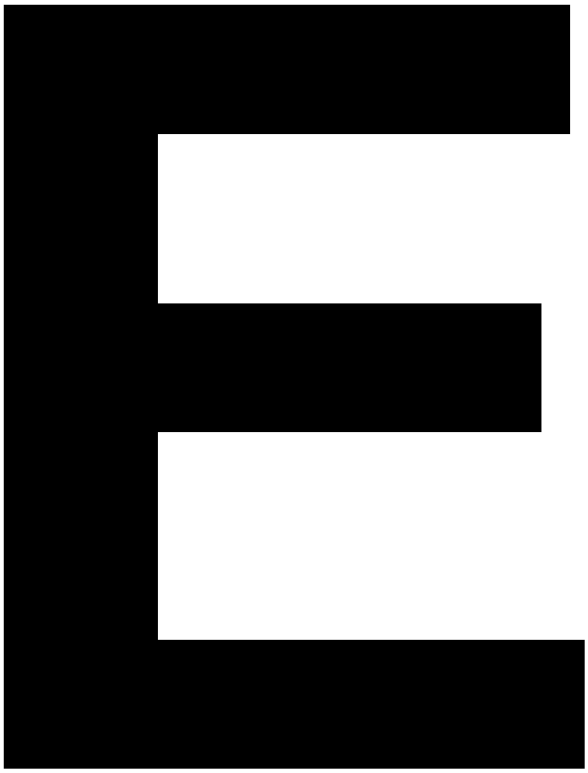

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COMMISSIONING GROUP

GOVERNING BODY MEETING

Title of the report:	**Urgent Care Report**
Author:	**Jane Taylor, Emergency Care Director LLR**
Presenter:	
Purpose of report: This paper seeks to update the governing body on the recommendations made by Dr. Ian Sturgess following his six month review of the urgent care system within Leicester, Leicestershire and Rutland and the subsequent actions taken in response to his recommendations.	
Actions required by Governing Body members: The CCG Governing Body is requested to: **Receive the report and note the actions taken.**	

EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP
GOVERNING BODY MEETING

9 December 2014

Urgent Care Report

Introduction

1. As highlighted by regular performance reports to the Governing Body there are long-standing challenges in providing consistently high quality emergency and urgent care services in Leicester, Leicestershire and Rutland. As a result people often wait longer than the national 4-hour wait standard in the Leicester Royal Infirmary's Emergency Department, stay in local acute and community hospitals longer than needed and aren't always given care in the place best suited to their needs.

2. There have been a number of reviews which have looked at elements of the system over recent years. The actions put into place in response to these reviews have delivered improvements in some areas but have not delivered the system-wide changes needed to consistently improve performance.

3. To build on the improvements already made and to support transformation of the urgent and emergency care pathway under Better Care Together, East Leicestershire and Rutland, Leicester City and West Leicestershire Clinical Commissioning Groups and University Hospitals of Leicester NHS Trust commissioned a world-renowned expert to look at the problems across the urgent care system.

4. The review was conducted between mid-May 2014 and mid-November 2014 by Dr Ian Sturgess, a former senior consultant geriatrician with extensive experience in the improvement of urgent care systems across the UK and overseas. During the six-month review period, Dr Sturgess spent time with clinicians and staff in primary care, acute and community hospitals, mental health services, NHS 111 and out of hours care, urgent care centres and social care teams to identify improvements across the health and social care system in Leicester, Leicestershire and Rutland.

5. Due to the nature and number of providers and services in primary and community services, Dr Sturgess was unable to visit everyone. However, his time spent in the wider system was spread between health and social care and focused on those services which have the most links with urgent and emergency care.

Findings

6. Dr Sturgess found that the local system has the potential to be ‘high-performing’ but is ‘relatively fragmented with barriers to effective integrated working’. He stresses the importance of recognising performance against the national 4-hour wait standard for the Emergency Department as a reflection of the performance of the whole health and care system and he makes 183 recommendations for transformation and improvement.

7. The recommendations focus on issues relating to the following themes:

    - **Admission avoidance** – ensuring people receive care in the setting best suited to their needs rather than the Emergency Department.
    - **Preventative care** – putting more emphasis on helping people to stay well with particular support to those with known long-term conditions or complex needs.
    - **Improving processes within Leicester’s Hospitals** – improving the Emergency Department and patient flow within the hospitals to improve patient experience and ensure there is capacity in all areas.
    - **Discharge processes across whole system** - ensuring there are simple discharge pathways with swift and efficient transfers of care

8. Dr Sturgess started his review in Leicester’s Hospitals and provided feedback on emerging key issues within the first six weeks. As a result of this urgent actions were swiftly undertaken to address the issues he raised. In his final findings he noted that there has been some early improvement seen within Leicester's Hospitals.

Links with system-wide initiatives

9. A number of Dr Sturgess’ recommendations relate to longer term transformation and many improvements are already underway or in development as part of the Better Care Together programme, which is ideally placed to help drive forward the integration of services, partnership working and cross-system changes recommended in the report.

10. Dr Sturgess’ contributed to the development of the vision for urgent care set out under Better Care Together, which aims to deliver better services within available resources within a 5-year timeframe. The vision is for better patient outcomes and experience and a system that is understandable, accessible, consistent and measurable. This will be achieved through maximising the benefits of integrating primary and secondary urgent care.

11. The findings detailed in his report are now being considered by the urgent care workstream within Better Care Together to help further strengthen the vision and supporting actions.

12. Within the area of Mental Health Services the review undertaken to support the transformation of crisis response services within the community links with the recommendations within the urgent care report. This will support alternative community pathways but also shape the mental health assessment process within the Emergency Department at UHL.

13. The *Learning Lessons to Improve Care* review; highlights the need for system-wide co-operation and collaboration in order to identify solutions and make improvements to care. Key themes identified are re-enforced in Dr Sturgess recommendations particularly the need for greater focus on and support for frail patients and those at the end of their life. There are also strong links to recommendations around behaviour and culture changes.

Progress so far

14. Dr Sturgess' report was finalised in mid-November but local NHS organisations and councils have not waited to take action, working closely with Dr Sturgess throughout the review period to tackle urgent issues.

15. Improvements already in place as a result of the review include a number of initiatives to ensure people are treated in the places best suited to their needs such as via GPs, in their own homes or in community settings. This means better care for patients and more capacity in the urgent and emergency care system. Initiatives already implemented include but are not limited to:

- A multi-disciplinary team set up at the Leicester Royal Infirmary to avoid admissions wherever possible for patients who are frail and who have complex needs. Evidence shows that this approach, particularly when supported by a geriatrician, helps people to receive care better suited to their needs and in turn relieves capacity pressures
- Simplification of discharge to three key pathways has been agreed across health and social care partners with pilot schemes already being tested for Pathway 2 – home with support and Pathway 3 – short term placement to support re-ablement.
- A multi-disciplinary team set up at the Leicester Royal Infirmary to avoid admissions wherever possible for patients who are frail and who have complex needs. Evidence shows that this approach, particularly when supported by a geriatrician, helps people to receive care better suited to their needs and in turn relieves pressure on the Emergency Department.
- GPs are stepping up use of combined health and social care solutions in the community so people are supported and treated by integrated health and

social care services. Examples include night services extended across the county and GPs referring older patients and those with long term conditions to community health and social care teams who treat the patient at home so that they retain their independence in familiar surroundings.

16. The review has confirmed a lot of what we already know about what's not working in our system and the barriers to achieving the care we want to provide. However, while many of these things are already being tackled or were planned, the report has helped re-focus system wide efforts.

17. All of the recommendations have been collated into one document (Appendix A) and have been considered in detail by all organisations.

18. In some instance the recommendations have not been wholly accepted but alternative interpretations or recommendations have been considered. Each recommendation has then been ranked on the basis of its impact and how quickly it can be implemented. Within the appendix the ranking of 1 – 4 are identified with 4 being high impact with a short time frame to implementation. The focus for future actions is then based on those ranked 4 and 3.

19. The Operational Winter Urgent Care Plan has now been developed to bring together the work streams that are already in place and to focus new actions underpinned by the recommendations made within the report.

20. The Urgent Care Action plan aligns to outcome measures and metrics as recommended within the report to monitor integrated process.

21. The Urgent Care Action plan focuses on actions over the winter period, some of the recommendations made within the report require a longer term strategy for improvement and the supporting working being undertaken through the BCT projects will take forward key areas of work particularly the frailty, long term conditions and the mental health work streams.

22. The Urgent Care programme will work closely with these work streams to ensure that actions and outcomes are aligned and resilient across the urgent care pathway as well as within the clinical pathways.

Next steps

23. All organisations are actively working to ensure there is sufficient capacity to support improvements within organisations and to support joint projects.

24. The Action Plan will be developed further following discussion at Governing Bodies and through the Urgent Care Board and delivery against the plan will be closely monitored.

Recommendations

The Governing Body are asked to receive the report and note the actions taken.

LLR Operational Winter Urgent Care Action Plan 2014/15

Organisation	Improvement Requirement	Actions	KPI trajectory	Accountable lead	Delivery date	Operational delivery group	Partner support requirements	Contribution to Resilience Plan metrics (no.s 1-50)	Alignment to Ian Sturgess review recommendations
DEMAND (inflow)									
Leicester City CCG	**Extra capacity & improved access to General Practice**	Discuss the Area Teams Christmas and New Year Extended opening hours scheme with all practices. The aim is to have at least four hubs across the city offering consultations over the Bank Holiday period.	All schemes will contribute to: Reduction in Leicester City CCG ED attendance of 5%, 72 per week leading to a run rate of 1375 per week	Sarah Prema	24th December 2014	Primary Care Delivery Group	General Practice Area Team	UHL EM Avoidable UHL EM by GP UHL EM by bed bureau UHL AE attends 65+ UHL EM via GP/BB with 0 day LOS	1,3,4,5,6,7
		Contact all practices to ensure all patients are offered on line booking.		Sarah Prema	31st December 2014	Primary Care Delivery Group	General Practice		
		Develop and implement an awarness rising campaign aimed at practices and the public to promote the availability of on line booking and repeat prescriptions.		Sarah Prema	31st December 2014	Primary Care Delivery Group	General Practice		
		Undertake quality visits to 18 practices with highest emergency admission rates and develop a plan for improvement, 16 practices by the end of December 2014 and 2 in January 2015.		Sarah Prema	31st January 2015	Quality Review Delivery Group	General Practice		
	Community alternatives to admission	Provide additional resources to expand the capacity of the following community services: 1. Practical Support at Home 2. Assistive Techonology 3. Night Nursing (double the night time capacity) 4. Primary Care Co-Ordinators (2 additional at the Front Door of ED) 5. Additional therapy capacity	Reduction in Leicester City CCG ED admissions of 5%, 32 per week leading to a run rate of 602 per week	Sarah Prema	31st December 2014	BCF Implementation Group	UHL LPT Leicester City Council	ED occupancy over 55 UHL AE Attends UHL EM via AE EMAS non-conveyance rate UHL EM Falls 65+	1,3,4,5,6,7
		Provide a 5 day a week ICRS presence in ED to pull patients into community services.		Sarah Prema	Daily to the end of March 2015	BCF Implementation Group	Leicester City Council		
		Have the Frailty Front Door Team in place a minimum two days a week pulling frail older people into community services. Cover additional days as medical capacity allows.		Sarah Prema	Weekly to the end of March 2015	BCF Implementation Group	UHL		
		Send all practices an information summary setting out the community alternatives to admissions.		Sarah Prema	31st December 2014	BCF Implementation Group	General Practices		
		Review the Directory of Services and update as necessary.		Sarah Prema	24th December 2014	BCF Implementation Group	ELR CCG DHU		

	Care/nursing homes	Implement a revised City Care Nursing Service including the provision of a one session a week UHL Outreach Geriatric service focused on those patients most at risk of admission from Care Homes.		Sarah Prema	31st December 2014	BCF Implementation Group	UHL Care Homes	UHL EM Avoidable UHL EM by GP UHL EM by bed bureau UHL AE attends 65+ UHL EM via GP/BB with 0 day LOS	1,3,4,5,6,7,9,14
		Reissue information to care homes on community alternatives to admissions.		Sarah Prema	24th December 2014	BCF Implementation Group	Care Homes		
	Weekly clinical review and feedback	Weekly clincial peer review of emergency attendances and admissions using real time data for Leicester City and feedback to practices on missed alternatives to admissions.		Sarah Prema	Weekly from January 2015	Primary Care Delivery Group	General Practice	UHL EM Avoidable UHL EM by GP UHL EM by bed bureau UHL AE attends 65+ UHL EM via GP/BB with 0 day LOS	1,3,4,5,6,7
		Weekly review of care home emergency attendnaces and admissions data and feedback to homes on missed alternatives to admissions.		Sarah Prema	Weekly from 15th December 2014	BCF Implementation Group	Care Homes		1,3,4,5,6,7,9,14
East Leicestershire & Rutland CCG	**Extra capacity & improved access to General Practice**	**All day weekend Access for complex patients by:** •Weekend & bank holiday routine surgeries - to support the area team LES during the period 20th December 2014 to 28th February 2015 at set periods on Saturdays and Sundays and Bank Holidays • Weekend and bank holiday extension to 7 day working pilot to run alongside the area team LES for focus on complex and high risk patients during the period 20th December 2014 to 28th February 2015 (practices being offere opp to either or both) •Urgent Home Visiting - 20 practices to provided additional home visiting service every am 8.30-12.30 for most risk of admission	All schemes will contribute to: Reduction in EL&R ED attendance of 5%, 35 per week leading to a run rate of 673 per week	Tim Sacks	20th December Week commencing 5th January 2015	Quality+Performance Committee CCG	CCG/Primary Care/Area Team	UHL EM Avoidable UHL EM by GP UHL EM by bed bureau UHL AE attends 65+ UHL EM via GP/BB with 0 day LOS	1,3,4,5,6,7,9,13
	Community alternatives to admission	**Extended Opening Hours for Oadby WIC** To extend the opening hours and access to the Oadby site from 8-Midnight (12am)		Tim Sacks	8 weeks from 5th January 2015	Quality+Performance Committee CCG	NHSE/CCG/WIC	UHL EM Avoidable UHL EM by bed bureau UHL AE attends 65+	1,3,4,5,6,7,9,13
		LTC AF Pathway Use All practices now trained to new standards NOACs now green on LMSG. Expect significant increase in prescribing/AF prevalence and reduced stroke related admissions	Reduction in EL&R CCG ED admissions of 5%, 19 per week leading to a run rate of 362 per week	Tim Sacks	Monthly	MMSG	GP/Primary Care	 UHL EM by GP UHL EM by bed bureau	1,3,4,5,6,7,9,13

	Care/Nursing homes	**Care Home/EOL** GP Practice management of patients with Care Plans (100%) working to educate homes and ensure compliance of completed care plans and link with EMAS/OOH/NHS 111 if there are any identified system failures		Tim Sacks	Weekly audits at ED on care home admissions. EMAS care home conveyance rates	Quality+Performance Committee CCG	GP Primary Care/OOH/NHS 111	UHL EM Avoidable UHL EM by GP UHL EM by bed bureau UHL AE attends 65+ UHL EM via GP/BB with 0 day LOS	
		3xWTE Care Home/Integrate Care Pharmacist To undertake reviews/admission avoidance with 2% vulnerable patients. 8 care homes have been visited YTD and plans are for another 5 are to be visited upto the end of February 2014.		Tim Sacks	Ongoing from November 2015	MMSG	GP/Primary Care/LCC	UHL EM Avoidable UHL EM by bed bureau UHL AE attends 65+	
	Weekly clinical review and feedback	**Prospective Peer Review** Every practice peer reviews every patient to ensure all community options are used. This will be undertaken prior to every admission		Tim Sacks	Ongoing from November 2014	Q+P Committee CCG	GP/Primary Care	UHL EM Avoidable UHL EM by GP UHL EM by bed bureau UHL AE attends 65+ UHL EM via GP/BB with 0 day LOS	
	Director of Services (DoS)	**LLR DOS** Updated with current live information to aide practices with urgent care/alternative to admission. This will be updating of new services, review of disposition orders and implementation of the CMS.		Robin Wintle/Tim Sacks	Guide to be sent out w/c 12th January 2015	Quality+Performance Committee CCG	ELRCCG	UHL EM Avoidable UHL AE attends 65+	1,3,4,5,6,7,9,13
	Reduce readmissions to UHL from community hospital	Community Hospital Out ot Hours service (CNCS) to face to face review deteriorating patients prior to transfer (excluding 999 patients)							
West Leicestershire CCG	**Extra capacity & improved access to General Practice**	Extra in-week capacity - additional 100 general practice consultations every weekday	All schemes will contribute to: Reduction in WL ED attendance of 5%, 34 per week leading to a run rate of 644 per week	Angela Bright	12 Dec 14 Funding Decision Area Team 12th January 2015 Provisional Start date	WLCCG Out of Hospital Implementation Board	Area Team	1, 3, 4, 9, 14, 15 and 16	9,11,14, 16 and 17
		Weekend & bank holiday routine surgeries - implement LES during the period 20.12.14 to 28.02.15 for agreed times of Saturdays, Sundays and Bank Holidays		Angela Bright	20-Dec-14	WLCCG Out of Hospital Implementation Board	Area Team	1, 3, 4, 5, 6, 7, 9, 14, 15 and 16	9, 11 and 14
		7 day locality pilots - embed GP led 7 day services. Targets care homes and at risk patients. Seeing 80 per week rising to 860 patients in total by March 2015		Angela Bright	20 Dec 14	WLCCG Out of Hospital Implementation Board		1, 3, 4, 5, 6, 7, 9, 14, 15, 16 and 18	10, 11, 12, 14, 15 and 18
	Maximise Utilisation of Community alternatives to admission	Loughborough Community Hospital - Ensuring we get maximum use out of EMAS support in utilisation of Loughborough Urgent Care Centre and Older Persons' Unit through conveyance diverts to this site		Angela Bright	15 Dec 14	WLCCG Out of Hospital Implementation Board	EMAS CNCS LPT	1, 3, 4, , 6, 7, 8, 9, 12, 14, 15, 16 and 18	11, 12, 13,
		Older Persons' Unit (OPU) - Implement the new dedicated transport solution to support OPU patients back to their own homes		Caron Williams	w/c 22 Dec 14	BCF Frail Older Persons' Group	LPT St John Ambulance	1, 3, 4, 9 and 16	11, 18, 43, 75 and 76

		Acute Visiting Service **-** Embed use of new AVS to increase utilisation from 100 rising to 400 by March 2015		Angela Bright	w/c 22 Dec 14	WLCCG Out of Hospital Implementation Board	SSAFFA	1, 3, 4, 5, 6, 7, 9, 14, 15 and 16	11, 12 and 18
		Single Point of Access (SPA) **-** Task and Finish group developing the SPA, resulting in a reduction in call answering time, dropped calls and target GP calls responded to within 30 seconds		Caron Williams	w/c 26 Jan 15	BCF Step Up Step Down Board	LPT	1, 3, 4, , 6, 7, 8, 9, 12, 14, 15, 16 and 18	38, 43
		Integrated Community Health and Social Care Crisis Response Service (ICRS) **-** Night Nursing Assessment Service extension to established provision ensures 24/7 365 day a year crisis service within a 2 hour response time preventing an average of 15 admissions per month		Caron Williams	W/C 8 Jan 15	BCF Step Up Step Down Board	LCC LPT	1, 3, 4, , 6, 7, 8, 9, 12, 14, 15, 16 and 18	42,43 and 44
		Effective alternatives to ED - LTC Integrated Management Care: • Maximise the capacity in the Rapid Access Heart Failure Clinic at UHL by continually promoting this service to GP's. Increase from an average of 14 - 17 a month from January to March. • Mobilise an Atrial Fibrillation Rapid Access Clinic at UHL from January – March. Reducing admission from by 3 a month from February to March, and reduce LOS from by 1.5 days. • Integrating HF Community and Secondary Care MDT – This will support the management of complex HF patients at home. This will reduce readmissions by 2 a month. • Integrating case management for Complex COPD patients (pilot) – Community Respiratory Nurse meets weekly with Respiratory Consultant. This will reduce follow-up activity for Complex COPD by 2 a month.	Reduction in EL&R CCG ED admissions of 5%, 21 per week leading to a run rate of 404 per week	Angela Bright	w/c 22 Jan 15	WLCCG CVD Delivery Group WLCCG Respiratory Delivery Group	UHL LPT	1, 3, 4, 9 and 16	15, 18
	Care/Nursing Homes	Reducing inappropriate Admissions from Care Homes - extend Acute Visiting Service to take direct referrals from care homes in hours and at weekends (see activity trajectory for 7 day pilot section 1)		Angela Bright	w/c 15 Jan 15	WLCCG Out of Hospital Implementation Board	All Care Homes SSAFFA	1, 3, 4, , 6, 7, 8, 9, 12, 14, 15, 16 and 18	11, 12, 13
	Weekly clinical review and feedback	• Weekly review of emergency attendance and admissions by GP Board Members using real time data for West patients • Identify and disseminate to practices one top tip each week based on themes from the previous week's ED data • Each practice to receive and review data with suggested alternatives to admission • Board clinical lead GP's to undertake weekly peer to peer feedback and challenge with identified practices		Angela Bright	Ongoing	WLCCG Weekly Clinical Leads Meeting	GEM CI	1, 3, 4, , 6, 7, 8, 9, 12, 14, 15, 16 and 18	13, 17
DHU - NHS 111	**Reduced Attendances and Admissions**	124.5 hours (5 heads) of call advisors to be added to the rota week commencing 8.12.14as due out of training. 550 hours (19 heads)of call advisors to be added to the rota week coming 22.12.14.	Additional hours added into the rota enabling 95% calls answered in 60 seconds	Pauline Hand	1 week 3 weeks	Collaborative Commissioning NHS 111 Group	None	95% calls answered in 60 seconds National Minimum Dataset	
EMAS	**LLR non-conveyance rate**	1. LLR Non-conveyance: Deliver Paramedic Pathfinder (EMAS wide) and Falls Assessment (LLR only) training to support access to appropriate pathways, clinical safety netting and treatment within the community.	LLR Falls Training: 25% by w/e 11/1/15 50% by w/e 18/1/15 75% by w/e 25/1/15 95% by w/e 1/2/15 EMAS Pathfinder Training: 30% by end Jan 15 60% by end Feb 15 90% by end Mar 15	Tim Slater (LLR) Adrian Healey (Falls) Andrew Mills (Pathfinder)	LLR Falls Training - scheduled to finish end January 2015 (subject to IA and REAP 4 impact) Pathfinder Training - continual programme working towards 90% of eligible EMAS staff by March 2015.	Currently providing updates on training to multiple forums including EMAS Locality Meeting, Inflow, Integration Executive, UCB and TDA weekly conference calls. This requires rationalisation to avoid duplication of reporting and performance management.	To be fully effective, this needs a consistent approach across all CCGs. We need a commitment to work to a true single point of access and seamless transition between in and out of hours provision.	EMAS LLR non-conveyance and LRI pre-handover within 15 minutes	

	LLR non-conveyance rate	2. Supporting pre-hospital clinical assessment: Both Pathfinder and Falls initiatives are supported by access to a DoS or SPA type approach but there is potential to extend and integrate a practitioner helpline within EMAS's Clinical Assessment Team to reduce the steps and consolidate access routes to provide a more direct and appropriate pathway to alternative services.	Incremental increase in EMAS LLR overall non-conveyance to 50% (trajectory to be set following pilot evaluation)	Tim Slater (LLR) Joe Garcia (EMAS EOC for CAT)	The integration and enhancement of dedicated EMAS LLR CAT is at this stage an aspirational objective with no agreed timeline, but is viable during Q4 2014/15 to Q1 2015/16. This could utilise the capacity provided to support the practitioner helpline but incorporated in to the EMAS CAT provision.	Inflow	CCGs/providers to map out current available capacity to identify practitioner provision to support.	EMAS LLR non-conveyance	
	LLR conveyance rate to UCCs	3. Increase usage of Urgent Care Centres - both earlier in the access to urgent care (e.g. referrals from 111 or HCP contact) and as an outcome of EMAS Hear & Treat and See & Treat	Incremental increase in EMAS LLR overall and LE11 area non-conveyance to 50% and referrals to UCC (trajectory to be set following activity review): 48% by end Jan 15 49% by end Feb 15 50% by end Mar 15 (all data is available on a daily/weekly basis to support KPI monitoring)	Tim Slater (LLR) Ian Mursell (EMAS Consultant Paramedic for care pathway review)	End of March 2015 but supporting reduced ED conveyance through winter.	Inflow	CCGs/UCC provider to review with EMAS the current utilisation and expected levels (including referrals that lead to self-presentation). 111 provider to review DoS to ensure UCC services are correctly signposted where appropriate.	EMAS LLR non-conveyance (specifically destinations other than ED)	
George Eliot Hospital (LRI urgent Care Centre	**Reduced Attendances and Admissions**	1. rearrange clinical audit to inform pathway design. 2. Move UCC to new premises by 24th December	1. To be determined 2. improve patient journey	Kim Wilding/Julie Dixon/ Josh Sandbach		1. UCC/ED Governance meeting 2.CCG UCC contracting Team	UHL		
LPT	**SPA:** **Improve the response rate within Single Point of Access**	1. Increase wte staff numbers within SPA to reduce healthcare professional answering times	45% of calls answered in 30 seconds (22nd Dec) and 60% by March 2015	Rachel Dewar	22nd December 2014 (40%) 30th March 2015 (60%)	Clinical Network Group	38	18, 11	
FLOW (internal)									
UHL	**Improve front door (UCC/ED) interface/alignment**	1) Continue weekly clinical meetings with UCC team	90% of patients triaged within 20 minutes	Julie Dixon	14-Dec-14	ED subgroup of EQSG	UCC/ GE	Reduce ED occupancy and time in ED	30-36
		2) UCC to triage all patients within 20 mins		UCC	14-Dec-14				30-36
		3) Ensure UCC is supported to manage the '30 min' rule		Julie Dixon	14-Dec-14				30-36
		4) Support the UCC where possible to ensure 'construction handover' date for the UCC takes place on the 19/12 and the move date is 23/12		Jane Edyvean	31-Dec-14				30-36
		5) Ensure ED is not used as an admission route by other specialities from UCC		Julie Dixon	14-Dec-14				30-36
	Improve ambulance turnaround	1) Work with EMAS and CCGs to introduce RFID as the sole data set	50% reduction in waits over 30 mins and 50% reduction in waits over one hour	Rachel Williams	31-Dec-14	ED subgroup of EQSG	EMAS and CCG commissioning team	N/A	25-29
		2) Use the new data set to agree the real scale of the problem		Rachel Williams	31-Jan-15			Reduce time in ED	25-29
		3) Continue to employ additional nurses to work in the assessment bay to minimise handover times		Rachel Williams	14-Dec-14			Reduce time in ED	25-29
	Implement the Ambulatory Emergency Care strategy	1) Cohort six member of AEC network	5% reduction in admissions (circa 4 patients per day)	Lee Walker	31-Dec-14	AMU subgroup of EQSG	CCGs	Reduce ED occupancy and admissions	80
		2) Select priority pathways for implementation		Lee Walker	31-Jan-15				80

	3) Implement priority pathways		Lee Walker	31-Mar-15				80
Improve the resilience of ED processes	1) Implement improvements to Gold Command	70% of time ED occupancy less than 55 and no more than one hour wait to be seen time	Julie Dixon	07-Dec-14	ED subgroup of EQSG	None		101-114
	2) Set up a weekly journey meeting which reviews delays in processes within the ED dept		Julie Dixon	31-Dec-14				101-114
	3) Address systematic delays identified in journey meetings (e.g. portering, transport)		Julie Dixon	15-Jan-15				101-114
	4) Ensure consistent application of floor management SOPs		Ben Teasdale	31-Dec-14				101-114
	5) Expand the use of EDU pathways		Ben Teasdale	31-Mar-15				101-114
	6) Ensure ED is not used as an admission route by other specialities		Julie Dixon	14-Dec-14				101-114
	7) Ensure ED is supported to manage the '30 min' rule		Julie Dixon	14-Dec-14				101-114
	8) Implement the 0800 'safety team'		Catherine Free	Complete				101-114
	9) Refresh ED medical staffing recruitment plan		Ben Teasdale	31-Jan-15				101-114
	10) Implement ED SOPs relating to managing activity spikes and when there is exit block		Ben Teasdale	31-Jan-15				101-114
	11) Develop and enforce whole hospital response relating to ED exit block (i.e. poor flow)		Andrew Furlong	31-Dec-14				101-114
Review ED staffing	1) Review existing ED staffing to ensure optimum balance of capacity and demand	70% of time ED occupancy less than 55 and no more than one hour wait to be seen time	Julie Dixon	31-Dec-14	ED subgroup of EQSG			101-114
Increase the proportion of GP bed referrals going directly to AMU	1) Validate and agree with CCG commissioning team that the data set is accurate	Greater than 40% in Q3 and greater than 70% in Q4 of GP referrals go directly to AMU	Rachel Williams	31-Dec-14	AMU subgroup of EQSG	CCG commissioning team	N/A	115-127
	2) Ensure senior decision maker presence within acute medical clinic between 0900 and 1700 seven days a week		Lee Walker	31-Jan-15			Improve AMU discharges	115-127
	3) Increasing bed capacity by three within the acute medical clinic (capital scheme)		Jane Edyvean	28-Feb-15				115-127
	4) Keep bed bureau clinic empty overnight enabling improved flow in the morning		Lee Walker	14-Dec-14				115-127
Reduce the time to assessment by a consultant on the AMU	1) Validate and agree with CCG commissioning team that the data set is accurate	Greater than 40% in Q3 and greater than 70% in Q4 of patients are seen by a consultant within six hours	Rachel Williams	31-Dec-14	AMU subgroup of EQSG	CCG commissioning team	N/A	115-127
	2) Ensure consultant presence on AMU is continuous with roving ward rounds between 0800 and 2100 Monday to Friday and 0800 and 2000 at the weekend		Lee Walker	31-Dec-14			Improve AMU discharges	115-127
	3) Start ward rounds at 0800		Lee Walker	07-Dec-14				115-127
Improve middle grade staffing resilience on AMU	1) Review remuneration rates for tempory medical staff on AMU	Greater than 40% in Q3 and greater than 70% in Q4 of GP	Lee Walker	31-Dec-14				115-127
	2) Develop more resilient middle grade staffing model for AMU		Lee Walker	31-Mar-15				115-127
Reduce bed occupancy on the base wards	1) All patients leaving the assessment unit must have a main diagnosis, plan and EDD	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Lee Walker	31-Dec-14	Base ward subgroup of EQSG	None	Reduce bed occupancy	128- 137, 169-172 and 176-184
	2) Start base ward rounds now at 0830 and then move to 0800 start by 31/3 five days a week		Ian Lawrence	31-Mar-14				128- 137, 169-172 and 176-184
	3) Increase consultant presence on short stay and key speciality base wards (34, 37 and 38) at the weekend		Ian Lawrence	14-Dec-14				128- 137, 169-172 and 176-184
	4) Establish the manpower, rota requirements and finances and necessary support staff for further extension of weekend consultant cover (links to seven day plan)		Ian Lawrence	31-Mar-15				128- 137, 169-172 and 176-184
	5) Implement peer review of ward rounds and long stay patients		Ian Lawrence	31-Dec-14				128- 137, 169-172 and 176-184
	6) Ensure that patients 'sit out' or move to the discharge lounge asap and book ambulances when TTOs are complete		Maria McAuley	31-Dec-14				128- 137, 169-172 and 176-184
	7) Use metrics to identify high/ low achieving wards and support low achieving wards to improve		Ian Lawrence	31-Dec-14				128- 137, 169-172 and 176-184
	8) Ensure accuracy of real time bed state		Gill Staton	31-Jan-15				128- 137, 169-172 and 176-184
	9) Develop plan to implement electronic bed management system		Rachel Overfield	31-Mar-15				128- 137, 169-172 and 176-184
Improve the discharge process in medicine and cardio-respiratory	1) Standardise the assertive MDT board round process seven days per week	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Ian Lawrence	End of March 2015	Base ward subgroup of EQSG	None		128- 137, 169-172 and 176-184
	2) Implement one stop ward rounds		Ian Lawrence	31-Jan-15				128- 137, 169-172 and 176-184
	3) Implement the long length of stay review process		Ian Lawrence	31-Dec-14				128- 137, 169-172 and 176-184
	4) Wards to generate a list of next morning discharges with TTOs written the prevous day		Maria McAuley	31-Dec-14				128- 137, 169-172 and 176-184
	5) Eliminate rebeds / failed discharges for non clinical reasons		Maria McAuley	28-Feb-15				128- 137, 169-172 and 176-184
	6) All patients to have an EDD and CCD set at first review on base wards including criteria for nurse delegated discharge		Ian Lawrence	31-Dec-14				128- 137, 169-172 and 176-184
	7) Prioritise therapy and specialist input to expediate simple discharge		Maria McAuley	15-Jan-15				128- 137, 169-172 and 176-184

		8) Reskill ward staff to facilitate simple discharges		Maria McAuley	15-Jan-15				128- 137, 169-172 and 176-184
		9) Liberate nursing time to drive discharges		Maria McAuley	15-Jan-15				128- 137, 169-172 and 176-184
	Reduce discharge delays caused by TTOs	1) Increase the volume of TTOs completed the day before discharge	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Maria McAuley	31-Dec-14	Base ward subgroup of EQSG	None		128- 137, 169-172 and 176-184
		2) Prioritise pharmacy support to admission areas and base wards		Maria McAuley	31-Dec-14				128- 137, 169-172 and 176-184
DISCHARGE (outflow)									
LPT	**Improve the flow of patients to and through Comnmunity Hospitals**	Community Hospital Matron to work out of UHL to identify suitable patients for discharge	Increase number of patients refered to community hospitals by 4 per day	Nikki Beacher	W/C 26th January 2015	CHS Strategic Development Group	UHL City/County Social Services	38,39,41,42	46,47,
		City CCG - PCCs will attend board rounds on 5 wards to increase rate of discharge	Reduction in excess bed days	Nikki Beacher	w/c 13 Oct one ward/month roll out	Clinical Network Group	City CCG, UHL	38,39,41,72	72,
		The use of pre-set LoS in community hospitals will cease	Reduction in LoS by 4 days	Nikki Beacher	26th January 2015	Clinical Network Group		N/A	46,47.48,49
		The daily community hospital MDT board round process will be reviewed and SOP deployed to standardise processes and facilitate timely discharge	Reduction in LoS by 4 days	Nikki Beacher	19th January 2015	Clinical Network Group		N/A	46,47,48,49
		All community hospital in-patients patients will have an EDD and CCD	Reduction in LoS by 4 days	Nikki Beacher	19th Janaury 2015	Clinical Network Group		N/A	46,47,48,49
	Community Services: improve of patients to and through community services	Community Hospital Matron to work out of UHL to identify suitable patients for discharge	Increase number of patients referred to community services by 4 per day	Nikki Beacher	W/C 26th January 2015	CHS Strategic Development Group	UHL/City and County Social Services	38,39,41,42	41,42,43
		Community staff will follow up patients discharged from ED by PCC to prevent readmission.	100% follow up within 72 hours	Rachel Dewar	W/C 22/12/14	Clinical Network Group		48,49,50	73,41,42,43
	Community Health Services: Community Nursing	Deliver 7 day service 8am to 8pm offering contact and support for children/young people in the community (e.g. IVs, wound assessment and management etc.)	Reduction in UHL admissions of 2 per week	Helen Perfect	December 2014 to March 2015	Children's Clinical Sub Group	UHL, Primary Care		
		Expedite discharge through discharge coordinators working in CAU and the children's Hospital to community nursing service	Reduce LOS for 2 patients a week by 1 day	Helen Perfect	December 2014 to March 2015	Children's Clinical Sub Group	UHL, Primary Care		
	Community Health Services: Community Nursing; Respiratory Physiotherapy	Work with a variety of long-term conditions such as neuro-muscular weakness to reduce hospital admissions associated with winter illness	Reduce LOS for 2 patients a week by 1 day	Helen Perfect	December 2014 to March 2015	Children's Clinical Sub Group	UHL, Primary Care		
	Community Health Services: CAHMS Urgent Admissions	FYPC CAMHS operate a 24 hour on-call service to support the assessment of patients at UHL. After 10pm child/young person is admitted to a UHL paediatric bed with assessment by CAMHS the following morning to discharge, admit to CAMHS bed or remain insitu	Reduce LOS for 2 patients a week by 1 day	Helen Perfect	December 2014 to March 2016	Children's Clinical Sub Group	UHL, Primary Care		
		CAMHS inpatient beds (LPT Tier 4 inpatient unit or an out of area bed) co-ordinated by LPT.	Reduce LOS for 2 patients a week by 1 day	Helen Perfect	December 2014 to March 2016	Children's Clinical Sub Group	UHL, Primary Care		
		Where the CAMHS on-call service cannot identify a CAMHS bed then the child/young person will need to be admitted/remain in UHL bed.	Reduce LOS for 2 patients a week by 1 day	Helen Perfect	December 2014 to March 2016	Children's Clinical Sub Group	UHL, Primary Care		
	Mental Health: Reduce attendence at UCC/ED for mental health related crisis intervention	Continue with mental health Triage service in UCC/ED to redirect and improve patient flow through UCC/ED.	Reduction of referrals to MH Triage nurse in UCC/ED - 5 per week from 9 Feb 2015 10 per week from 1 March 2015	David Gilbert	09/02/2015	Acute/Low Secure Ops Group (LPT) and AMH/LD Divisional Assurance Group (LPT)	UHL, Primary Care, CCGs		55-58
		Crisis House beds, Crisis Support Telephone line and drop in centre to be fully operational 9 Feb 2015	Reduction of referrals to MH Triage nurse in UCC/ED - 5 per week from 9 Feb 2015 10 per week from 1 March 2015	David Gilbert	09/02/2015	Acute/Low Secure Ops Group (LPT) and AMH/LD Divisional Assurance Group (LPT)	UHL, Primary Care, CCGs		55-58

		Crisis team re- modelling Project Implementation Plan agreed and management of change commenced.	Reduction of referrals to MH Triage nurse in UCC/ED - 5 per week from 9 Feb 2015 10 per week from 1 March 2015	David Gilbert	09/02/2015	Acute/Low Secure Ops Group (LPT) and AMH/LD Divisional Assurance Group (LPT)	UHL, Primary Care, CCGs		55-58
LLR CCGs	**Discharge Pathway work**	Weekly monitoring and evaluate the Brookside Court (city pathway 3) pilot making any necessary changes.	Brookside Court 6 pilot beds to remain full.	Jane Taylor	6 month pilot with weekly review 1-2 wks	Discharge Steering Group	CityLA City CCG Strategy, planning and finance leads. CHC lead. LPT communitylead, UHL discharge leads	DTOC rates	No 60,62,63,65,66,
		Set up task and finish group for the implementation of the Catherine Daley (county pathway 3) pilot.		Jane Taylor	1-2 weekly meetings for pilot to start early January	Discharge Steering Group	County LA, EL&R CCG and WL CCG Strategy, planning and finance leads. CHC lead. LPT community lead, UHL discharge leads	DTOC rates	
		Commence evaluation of the D2A home first pilot (pathway 2) for the county.		Jane Taylor	20 patient pilot - evaluation and the roll out	Discharge Steering Group	County LA, EL&R CCG and WL CCG Strategy, planning and finance leads. CHC lead. LPT community lead, UHL discharge leads	Patients discharge to admission address	
		Establish task group to prepare the rutland pathway 3 pilot .		Jane Taylor	Pilot for January start	Discharge Steering Group	Rutland LA and EL&R CCG Strategy, planning and finance leads. CHC lead. LPT community lead, UHL discharge leads	DTOC rates	
	Minimum Data Set	Commense MDS implementation		Jane Taylor	1-2wks	Discharge Steering Group	City, County and Rutland LA. All 3 CCG Strategy, planning and finance leads. CHC lead. LPT community hospital lead, UHL discharge leads, IT leads at each organisation		
		Set up the MDS Cross Organisation Work Group	Electronic sharing and transfer of patient needs assessments	Jane Taylor	1-2wks	Discharge Steering Group			
	Fast Track	Monitor and review the weekly CHC data.	(Aim is to bring in line, over the next 2years to our national bench mark level)	Jane Taylor	2 wks	CHC tasks group	City, County and Rutland LA. All 3 CCG Strategy, planning and finance leads. CHC lead. LPT community lead, UHL discharge and management lead	Weekly activity data for CHC mainstream and fast track	
		Review the results of the CHC finance and quality data cleanse.	Reduce the number of packages of care	Jane Taylor	2 wks	CHC tasks group			
		Agree and implement the process for community nurses to notify the CHC team when CHC funded patients have died or have moved off their case load.	Reduction in CHC packages	Jane Taylor	2 wks	CHC tasks group			

		Develop a joint CHC and fast track action plan, incorporating the requested changes.	Reduce the number FT per week (UHL and LPT) Reduce the number of packages of care Reduce the number of hours of care Reduce the number of placements	Jane Taylor	2 wks	CHC tasks group			
		Develop a clear link to the EOL Working Group.	Reduce the number FT per week (UHL and LPT)	Jane Taylor	2ks	CHC tasks group			
		Agree and circulate a uniformed CHC consent form for all provider organisations to use.		Jane Taylor	2 wks	CHC tasks group			
Leicestershire County Council	**Targeted Early Reviews within 2 weeks of hospital discharge to independent sector provision**	All packages of care placed with independent sector providers to be reviewed within a two week timeframe. Review Officers to alert Brokers on a daily basis to capacity created, including number of hours, provider and geographical zone/area.	Reviews completed Cases maintained at same level Cases increased Cases reduced Cases ended Reduced/ended Details of hours released and the provider details to be shared with Care Brokers on a daily basis Cumulative figures to be produced monthly.	Tracey Burton	01-Dec-14				
	STOP specifying timed calls. START specifying time bands. Set periods for time critical call and communicate with commissioners.	Setting time-banded POCs and allowing more felxibility for when the carers go to visit will lead to shorter time spent on the Await Care list, and service users get care quicker. The knock-on effect in HART will be released HART capacity to reable new people. Only time critical calls to be commissioned at specific times, care commissioners and HART to be reminded that calls will be in time brackets am = Morning 7am – 10am, Lunch, 11.30am – 2.00pm Tea, 4.00pm – 6.00pm and Night 7.00pm – 10.00pm. Service users to be advised of these timings and the point of the assessment for the need of care being made. This is an existing process which should be being followed. Embed cultural change and adhere to business process - messaging to service users and managing expectations. Team senior workshops to be held. Commissioning document updated	Number of time-banded vs time-specific commissioned requests. Requests for time critical calls reduced and reduction in await care list through analysis of the HC request forms and the await care list	Tracy Ward	01-Dec-14				

	UHL Inflow reduction/prevention: From 1 November – operational SW team based at LRI to assess and navigate patients in ED (A&E and Assessment wards) to prevent admission on Saturday and Sunday	Weekend admissions prevented/ reduced through increased SW capacity in LRI ED	Changes in ED admission rates at weekends	Jackie Wright	ongoing				
	UHL Inflow reduction/prevention: stronger capacity in ED	Doubling of resources to assess and navigate patients in ED (A&E and Assessment wards) to prevent admission	Changes in ED admission rates	Jackie Wright	ongoing				
Leicester City Council	**Reduced LOS , minimising lost bed days, reduced DTOC levels**	Daily Liaison between ASC and UHL base wards to reduce LOS, minimise lost bed days and improve DTOC levels to include the ICRS offer.		Ruth Lake	1 Week			Sitreps	