APPENDIX 2A

LLR EMERGENCY AND URGENT CARE OPERATIONAL NETWORK - SYSTEM IMPROVEMENT PLAN

Senior Responsible Officer:	Dr Simon Freeman, Managing Director & Accountable Officer, Leicester City Clinical Commissioning Group & Chair, LLR Emergency And Urgent Care Operational Network
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Last updated:	Rachna Vyas, 30th May 2013

APPENDIX 2A

OVERARCHING GOVERNANCE					
Issue *Ref to NHSE checklist*	**Actions**	**Lead**	**Outcome measure**	**Target finish date**	**Progress**
New governance framework for the urgent care work stream Ref 1, 2, 3, 4, 5	▪ Establish revised EUCON framework ▪ Recruitment of Director-level post to deliver the EUCON programme ▪ Revise Terms of Reference and membership ▪ Agree priority actions for implementation and baseline associated performance ▪ Agree contractual recovery trajectory and associated contract penalties ▪ Agree MRET spend via EUCON	Simon Freeman, Leicester City CCG	Programme governance mobilised Director in post Recovery trajectory agreed & monitored formally through UHL CPM	June 2013	ECN review complete Revised structure to be live for Q2 2013/14 UHL CPM will monitor recovery against trajectory via contract management route MRET funding proposal to be agreed at May CCB
Revise current ECN dashboard with performance measures Ref 6	▪ Refresh current performance framework to highlight areas of concern within the urgent care system ▪ Map to NHS England (gateway 00062) recommendations	Hina Naik, GEM CSU	Populated performance framework with target and baseline	June 2013	Cross checking complete Data flows to be added by June 30th 2013
Urgent care commissioning strategy Ref 14-17	▪ Urgent Care commissioning strategy required for 14-15 onwards, including future vision of the system across health and social care ▪ Continue with LC CCG as lead commissioner for Urgent Care ▪ Communication mechanism required across health and social care	EUCON Director Lead	Agreed LLR strategy	August 2013	Cross-referenced to Better Care Together board, strategy to be written in line with this

INFLOW MANAGEMENT; Attendance/Admission avoidance. 13/14 LLR INFLOW TARGETS: Emergency admissions 62,605, ED attendances 151,745					
Issue *Ref to NHSE checklist*	**Actions**	**Lead**	**Outcome measure**	**Target finish date**	**Progress**
Attendance/admission avoidance: **LLR Surge and resilience plan**	• Surge and resilience plans to be continually monitored and refreshed. • Winter and flu resilience plans to be written and agreed across LLR • Daily conference calls to take place during times of surge	Rachna Vyas- City CCG, EUCON	• Average bed occupancy rates at < 85% for UHL **Daily SitRep monitoring at system level:** • A&E Performance	Plan complete and signed off at EUCON in September 2013	Lessons from previous bank holidays incorporated into refreshed versions of surge and resilience plans.

Ref 12, 13, 46	• Multi-agency Resilience Planning Group meetings • Improve Continuing Healthcare interface with UHL		• Ambulances queuing • Length of ambulances queuing • Cancelled Operations • Beds unavailable due to DTOC • Beds days lost to Norovirus		Predictive modelling tool to be live by July 2013
Attendance avoidance: **LLR Choose Better Campaign** Ref 7, 9, 24	• Launch Choose Better 2013/14 • Integrate with individual CCG coverage across LLR • Easter, BH and summer press releases written and signed off • Social marketing plans across CCG aligned and designed to be convergent	Rachna Vyas- City CCG, EUCON Sue Cavill, GEM CSU	• Reduction in avoidable ED attendances	Ongoing	90k leaflets and posters distributed, 2 Ad Vans live in targeted areas, Social and radio media campaigns live
Attendance avoidance: ED-UCC Interface/Single front door Ref 38, 36, 37, 39, 40-43, 83	ED Front Door Triage • The concept of the ED Front Door project is to implement a virtual single front door on the LRI site, which will use the same pathways and protocols whether a patient arrives at the UCC or at ED. • Currently the ED Triage nurses are unable to bounce a patient back to their GP as and when appropriate, they are unable to prescribe when this is all that a patient requires and they are unable to discharge a patient. Therefore all patients will be sent into ED unless they are diverted to the UCC. • Furthermore, the current '4 hour' performance is poor, the number of patients arriving in ED is high, the processes are varied depending upon where a patient arrives/who a patient contacts. • The resulting ED Front Door Triage service is expected to create a left shift in both activity and resulting finance in line with the ECN Left Shift Strategy.	Dr Prasad – City CCG Michael Kaiser, LCCCG Kim Wilding, Urgent Care Centre	• Number of Patients Sent to GP to be >1,920 per year. • Number of Patients Sent to ED to be < 55,635 per year. • Number of Patients Discharged > 1,460 per year. • Number of Patients Sent to UCC to be > 15,003. • 100% patients seen in UCC in 4hrs	August 2014 Pilot will be operational by mid-July to allow embedding before early August (95% compliance date)	As at April 2013, 976 patients have been sent back to GP in the six month period • Data modelling undertaken and categorised. • Financial modelling completed. • Service pathways completed and agreed by all organisations. • Resource requirements for new service agreed. • Performance dashboard finalised. • Staff recruitment

					still in progress • SOPs in draft but not yet signed off • 4 hour counting issues to be resolved
Attendance avoidance: **Review of ED attendance levels across all 3 CCG's** Ref 6, 7, 8, 9	Full review of 13/14 ED attendances at practice level with resulting action plans at CCG level	CCG COO's	Reduction in ED attendance levels by CCG based on review	June 2013	Review agreed across CCG's

Attendance avoidance:
 	
Optimise delivery of EMAS 999 services
Ref 23, 72-74
	• Optimise GP Urgent conveyance 8am-8pm
	  ○ Target batching of patients via GP in a car
	  ○ Earlier home visits via CCG's
	• Implement turnaround plan to decrease pre and post clinical handovers
	• Alternative pathway for conveyance to UCC/8-8/MIU's for Cat c minors calls
		Rachna Vyas, EUCON
		
		Karlie Thompson, EMAS
		
		Drs Prasad (City CCG)/ Willmott/ Wooding (WL CCG) (CCG Urgent care Leads)
			• 80% within 2-4 hours GP urgents
			• 5% Increase in conveyance rates to community services
			• % pt presenting before 8pm to be increase to 70%
			• Achievement of A8 Red 1
			• Achievement of A8 Red 2
			• Achievement of A19
			• Achievement of turnaround targets
				May 13-April 14	Alternative pathways – COMPLETE
					
					GP urgents – Plan agreed for Sept 13 to Mar 14 (1200 extra hours per month, targeted to high footfall times)
					
					Aligned to CCG schemes for GP urgents and earlier home visits

Attendance avoidance: **Optimise delivery of EMAS 999 services** Ref 72-74	High Volume Service Users (HVSUs): CCGs to receive a monthly anonymised report identifying HVSUs by practice, patient identifiable information will go direct to the GP practice. Reports will identify number of calls, times/dates, reasons and response from EMAS.	Rachna Vyas – City CCG, EUCON Karlie Thompson, EMAS Drs Prasad (City CCG)/ Willmott/ Wooding (WL CCG) (CCG Urgent care	• Target to be agreed	June 2013	Reports being designed currently and will be available from June. April/May data will provide retrospectively.

		Leads)			
Attendance avoidance: **EMAS– PolAmb/mobile treatment centres** Ref 24	• PolAmb service for Leicester City Centre and Loughborough City Centre • Mobile treatment centre for use during sporting events, demonstrations etc.	Rachna Vyas, EUCON Karlie Thompson, EMAS	• 60% non-conveyance rate of patients treated by PolAmb • 60% non-conveyance rate of patients treated within mobile treatment centre	2 x POLAMB live April 2013 MTC May 2013	COMPLETE 60% + non-conveyance achieved
Attendance avoidance: **EMAS– GEH GP-in-a-car** Ref 24	• Launch pilot of GP in a car across LLR • Evaluate initial data • Set up longer term pilot	Rachna Vyas, EUCON Karlie Thompson, EMAS Kim Wilding, GEH	• 1460 admissions saved per day FYE • 2920 ED/999 attendances saved FYE • 80% non-conveyance rate	Launched Feb 2013	Initial 90 days results show 494 attendances saved and 180 admissions diverted

Attendance/admission avoidance:
 	
Achieve 1 SPA for LLR/align with introduction of 111
 	
Ref 10, 70
	• Integrate city and county SPA/bed bureau
	• Facilitate bed bureau pathway
	• Complete and validate eDoS
	• Roll out to SPA & associate clinicians
	• Enable both urgent and routine referrals to contact SPA via a single point of access with a single number.
		Nikki Beacher, LPT	• Total no. of calls handled
			• Total no. of SPA referrals: Case Type
			  ○ Urgent
			  ○ Non Urgent
			• Total no. admission avoidance
			• Total no. of referrals by case:
			  ○ GP
			  ○ Patients/carers
			  ○ UHL
			  ○ LPT Community Staff
			  ○ Other Health Care Professionals
				Live on 14th May 2012	Single SPA COMPLETE
					
					Alignment to DoS ongoing
					
					Ongoing development of SPA function including capacity planning to reduce waiting time for clinicians

Attendance avoidance: Develop integrated 111 & OOH service Ref 10, 2-3, 5, 70	• Develop and implement NHS 111 & OOH across LLR • Deliver improved urgent care pathways, increased productivity and efficiencies by reducing duplication, and pressure on emergency services and A & E by rerouting non-emergency patients to NHS 111 using NHS Pathways to more appropriate primary and community care settings • To provide a telephony, technical and	Toby Sanders, WLCCG Tony Menzies, LCCCG Dave Briggs ELRCCG	• As per NHS 111/OOH minimum standards	NHS 111 due to go live in September 2013 Fully integrated 111/OOH model to go live in Oct 2014 (Timescale subject to CCB agreement)	Service to be mobilised with soft launch date of September 2013 LLR DoS populated, clinically validated and signed off in August 2013

	information management structure that will deliver integrated working • Ensure the DOS is clinically validated and available to health community to use service and clinical search facilities (including care plans) • Service to be fully integrated with LLR OOH service				
Admission avoidance: **GP helpline** Ref 21,23, 55	Telephone system to enhance patient care. The system allows GP and Consultant to discuss patient cases rapidly	Jade Atkin, UHL	• 10% reduction of in-hours ACSC admission rate via bed bureau • 10% saved admissions • 10% of outpatient appointments saved	Launched May 2012 Extended in April 2013	COMPLETE ~200 admissions saved per month
Admission avoidance: UHL OPAT pathway Ref 51, 56	• Develop a comprehensive outpatient parenteral antimicrobial therapy service, enabling early discharge for patients requiring IV support	Rachna Vyas, EUCON Phil Walmsley, UHL	• Reduction in excess bed days • Reduction in length of stay • Reduction in no. of occupied beds for 'medically stable' patients	Launched in Sept 2012, approved for extension in April 2013	1200 bed days saved in 6 month pilot Approved at May CCB for extension for further 12 months
Admission avoidance: Acute Mental Health Ref 60-61	▪ ED mental health psych liaison service ▪ Reduction in multiple assessments by LPT in LRI ED between ALPS and Crisis Resolution Home Treatment Team ▪ Meet agreed annual activity targets once baseline agreed ▪ Multi agency group will formally review the acute care pathway: - Early intervention, - Admission preventions to an acute bed - Step down care after in patient stays ▪ Identification of actions required for improvements to the Mental health pathway ▪ Review of acute paediatric pathway	Jim Bosworth, WLCCG Teresa Smith, LPT	98% of patients have initial assessment within 2 hours of referral (between 9am and 12 midnight) Duplication of assessments by ALPS and CRHT within LRI ED Q4 – 50% Q1 – 25% Q2 – 10% Q3 – 0% To be reported via SORD	Enhanced psych input into ED live	Service to be funded recurrently from 13/14 91% of patients receiving LPT input within 2 hours
Admission avoidance: Mental health triage car	▪ Launch MH triage car in partnership with Leics Police	Jim Bosworth, WLCCG	▪ No of Contacts per week ▪ No of ED attendances saved	Live in July 2013	Agreement of model reached with Leics

Ref 60-61		Teresa Smith, LPT			Police LPT/WLCCG to agree cost envelope and model
INFLOW MANAGEMENT: East Leicestershire and Rutland CCG					
Issue ***Ref to NHSE checklist***	**Actions**	**Lead**	**Outcome measure**	**Target finish date**	**Progress**
Attendance avoidance: Minor Injuries Review Ref 36, 37, 39, 40, 43	Consult, procure and implement the review of the minor Injuries services across ELR to commission a service that maximises use in primary care and reduce the reliance on ED Ensure effective and efficient service provision for delivery of the out of hours minor injury service component, aligned to 111 and out of hours primary care service	Tim Sacks ELR CCG	Reduction in minor non-emergency attendances at ED In hours service delivery by 100% ELR practices	October 2014 (Timescale subject to CCB agreement)	Review completed, with report due to be considered by CCG Board. . Public consultation planned, subject to Board approval.
Admission avoidance: Care Homes Alternative Beds Scheme Ref 52-55	Scheme to provide an alternative to hospital admission for the frail elderly. Patients are admitted to care homes instead and remain under the care of their GP. It is estimated that it will prevent emergency admission for 120 ELR elderly patients this winter. (approx 1694 bed days)	Simon Wooding – ELR CCG / Tracey Shepherd – ELR CCG	Number of patients admitted = 59 Length of Stay = 988 Patient Satisfaction (Net Promoter Score) = 100% Cost Savings = 33% Number of emergency admissions for patients admitted within the scheme Comparison with previous year activity using non participating practices as a control group	Ongoing into 2013/14	Scheme formally launched in September. About 40% of ELR CCG patients are now covered by practices that have signed up to scheme.
Admission/attendance avoidance: End Of Life Care Ref 25	Introduce an End of Life strategy in year using transformation funding and recurrent funding into 2013/14. Currently only 0.3% of ELR patients are on a register, where the prevalence is expected at 1%. The QOF PC2 & 3 are paid based on a practice register and on going management, but we will introduce in November to a on a cost per patient basis and retainer scheme for practices to maintain	Tim Sacks – ELR CCG / Tom Rowley – ELR CCG	Focus on ensuring every EOL patient has an ACP in year and is regularly reviewed. This aims to increase numbers by up to 2000 in year, which link to OOH and EMAS.	On going into 2013/14	To commence in December 2012

	a comprehensive GSF End of Life Care register, with regular MDT meetings and an advanced care plan for each patient that is shared with the OOH service.				
Attendance avoidance: Bounce Back Scheme Ref 24	Bounce Back / Right Place- Right Time Scheme. This is currently being piloted for City patients, where the issue of inappropriate ED attendance is much bigger.	Simon Wooding – ELR CCG	Based on City results this could lead to a reduction in Q4 attendances	On going through 2013/14	To commence in December 2012
Attendance/Admission avoidance: Care Homes Ref 52-55	Every patient within in care homes to have either an ACP for EOL or a care plan, linked in with the OOH service Education and training to be given to staff in the care homes by practice nurses. This will include a set of "worsening instructions / Protocols" for each condition, which provides the care home staff with a plan of how to deal with patients rather than just calling 999, especially using the OOH service This will need to be delivered every three months due to high turnover of staff Link with CQC, Local authority and Social Care for key performance issues relating to excessive and inappropriate admissions.	Tim Sacks – ELR CCG/ Nick Glover – ELR CCG	Measure number of homes who have had training sessions for staff Measure number of care plans undertaken Measure number of EMAS calls from care homes in and OOH. Measure through OOH service, the number of calls and the outcome of these calls leading to visits rather than advice to call an ambulance Outcome on ED attendance hard to measure	On going through 13/14	To commence in December 2012
Attendance/Admission avoidance: Risk Stratification / Integrated Care Ref 49, 50	IT system that highlights patients at risk of admission. Practices will set up process through MDT and links to social care to put in place pre-emptive health and social care to stop admissions	Jane Chapman – ELR CCG / Tome Atack (from 1st July 2013)– ELR CCG	The Use of the tool will be available to practices in December with the model piloted from January. Outcome should be significant when fully working,	On going into 2013/14	Pilot currently being evaluated
Attendance avoidance: Dementia	New system pathway to be introduced in April 2013, the proactive work of diagnosing and setting up care plans for early onset dementia patients to commence in January 2013 across all practices	Andy Ker – ELR CCG / Tim Sacks – ELR CCG	Outcome hard to measure, but should lead to fewer patients attending ED	On going into 2013/14	National DES commences in Q1, This replaces the local system pathway.

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NFLOW MANAGEMENT: Leicester City CCG					
Issue ***Ref to NHSE checklist***	**Actions**	**Lead**	**Outcome measure**	**Target finish date**	**Progress**
Attendance avoidance: Reduction in Inappropriate A&E attendances Ref 21, 28, 29	Extended opening hours enhanced service • Offer patients additional appointment time outside core contracted hours. • Extended hours on bank holidays.	Clare Sherman - LCCCG	Delivery by 75% of city practices	On going	▪ 80% coverage in 2012/13 • 49 out of 60 eligible practices delivering a total of 178 additional hours of clinical appointment time. • Over 40 hours of appointments on Mondays and Saturdays. The majority of Monday to Friday extended hours is provided after 6.30 • 6 practices providing Bank holiday hours • CCG considering opening up coverage for other practices to undertake extended hours work on behalf of other practices. Currently consulting with LMC and Area Team.
Attendance avoidance: **A&E Avoidable**	Right Place, Right Time • To redirect those patients that present at	Michael Kaiser - LCCCG	• 100% of City Practice to sign up to the Service. • Measurable reduction in urgent	March 2013	91% coverage across the City at October 2012.

Attendances Ref 24	A&E during the hours 8.00 to 18.30 Monday to Friday with conditions that could be treated in primary care back to their GP.		care centre presentations in-hours • Measurable reduction of in/out-of-hours for urgent care centre and Emergency dept.		100% coverage across the EL&R at January 2013. 100% coverage across the WL at May 2013. 976 patients were bounced back in 2012/13.
Attendance avoidance: **A&E Avoidable Attendances** Ref 49, 50, 62, 63	QOF QP 13/14 GPs to undertake internal review of patients attending A&E during the period 1 January 2013 – 30 April 2013, data to include • Patient details • reasons for attendance/diagnosis • time/date of the attendance The review must:- • Explore the reasons for registered patients' attendance(s) at A&E • Identify any emerging patterns • A discussion with reference to available care pathways and the capability and access within primary care services to see and treat patients. Focus should be given to:- • Older patients with co-morbidities at high risk of admission (patients aged 65 years and over) • children with minor illness/injury (patients aged 15 years and under • Patients who frequently re-attend A&E that could be dealt with in primary care	GP Practices - LCCCG	Review undertaken prior to 31 July 2013 and Improvement Plan Developed Report to the CCG to include • Date of meeting and people in attendance • A summary of the discussion that took place at the meeting • Information on what, if any, comparisons have been drawn between same day access to clinicians in the practice and the level of A&E attendances • Information on the practice's current access arrangements • How the practice defined "avoidable attendances • Implement Improvement Plans	31 July 2013 31 July 2013 31/03/2013	Practices will be supported throughout review process

	And should specifically consider whether same day access to clinicians in the practice is appropriate and whether any comparisons can be drawn between this and the level of A&E attendances.				

Attendance avoidance:
 	
Primary Care Access
 	
Ref 21-31
	QOF QP 2013/14
	• Undertake an external peer review to include, if appropriate, proposals for improvement to access arrangements in the practice ay, also include proposals for commissioning or service design improvements.
	• Practices may wish to discuss where improvements may be made to improve the quality of care for patients at the interface of primary care and A&E.
	• Practice Improvement Plan to be approved during external peer review.
	• A report to the CCG by the 30 September 2013 containing the following information.
	  • Date of meeting and details of practices in attendance
	  • A summary of the discussions that took place at the meeting
	  • Details of the agreed improvement plan that aims to reduce avoidable A&E attendances.
	• Implement improvement plan and produce a report of the action taken to the PCO by the 31 March 2013.
		GP Practices - LCCCG	• External Peer Review undertaken prior to 30 September 2013.
			• Practices' Improvement Plans Peer Reviewed and Agreed Prior to 30 September 2013
			• Report to the CCG
			• Implementation of Improvement Plans and report of actions taken to CCGT by 31 March 2014
				August 2013
				
				August 2013
				
				September 2013
				
				March 2014
					Key themes from 12/13 Imp plans sent to city practices:
					• Sign up to / continue with Right Place, Right Time
					• Promotion of practice opening hours.
					• Review of opening hours
					• Review of appointment times for emergencies
					• Telephone Triage for emergencies
					• Use of Telephone Consultations
					• Improved usage of extended opening hours
					• Patient Education
					• Us Patient Participation Group
					• Appropriate use of A&E and GP Practices
					• Available community services other than A&E

					• Frequent attenders. • Who to contact first. • Display Choose Well literature • Use practice newsletters /posters/leaflets Promote minor injury/illness treatments available within practice.
Attendance/Admission avoidance: **Primary Care Access** Ref 21-31	The Primary Care Strategy Group of the City CCG undertakes performance reviews across a range of access measures. Access Action Plans for the top 10 over performing practices across a range of metrics will be produced in conjunction with the practices concerned.	David Riley - LCCCG	Metrics included in the analysis: • National Patient Experience Survey results • A&E attendances • Emergency Admissions • GP Consultation rates • Extended opening hours • Ability to book appointments **online**	On-going	Locality Leads meeting with practices concerned for initial action planning meeting during May 2013.
Attendance/Admission avoidance: **HERA: data analysis** Ref 6, 24	GPs to undertake internal review of data on HERA to monitor the trends of emergency attendances and admissions. Undertaken internally, and in discussion with other GPs at weekly/fortnightly meetings: • to review their practice data • to identify variations/ trends/ ACSC/ frequent flyers etc • to develop action plan to address the variation • to try to identify modifiable reasons for that variation. • to undertake an audit of referrals discharged at first attendance. At locality and at PLT events, practices are briefed,	Practice/ GP lead and Locality Managers - LCCCG	• Regular use of HERA and UC dashboard • evidence of analysis and understanding of practice activity • evidence of active and frequent peer interaction and the outcome of this shared within locality • evidence of actions taken and planned within practice. • ideas or suggestions for actions at locality meeting or	On going On going On going	HERA and UCC dashboard presented at City PLT on regular basis Training for practice managers and admin staff planned

	trained on • HERA – how to review data on HERA • UC dashboard				
Attendance/Admission avoidance: **UCC dashboard** Ref 6, 11	Practices actively reviewing the UC dashboard on regular basis to ascertain their current status. The information gives a graphical snapshot on a daily basis to help practices view: • Emergency attendances by type. • A & E Arrival time(surgery hours) • Frequent flyers • Re-admissions within 30 days	**Practices/ GP lead** - LCCCG	• Active use of UC dashboard • Use of patient level information to help address the issues – by contacting patients/education/ improving access.	**On going**	This is discussed at every practice visit and has a regular slot at City PLT
Attendance/Admission avoidance: **Emergency Response and Care Home GPs** Ref 30, 31	1) 4 GPs to be recruited to provide emergency response home visits across the City within GP morning surgery hours for those patients considered an emergency by their GP to prevent avoidable A&E Attendances. 2) 4 GPs to provided patient care plans for patients residing in Care Home across the City to prevent emergency admissions. Care Home staff to be educated in relation to who to contact first, i.e. GP, nurse, etc. • Recruitment of GPs via Procurement • Referral criterion established • GP base agreed • IT Logistics and equipment completed • Reporting mechanisms to practices agreed • Reporting outcomes finalised • Governance arrangements established	**Sarah Smith** - LCCCG	• Reduction in avoidable A&E attendances. • Reduction in emergency admissions • Reduction in inappropriate use of ambulance services • Increase in patient care plans to include DNAR/EOL • Evidence of carer/relative/patient agreement to care plan	Service launches 1st July 2013	Procurement process complete, LCCCG working with provider to mobilise service Pilot to 31 March 2014

Attendance/Admission avoidance: **Alcohol engagement initiative** Ref 59	• Alcohol Engagement workers to engage with those patients who present at A&E on a regular basis who are not currently on the caseload of any existing alcohol service. • Clinics to be based in GP practices / or community venue • Referral to existing alcohol services where required	Jeremy Bennett - LCCCG	• Reduced attendances 581 • Reduced admissions 279	Late 2012/ early 2013	Admissions data being collated. Project reports 201 patient contacts in May, with 51 having been identified as eligible and 47 having completed the brief intervention
Admission avoidance: **Diabetes** Ref 30, 69	EDEN - Effective Diabetes Education now The health burden of diabetes Financial issues/risk to the NHS in LLR Improving quality and cost effectiveness of diabetic service Unmet need Variation in primary care • To meet the diverse educational needs of the workforce involved in the delivery of care for people with diabetes • Flexible approach reflecting the different levels of knowledge and skills required to provide high quality care • Leicester Diabetes centre will work with CCG to deliver HCP programme • Locality Diabetes Leads to be recruited Engagement at practice level.	GP Locality Clinical Leads - LCCCG	• Access to high standard diabetes knowledge and skills training • Improved outcomes for patients • Effective prescribing • Mentorship and coaching available • Meet national and local targets	July 2013	Project recently initiated.
Admission avoidance: **ACS pathways** Ref 52-55	QOF QP 2012/13 • GPs to undertake internal review to engage with the development of and implementation of 3 care pathways in the management and treatment of their patients. With the aim of providing alternative care options for patients in order to avoid inappropriate emergency admissions. • The focus of the review - how practices can amend or improve their treatment and management of patients in primary care to help avoid emergency admissions.	GP Practices - LCCCG	• Select 3 pathways for internal Peer Review. • Pathways selected – COPD – Frequent Fliers (attenders) – UTI – Lower Respiratory Tract Infections – Upper Respiratory Tract Infections – Care Homes / Housebound patients – Early Pregnancy Bleeds – Hepatitis C – Hyperkalaemia – Pneumonia • Undertake internal review	July/August 2011	Completed

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Admission avoidance: End of Life Care Ref 25-27	• To comply with the 2008 Government End of Life Care Strategy – promoting high quality care for all adults at the end of life. • To provide people approaching the end of life with more choice about where they would like to live and die, encompassing all adults with advanced, progressive illness and care given in all settings. • Advance care planning including confirmation of resuscitation plans to prevent unnecessary admissions and ensure patients receive care in line with their wishes and plans. • Four GP locality mentors (one session per week) trained to Diploma level in Palliative Care, with group mentoring provided by LOROS	Wendy Pearson - LCCCG	Outcome measures by 31.3.14 1) Reduction in emergency admissions at EoL – 80 2) 90% (57) practices have LES 3) 1689 (0.45%) registered population on palliative care register	December 2012 – March 2015	GP clinical lead and 4 GP locality mentors appointed. 3 mentors completed DMU Principles and Practice in Palliative Care module. All participate in Development Group 43/63 practices signed up to LES by 31.3.13 Most GP practice leads for EoL care have attended training – 'mop up' sessions planned in June 439 patients on Palliative QoF register as at 31.3.13
Admission avoidance: Annual Quality Reviews (AQR) Ref 21-31	Improving the Quality of primary care is the key driver for the introduction of this process which has been in place or three year. A number of key targets are monitored which have a direct impact on helping to reduce emergency admissions into UHL • Assess individual practices' performance in quality and governance. • Revised process to be agreed by Quality and Clinical Governance group. • Revised Balanced Scorecard (BSC), format to be discussed and agreed.	Independent Lay Members Locality Chairs Locality Managers - LCCCG	Range of measures included on BSC including: • QIPP – New Out Patients • QIPP – Emergency All LOS • NHS Health Checks activity • Other Enhanced Services provision • Access and Patient Experience • Public Health targets • Medicines Mngt targets	June 2013	Year 4 visits commencing November 2012. We have completed 41/63 visits at w/c 22 April, and is a key element of each agenda
Admission avoidance: Emergency Admissions	Emergency Admissions Reduction Project • 12 practices within the City involved with the	Clare Sherman - LCCCG	This project will continue and look to provide:		**On-going** The CCG have agreed

Reduction Project
 	
Ref 11, 24, 25, 29
	project over a 12 month period
	• The key theme for the model is that quality of care for patients is paramount which has resulted into a reduction in emergency admissions
	• Two locality GP mentors in post to mentor 6 of the selected practices each
	• First phase pilot to evaluate and assess impact from Dec 2011 to Dec 2012
	• Present positioning paper for CCG board to agree next actions to
	  ○ evaluate the realised improvements, benefits, working procedures and learning experiences and have they been identified and recorded
	  ○ Engage with all LCCCG practices to take on phase 2 to extend the learning and impact of the pilot
	• Practice access to the 'Bolton Dashboard' as part of that particular project's rollout
	• A suite of key performance indicators for quantitate and qualitive measurement of the service.
	• Agreed project evaluation criteria, process and reports
	• A toolkit process guide for use by all
	• An independent evaluation of the progress undertaken by CLARHC
			• Defined processes and methods of work that enable and encourage a holistic approach when planning and delivering the intervention package, to include:
			  ▪ Evaluation of each selected practice, using data available to CCG/practices
			  ▪ 'Real time' data analysis of admissions using HERA
			  ▪ Case reviews and audits
			  ▪ SystmOne template
			  ▪ Practice development plans
			  ▪ Training.
				Pilot first phase & closure with participating practices end November 2012	to continue the project for 2013/14.
					
					Evaluation is currently with cohort 1.
					
					Practices have been identified for cohort 2 with an estimated start date of end of May 2013.

Admission avoidance: 3T Cardiology Pilot	The 3 T Cardiology pilot has been initiated to improve CVD outcomes across Leicester City by increasing the detection and diagnosis of Atrial Fibrillation and Heart Failure and optimising their management in keeping with current evidence based practice.	Clare Sherman - LCCCG	• Improve the patient pathway and swifter access to specialist services • Provide equity for patients • Increase in the appropriate detection, diagnosis, treatment and management of patients with HF and AF in primary care • Teaching and training of GPs completed.	September 2013	Training completed for pilot site GP's 21 practices are involved in the initial pilot representing a caseload of 132,830 patients.

	Download national GRASP AF tool to identify patients at risk or not optimally managed. • Teaching and training for GP's to detect and perform required tests and to prescribe optimal therapy. • Access to direct Echocardiogram to make a diagnosis of both conditions • One GP per practice to be trained as a GP cardiologist to ensure consistency and continuity for patients and this GP will be supported by mentoring and peer review.		• Reduction in the numbers of emergency admissions • Reduction in costs associated with the on-going provision of heart and stroke services. • Reduction in mortality - this will take some time to be realised. • Improve shared knowledge amongst health professionals across the health economy and within localities • Relationships between primary and secondary care, and between cardiac and stroke clinicians • It will with AF and HF and improve the quality of life and longevity of the affected groups		GP's in the process of doing their pre pilot audits and reviewing their current caseloads Cohorts 1 and 2 training completed. Measures and metrics identified and will be in place by mid-May.

INFLOW MANAGEMENT: West Leicestershire CCG					
Issue ***Ref to NHSE checklist***	**Actions**	**Lead**	**Outcome measure**	**Target finish date**	**Progress**
Attendance avoidance: **Proactive Care** Ref 49, 50 Ref 57-58	An integrated approach to increase capacity and capability within practice teams including delivery of the practice specific elements of Proactive Care for patients with long term conditions and the frail elderly.	Dr N Pulman / Angela Bright Chief Operating Officer - WLCCG	Emergency admission hold at 2012/13 levels The key components of the scheme are: (details on each are provided below) • Emergency Admissions • New Outpatient attendance • Practice engagement • Diabetes • COPD • End of Life • Proactive Care • Cancer • Heart Failure	On-going	Implementation is coordinated through locality specific Planning and Engagement Managers working closely with clinical leads and practice managers across our 4 localities. Progress is reported monthly to the Finance and Performance Sub Group

ATTENDANCE AVOIDANCE Primary Care Urgent Care Ref 24, 71	**EMAS Bounce Back:** The scheme aims to deflect, where appropriate, secondary care activity generated by 999 ambulance call outs. EMAS Referral of clinically assessed patients that do not require treatment in a secondary care setting, who during surgery hours, can be appropriately treated by their own GP practice. **Bounce Back Scheme:** Patients presenting at UHL A&E or the UCC (at UHL or Loughborough) will be assessed by a triage nurse where patients will be directed to the most appropriate care setting – one of which is primary care. The scheme will be start from May/June 2013 and will in operation Monday – Friday between 8am – 6.30pm. **ECP Scheme:** Patients calling the GP surgery where the care can be provided by an ECP rather than being referred/signposted to A&E/UCC	Dr Nick Willmott / S Shrestha - WLCCG	Reduced attendances during surgery opening times	On-going To commence in May/June 2013 Commencement date TBC	EMAS bounce back: 224 successful pass backs to primary medical care since the start of the scheme.
ATTENDANCE AVOIDANCE Improving Access Ref 21-31	Access Survey conducted across all 50 practices and triangulated against quality appraisal data and PES data, to determine trends.	R Bruce - WLCCG	Reduced emergency attendances during surgery opening hours / appropriate access to services	Trends determined by July 2013	Active engagement with those practices who are clear outliers in terms of data; P&E team targeting practices to ensure awareness of issues and actions in place to improve access as required. Further work undertaken to determine any correlation between access and emergency attendances.
ATTENDANCE AVOIDANCE	Continuation and development of the Care Home LES for GP practices to provide enhanced medical support over and	M Arnold - WLCCG	Reduced emergency admission from care homes.	Scheme commenced 1st	Data mapping to be completed in Q2

Care Home Locally Enhanced Service Ref 52-55	above core contract but actively engaging with and assessing individual patients within nursing and residential settings.			April 2013	
ATTENDANCE AVOIDANCE Child Health Booklet Ref 62, 63	WLCCG specific booklet, app, and website for parents of children aged 0-5 years, providing information on common childhood illness and how to treat and appropriate access to services	Jennie Caulkwell - WLCCG	Appropriate access to services	On-going	Booklet has been well received by patients and healthcare professionals.
STEP UP/ADMISSION AVOIDANCE **Assess before Decision to Admit Model** Ref 57-58	To improve the urgent care pathway for FOP, bringing care closer to home where that is clinically and financially viable to do so. To reduce unnecessary acute admissions, acute LOS and to reduce medical readmissions for people over the age of 75. The project aims are to: agree a model of care, for community frailty needs and ambulatory case sensitive interventions , built on the health needs assessment and clinical case for change; use experience-based design in each locality; develop a robust involvement strategy; consider the options for service configurations in each locality.	Caron Williams/ Sharon Creber-WLCCG	-reduction in rate of emergency admissions / readmissions for 75+ ('left shift 'of activity) -reduction in ALOS increase in levels of CGA -more older people supported to live at home -improved utilisation of community hospital facilities	Started April 2013	Specific workstreams will sit under "Step Up" with clearer timelines defined by July 2013
STEP UP/ADMISSION AVOIDANCE **Care home support service** Ref 52-55	To improve the opportunity for older people to remain in their choice of place of care in line with Health and Wellbeing board and member practice priorities by support nursing home settings to improve the care they can provide for the people who live there by : Enhancing training in the setting; Offering rapid response from Nursing Specialists to support people to remain in the setting; To support settings with Enhanced Primary Medical Care: and to Ensure specialist needs of patients, eg those with dementia, can be met in the setting.	Caroline Trevithick - WLCCG	-reduction in rate of emergency admissions / readmissions for 75+ ('left shift 'of activity) -reduction in ALOS for nursing home patients -Increased opportunity to remain in place of care -Death in Usual Place of Residence increase -Reduction in deaths in acute trusts in 0-2 day length of stay -Improved quality of care in Nursing Home setting		

			-Improved experience for those living in nursing homes		
STEP UP/ADMISSION AVOIDANCE **Heart Failure – Urgent Access Clinic Pilot** Ref 69	Heart failure "Hot Clinic" - to stabilise conditions and reduce admissions or readmissions to secondary care. The service is for adults with newly diagnosed heart Failure and previously diagnosed, recent admission to hospital or are at high risk of admission are unable to wait for routine follow up or diagnosis. This pilot is only open to WLCCG patients.	Nick Willmott - WLCCG /Arlene Neville - WLCCG	-Patients are seen within 72 hours of referral -Patients are seen by a cardiologist in a planned care setting -decisions are made with no delay	Pilot started in November 2012	Initial evaluation shows that numbers of patients are low and therefore impact is difficult to quantify. Patients/GP's love the service and pilot will need to run for longer to measure the impact
STEP UP/ADMISSION AVOIDANCE **End of Life Care (EOLC)** Ref 25-27	To increase patient choice. improve patient experience, and reduce utilisation of secondary care. The evidence based methodology for improvement will be the systematic introduction of the EOLC pathway supporting by guideline introduction with education and training. There are three specific components to the programme: I prevalence in primary care, advance care planning and sharing of key information across key providers.	Mayur Lakhani - WLCCG	-Prevalence increased to 0.33-0.44% -Increase in home death rate -Reduction in avoidable 2ndary Care admissions -Shortened LOS on acute episodes in the age range -Increased patient choice on care setting for required interventions -Improved patient experience.		
STEP DOWN **Discharge to Assess Model** Ref 105	Establish 3 pathways which routinely allow patients to go home to be assessed for their onwards care journey. To link these pathways to care offers such as pro-active care and rehabilitation and reablement. Where this is not enough because people have night needs to craft pathway offers with telehealth, telecare and small amounts of night care or pathways in other settings of care. To allow patients to be assessed in settings where their care needs will not be overstated and they have the best change possible to be rehabilitated. To reduce inappropriate access to Continuing Healthcare because there is 'no where else' to have care needs met. Reduce barriers to discharge, and increase flow through the urgent care system. Reduce the number of people who are delayed in their transfer of care. Reduce the number of people readmitted for medical care within 30 days of discharge by making safer first time discharge arrangements. Reduce mortality and increase quality.	Caron Williams - WLCCG (Dave Briggs & Yasmin Sidyot ELCCG)	-Shortened LOS on acute episodes in the age range -Increased patient choice on care setting for required interventions Improved patient experience. -Reduction medical readmissions 30 days and 91days -Increased adherence to EDD Reduction in DTOC	Started April 2013 (Specific workstreams will sit under "Step Down" with clearer timelines	

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STEP DOWN **Assistive Technology "Flo"**	Deployment of FLO – Flo helps patients to monitor their own vital signs at home such as blood pressure, pulse and oxygen level. The patient can then communicate directly using a mobile phone text service.	Cathrina Tierney-Reed /Sandeep Chohan - WLCCG	Increase patients levels of awareness of their own disease Care closer to home	Phase 1 = Pilot – roll out to 18 practices in WLCCG by 24th May	18 practices signed up and 6 set up by 3/05/13

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EFFECTIVE THROUGHPUT – UHL INTERNAL FLOWS

13/14 LLR THROUGHPUT TARGETS: Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins

Issue *Ref to NHSE checklist*	Actions	Lead	Outcome measure	Target finish date	Progress
ED PROCESS **Minors stream** Ref 76, 77, 83	See and Treat processes implemented in Minors	Andy Coser/ Ben Teasdale - UHL	Time to Initial Assessment <15 mins, Time to treatment < 60 mins	18/02/13	Implemented, but KPI's not at 100%
	Direct access where wait to be seen is less than 30 minutes	Andy Coser/ Ben Teasdale - UHL	Time to Initial Assessment <15 mins, Time to treatment < 60 mins	18/02/13	Implemented but KPI's not being delivered
	Not to see patients suitable for UCC	Andy Coser/ Ben Teasdale - UHL	Time to Initial Assessment <15 mins, Time to treatment < 60 mins	18/02/13	Single Front Door will prevent this
	Staffed with ENPs (2 off peak/3 peak), HCA and registered nurse with a clerical coordinator during peak periods and therapies input 7 days	Andy Coser/ Ben Teasdale - UHL	Time to Initial Assessment <15 mins, Time to treatment < 60 mins	24/06/13-ENP's 22/07/13-HCA's	ENP recruited awaiting start date
ED Assessment Bay **Ambulance Arrivals** Ref 20, 72, 75, 76, 77	Senior clinical decision maker covering 24/7	Ben Teasdale - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	30/05/13	In place although variations occur in cover due to staff shortages
	Direct referrals to UCC, Medicine, clinics or GP to bypass Majors	Ben Teasdale - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	18/02/13	In place but depends on bed capacity (see below)
	Initial clinical assessment within 15 minutes	Ben Teasdale - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	18/02/13	See above
	Physical space to manage up to 20 ambulance arrivals per hour	Ben Teasdale - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	30/05/13	Complete
	Ambulance Turnaround pre-clinical action plan implemented	Helen Stubbs , ELR CCG Ben Teasdale - UHL	Pre-clinical handover < 15 mins	31st July 2013	EMAS-UHL group set up to identify areas for improvement: linked directly to EPC actions for process in ambulance arrival area
Coordination of the Unit Ref 78, 79	Clear escalation plans in place for all areas and roles	Tim Coats/Jane Edyvean - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	18/02/13	Further work being undertaken to embed
	A real time dashboard in place for each area and an overview	Tim Coats/Andy Curruthers - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	31/07/13	

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	Refined NIC, Tracker and DIC roles with a clear single leadership role	Lisa Lane/Kerry Morgan - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	30/04/13	NIC role being revisited to have overall authority of the department
ED PROCESS **Majors** Ref 84-88	Majors to be used only for undifferentiated patients to establish a plan and decision in less than 180 minutes	Ben Teasdale - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	18/02/13	Need to ensure 100% compliance
	Patients in area to have an initial plan from ambulance assessment or following purple team input post walk in assessment	Ben Teasdale - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	18/02/13	need to ensure 100% compliance
	Patients in area to have had initial bloods and imaging	Ben Teasdale - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	18/02/13	Need to ensure 100% compliance
	To follow initial plan and act on blood and imaging results to ensure timely decisions are made	Ben Teasdale - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	18/02/13	Need to ensure 100% compliance
	To have a red, blue and flex purple team for assessment capacity and to cherry pick likely discharges directed by senior clinician	Ben Teasdale - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	18/02/13	Need to ensure 100% compliance
	To refer patients on from the department as soon as an appropriate disposal is established	Ben Teasdale - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	18/02/13	Need to ensure 100% compliance
	To move patients out of the department as soon as an allocation is made	Ben Teasdale - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	18/02/13	Capacity constraints mean patients can remain in AED for long periods of time (see below)
ED PROCESS **Resus** Ref 84-88	To be used only for patients meeting Resus criteria. Criteria to be defined and disseminated	Ben Teasdale - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	26/03/13	New lead to be identified for SOP revision
	Escalation where <2 beds. Capacity for 8 patients	Ben Teasdale - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	18/02/13	Outflow to assessment/ACB can hinder this
	Rapid access to external teams where required e.g. ICU, GI etc. Timely transfer of patients with written plan and verbal handover out of the unit	Pete Rabey- UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	31/03/13	Variable speciality team response
Diagnostics and Therapies Support	Radiology pathways and ICE systems in place	Cathy Lea - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	30/04/13	Pathways in place

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	Pathology pathways and ICE systems in place	John Mortimer/ Ben Teasdale - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	30/04/13	Pathways in place
	Therapies support implemented	Chris Shatford - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	31/03/13	Recruitment underway
EDU – Emergency Decision Unit	New Pathways developed and operational	Martin Wiese/Ben Teasdale- UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	31/03/13	Complete
	Mental Health Assessment space enhanced	Ben Teasdale- UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	TBC	Impact of new EFU moving to EDU to be assessed in terms of space allocation for Mental Health
Overall ED Resourcing Plan Ref 64, 80, 82	Full staffing model developed for ED/EDU	Ben Teasdale/ Kerry Morgan - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	30/6/13	Medical staffing review being undertaken. Nursing review completed.
	Budgets signed off for additional resources	Catherine Free/Jane Edyvean - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	31/5/13	In progress
	Recruitment/resourcing plans confirmed	Catherine Free/Jane Edyvean - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	31/03/13	Confirmed and in progress
	Rotas implemented for the ED/EDU	Ben Teasdale - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	31/03/13	Extensive recruitment plan
	Need high level matching of activity to staffing	Catherine Free/Jane Edyvean - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	31/05/13	Matching review completed – shows reasonable balance
	Development of plans for emergency floor to improve current accommodation	Nicky Topham/Catherine Free - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	Sept 2014	Planning underway – initial case submitted to NTDA
Clinical Handover from ED to Assessment Units	Handover from ED doctor to Assessment Units Floor coordinator to facilitate safe clinical handover of all patients	Julie Burdett - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	31/03/13	Revised role with support from bed coordinators working well

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Documentation of new ways of working Ref 81	Finalised SOP for all ED areas	Ben Teasdale/ Lisa Lane - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	30/04/13	Majority of components complete – revisions needed for Minors, Resus and Majors
Assessment Units – LRI and Glenfield Sites Ref 90-99	Creation of a Rapid Assessment Function (6-14 hours) and Dedicated Short Stay area (48-72 hours) on both sites	Lee Walker - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	18/02/13	Re-launch of standards on 03/06/13
	Assessment area processes for LRI and GH are clearly defined, documented within the SOP	Lee Walker - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	18/02/13	On track
Consultant -delivered dedicated 12 hour cover on assessment and short stay areas Ref 90-99	A clear rota is developed to cover 12 hour acute/general physical (LRI) consultant input 7 days per week	Lee Walker - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	06/05/13	Complete
	A clear rota is developed to cover 12 hour consultant input in Respiratory and Cardiology Glenfield 7 days per week	Lisa Jeffs - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	30/07/13	Funding source to be agreed
	Rapid Assessment model (6-14hours) and Short Stay (48 hours) • LRI Ward rounds at 8am, and 3.30pm • LRI Board rounds at 12/1pm and 6pm and 8pm • LRI Ward round (16 consultant – ACB at 8am-9am/2-3pm) • CDU Ward round 8am, Board rounds 2pm and 5pm	Jane Edyvean/ Lisa Jeffs - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	18/02/13	Daily Audits through manager of the day role to monitor adherence to standards
	Direct GP admissions to LRI and GGH Assessment units	Catherine Free - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	18/02/13	Re-launch of RAU standards
	Senior review within 30 minutes of admission	Jane Edyvean/ Lisa Jeffs - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	18/02/13	Re-launch of standards on 03/06/13
	Floor Coordinator role to oversee and coordinate the units and take clinical handover	Julie Burdett/ Kerry Tebbutt - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	18/02/13	Re-launch of standards on 03/06/13
Frailty Units and Integration with the Assessment Units	Dedicated Acute Frailty unit for patients meeting defined frailty markers	Catherine Free/ Simon Conroy - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	06/06/13	On Track

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Ref 57-58	Ambulatory Frailty patients to be managed with clear criteria and MDT input in EDU	Catherine Free /Simon Conroy - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	06/06/13	On Track
	Clear mechanisms for geriatric and MDT In Reach into assessment unit on both sites where required based on frailty markers	Catherine Free /Simon Conroy - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	06/06/13	Clear model to be defined in detail
	Frail friendly ED plan defined and implemented	Emily Laithwaite - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	06/06/13	Plan documented
Diagnostic Response to Assessment Units **Ref 92**	SLAs have been developed for pathology and imaging outlining request and order expectations, urgency criteria and expected turnaround times and KPIs	Cathy Lea - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	18/02/13	Complete
	SLA standards implemented (Radiology and Pathology) 1-2 hour turnaround time for urgent tests at the LRI site	Cathy Lea - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	18/02/13	KPI's in place to monitor
	SLA standards implemented (Radiology and Pathology) 1-2 hour turnaround time for urgent tests at the Glenfield site	Cathy Lea - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	30/09/13	Budget allocation confirmation required
Ambulatory Care Pathways Ref 65-69, 89	Existing Ambulatory care services moved to the fracture clinic located near ED (TIA and DVT)	Helen O'Connell - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	31/03/13	Complete
	Acute Neurology ambulatory care services are documented, staffed and housed in the fracture clinic – First fits and acute headache	Helen O'Connell - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	01/07/13	Will start as 5 day service
	Directory of services written and publicised	Helen O'Connell - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	31/07/13	
	Acute Medical clinic and CDU green chaired area available for direct referral from ED 7 days per week with acute physician/respiratory physician cover	Catherine Free - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	18/02/13	Re-launch standards 03/06/13
Ward Rounds in Acute Division and In Reach Ref 18, 19, 101-104	Implemented 7/7 consultant reviews and daily MDT in Stroke	Tim Petterson/Martin Fotherby - UHL	Minimum standard – 3 morning senior reviews/week and a daily MDT board round	03/06/13	On track
	Minimum standards implemented in Geriatrics	Tim Petterson/Simon Conroy - UHL	Minimum standard – 3 morning senior reviews/week and a daily MDT board round	07/06/13	On track

	Minimum standards implemented in Respiratory	Nick Moore/ Jon Bennett - UHL	Minimum standard – 3 morning senior reviews/week and a daily MDT board round	03/06/13	On track
	Minimum standards implemented in Diabetes	Tim Petterson/ Rob Gregory - UHL	Minimum standard – 3 morning senior reviews/week and a daily MDT board round	01/07/13	Plan being developed
	Minimum standards implemented in Cardiology	Nick Moore/ Jan Kovac - UHL	Minimum standard – 3 morning senior reviews/week and a daily MDT board round	01/07/13	Plan still to be devised by Cardiology
	Minimum standards implemented in Renal, ID and Neurology	Tim Petterson/Heads of service - UHL	Minimum standard – 3 morning senior reviews/week and a daily MDT board round	01/07/13	Plans in development
	Gastroenterology In Reach into Assessment Units – Monday to Friday consultant delivered	Alistair Grant - UHL	Minimum standard – 3 morning senior reviews/week and a daily MDT board round	17/06/13	On track
	Standardised ward round documentation, including EDD and reasons why EDD not met.	Ruth Denton-Beaumont - UHL	Minimum standard – 3 morning senior reviews/week and a daily MDT board round	03/06/13	On track
	Implementation across Acute Division stretch target – 5 day consultant delivered ward rounds (Monday to Friday) with weekend cover arrangements	Tim Petterson - UHL	Minimum standard – 3 morning senior reviews/week and a daily MDT board round	04/11/13	Plans to be developed
	Ward Managers to be supernumerary	Monica Harris - UHL	Minimum standard – 3 morning senior reviews/week and a daily MDT board round	04/11/13	Funding allocated – planning underway
Corporate Capacity Management and Escalation Ref 100	Redefine roles and responsibilities of bed coordinators and those staff involved in capacity management	Phil Walmsley - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	17/05/13	Complete
	SOP complete for new bed meeting function, agenda, times, frequency and membership	Phil Walmsley - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	29/05/13	On track
	Implement new capacity management processes including new meeting times, agenda and attendees	Phil Walmsley - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	04/06/13	On track
	Review SMOC roles and responsibilities to align to proposed action to have a senior manager 8-midnight rota supported by a Duty Manager	Phil Walmsley - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	04/06/13	On track

	Design revised Trust wide escalation processes and roles/responsibilities action cards (for when demand exceeds predicted capacity)	Phil Walmsley - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	17/05/13	On track
	Develop demand and capacity predictor tool	Phil Walmsley - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	29/05/13	On track
	Implement necessary e-bed state changes to support new plan/process to provide real time bed state information	Phil Walmsley - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	24/06/13	
	Design and implement new dashboard on Insite	Phil Walmsley - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	24/06/13	
	Phased implementation of escalation plan:	Phil Walmsley - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	17/05/13	
	- Pilot the new Escalation Plan in imaging, AMU, ED, and Transport	Phil Walmsley - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	24/05/13	Revised rollout date for transport TBC
	- Rollout escalation plan in line with ward round implementation timeframes across Acute Division	Phil Walmsley - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	03/06/13	On track
	Evaluate Escalation pilots and amend processes/SOP as required	Phil Walmsley – UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	28/06/13	N/A
	Full rollout of Escalation Plan	Phil Walmsley - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	01/07/13	N/A
Increase Capacity	Plan how haematology ward can be renovated without removing acute medicine from ward 19	Phil Walmsley - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	24/05/13	Complete
	Paper on all accommodation moves to come to ECAT describing how to increase bed capacity	Phil Walmsley - UHL	Time in Dept < 240mins, Time to Initial Assessment <15 mins, Time to treatment < 60 mins	24/05/13	Complete awaiting full costs and operational plan

EFFECTIVE SYSTEM FLOW; Discharge improvement across the system

13/14 LLR OUTFLOW TARGETS: DTOC RATE 5.2/100,000

Issue *Ref to NHSE checklist*	Actions	Lead	Outcome measure	Target finish date	Progress

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Project Management: Insufficient direct management of implementation of strategy Ref 1-5, 9	Communicate and monitor implementation of the multi agency programme plan down to the operational level. This must include dependency mapping and shared milestones. The plan should be communicated by the end of December 2012 and implementation at operational level should be monitored on an ongoing basis thereafter by all organisations of the ECN. Programme managers should be allocated on a rotational basis including members from all involved organisations.	Dave Briggs, ELR CCG	Sufficient resource sourced to PM this work stream	June 2013	Team in place in July 2013
Project Management: Discharge Governance across LLR Ref 1-5, 9	Establish Discharge Governance Framework inc. Project Board & Operational Group	Dave Briggs, ELR CCG	Revised structure in place	June 2013	Recruitment underway
Community Capacity: Step down models of care across CCG's Ref 105, 106, 107	• Pilot ICS in West CCG • Apply learning to City and ELR models of care & commission additional community based services	Sarah Prema LCCCG Jane Chapman ELRCCG Caron Williams WLCCG	Substantial decrease DTOC due to patients 'awaiting further NHS Care' – to be quantified following agreement of model	Through 2013-14	ICS live in West CCG City model proposed, expected to have 23 beds live by October 2013 and additional ICS-type service by Q3 2013 for City and ELR
Community capacity Therapy services	Demand and capacity modelling for community therapy service for City in particular	Rachna Vyas LCCG, EUCON Sarah Prema, LCCCG	Decrease P1-P3 waits in City	Revised model dependant on recruitment – exp. late 2013	Demand vs. capacity analysis started May 2013
Discharge process: **Single assessment process** Ref 118, 52-56, 105, 106, 107	A detailed review should be undertaken to identify points in the discharge process where assessments are being repeated unnecessarily by different professional groups.	UHL	Increase discharge rate before 1pm to 29.8% by YE Increase discharge rate before 11am to 14.6% by YE	30th June 2013	
	When these points are identified, the repeated assessment should be discussed with the identified professional groups and the process re-engineered to remove the duplication of effort.	DTOC steering group – led by Dave Briggs, ELR CCG	DTOC rate reduced to 5.2/100,000 - Increase discharge rate before 1pm to	31st July 2013	Requirement agreed across all agencies Meeting workshop

	The review should focus on two separate areas in particular: repeat assessments by care homes before taking on patients and re-assessments by multiple consultants such as after wards transferrals.		29.8% by YE Increase discharge rate before 11am to 14.6% by YE		arranged for July 2013
Discharge Process – UHL & LPT: Discharge earlier in the day Ref 57-58, 105, 106, 107, 108-118	Introduce Discharge Coordinators and Board Rounds across all wards using a consistent approach including MDT involvement and EDD setting.	Andy Jones, UHL	Increase discharge rate before 1pm to 29.8% by YE	31/10/13	ONGOING Need to recruit for discharge co-ordinators
	Discharge Co-ordinators and ward teams (including Consultant and medical staff) should adhere to documented processes in relation to discharge. These should focus on clear and early definition of baselines and needs, active planning for discharge from the point of admission and appropriate involvement of social services.	DTOC group – Dave Briggs, ELR CCG Phil Walmsley, UHL Nikki Beacher, LPT	Increase discharge rate before 1pm to 29.8% by YE for UHL Reduced DTOC rate for awaiting further non acute NHS Care DTOC category	Agreed process in place by June 30th 2013	Part of ECP work programme in workstream 4. May 18th Deadline for UHL work
	An education programme should be established in relation to these processes and rolled-out in the 1st Phase across high-footfall wards by the end of December 2012, followed by the 2nd phase of roll-out across all other wards by the end of July 2013.	Andy Jones, UHL Nikki Beacher, LPT	Increase discharge rate before 1pm to 29.8% by YE Reduced DTOC rate for awaiting further non acute NHS Care DTOC category	31.07.2013	307 staff have had the discharge training, including nursing, therapy, administration and social care staff. Over 100 staff have had competency assessments.
	Eligibility criteria for similar services across organisations should be harmonised and communicated to all service referrers.	DTOC group – Dave Briggs, ELR CCG Phil Walmsley, UHL Nikki Beacher, LPT	Reduction in time from referral to discharge destinations 1. CHS bed 2. CHS service 3. Care home 4. Home 5. LA service	31.07.2013	Initial meetings held with DTOC with agreement for need of a single assessment process. DTOC group to take forward

APPENDIX 2A

Discharge process - UHL: NWB pathway Ref 105	Transfer from Non-recurrent scheme to recurrent scheme in UHL contract	Rachna Vyas LCCCG, EUCON Mandy Gillespie UHL	Reduction in occupied bed days whilst patients NWB Improved patient experience	For 14/15 contract	13-14 funding agreed via May CCB.
Discharge Process - UHL: Discharge earlier in the day Ref 57-58, 105, 106, 107, 108-118	Embed routine discharge planning processes inc. use of EDD, MFFD, daily board round, daily ward round, discharge criteria etc. Improve effectiveness of MDT Board rounds	Andy Jones UHL	Increase discharge rate before 1pm to 29.8% by YE Increase discharge rate before 11am to 14.6% by YE	Live' EDD (on Patient Centre) for all inpatients - Nov 12 Introduce MFFD to Medical staff Oct 12	COMPLETE Board rounds and EDD now need to be used more effectively Discharge Planning boards in place & daily MDT Board Round on all Acute Care wards At least daily Medical Ward rounds on all wards (M-F)
Discharge Process - UHL: Discharge Lounge Usage Ref 108-118	Review discharge lounge usage, particularly regarding the times of service utilisation. The discharge lounge should operate a pull-mechanism based on capacity throughout the day to avoid the peak-time usage through wards pushing patients through.	UHL	Increase discharge rate before 1pm to 29.8% by YE Increase discharge rate before 11am to 14.6% by YE	31.07.13	Discharge lounge times have changed and GGH opens at weekend. Currently expanding LRI DL to make it bigger
	Wards should be given a target percentage to discharge patients via the discharge lounge. These targets should be based upon the type of ward and likely functional needs of the patients in accordance to the discharge lounge policy.	UHL	Increase discharge rate before 1pm to 29.8% by YE Increase discharge rate before 11am to 14.6% by YE	31.07.13	COMPLETE. Poor performers being followed up
Increase LRI Discharge Lounge Capacity	Increase LRI discharge lounge capacity - Develop & submit business case	James Wray - UHL	Reduction in DTOC rate to max 5.2/100 000	Complete and submit Business Case Sept 12 Increased capacity Dec 12 / Jan 13	Increase LRI Discharge Lounge Capacity LRI discharge lounge Currently being rebuilt
Discharge Process - UHL: **TTO process**	Identify barriers to completion of TTO day before discharge and create action plan to remove delays	Claire Ellwood / Dr Beverly Collette UHL	Increase discharge rate before 1pm to 29.8% by YE	Roll out of EPMA (Electronic Prescribing) -	EPMA Roll out COMPLETE in paeds

Ref 108-118			Increase discharge rate before 11am to 14.6% by YE	Ongoing Medical staff engagement Sept / Oct 12	EPMA Roll out started in Medicine Input to Junior Drs training & induction 15% improvement noted
Discharge process – UHL & LPT: Improve practice & culture towards discharge across providers Ref 108, 114, 115	Improved discharge training programme for ward staff Discharge processes guide to be produced for display on each ward. To include Department of Health 10 Steps of Discharge. Update the "Discharge Planning Tool" to include discharge reference guide on front page. Standardisation of SITREP coding and reporting to ensure all wards report consistently.	Matrons/ Academy UHL & LPT Matrons UHL/LPT Matrons UHL/LPT Matrons UHL/LPT	Increase discharge rate before 1pm to 29.8% by YE Increase discharge rate before 11am to 14.6% by YE	August July October June	Discharge training to all band 5, 6 and 7 MDT members between August and February. NOT COMPLETE due to trainer leaving. Large amount of training has taken place Completed Trial being undertaken on all wards. Review to take place in October. This information incudes summary information on discharge dates, section 2 and 5, EDD and fit for discharge dates COMPLETED. Consistent reporting across all community hospitals. Matrons review delayed discharges on a weekly

					basis
Discharge Process – UHL & LPT: Care Home delays Ref 52-56 Ref 57-58	Pilot 'Care Home Select' for 6 months to reduce delays caused by care homes across LLR Work with EMCARE and partners to pilot a single assessment process to reduce delays Create a care home circulation list to ensure providers are aware of any escalations within the system	Rachna Vyas LCCCG, EUCON Phil Walmsley, UHL Mandy Gilespie, UHL Alison Cowley, EMCARE	Reduction in DTOC rate to max 5.2/100 000	Pilot start end of Sept 12	CHS pilot started in Jan 2013. Reduction in delays from 6 days to 1.2 days seen in Q1 Single assessment process ongoing. Multi-agency meeting arranged for July 2013 Circ list in process
Discharge process – all providers: Equipment delays	Discharge Admin team to access the NRS ordering system - Meet with Soc Services re: Section 5 Notification and equipment delivery. Roll out of on line ordering Additional NRS driver and van for urgent deliveries	Mandy Gilhespie , UHL Rachna Vyas LCCCG, EUCON	Reduction in DTOC rate to max 5.2/100 000	April 2013	COMPLETE Further work ongoing to map 'top 10' equipment lists to ensure these are in stock as standard across all satellite stores
Discharge process – UHL & Arriva Patient transport delays Ref 73	Streamline processes for patient transport service	Rachna Vyas LCCCG, EUCON Helen Stubbs, ELR CCG Louise Bettany, Arriva	0 rebeds Reduction in time from discharge to discharge destination 25 % reduction in aborts and cancellations	July 31st 2013	Ongoing – service improvement meetings set up & resourced.
Patient choice project – UHL & LPT: Improve transfer of patients between UHL/LPT	To improve the transfer of patients between provider organisations to reduce delays, length of stay and ensure patients receive on going care in the most appropriate setting to meet their needs	Nikki Beacher, LPT Andy Jones, UHL	Reduction in received to transfer time from UHL to Community Hospitals Development of an electronic discharge referral from UHL to CHS	March 2014	Electronic discharge referral in development Current process mapped

Patient choice project – All providers: Design a set of joint information that can be used across UHL, LPT and Local Authority to support the discharge process and inform patients and their families and staff	1. Set up a joint LPT, UHL and LA task and finish group to review current documentation and develop best practice. 2. Involve patient and carer groups in development of documents	Andy Jones, UHL Nikki Beacher, LPT	Reduction in DTOC rate to max 5.2/100 000 Reduction in delays due to choice Development of shared information leaflets for patients relating to discharge and transfer	Documentation to be completed by end of July 2013	Design a set of joint information that can be used across UHL, LPT and Local Authority to support the discharge process and inform patients and their families and staff Rehabilitation leaflet
Communication: Strengthen communication with Social Services Ref 117	Amended SSAF form to be faxed to Social Services with Section 2. Matrons/Ward Managers meeting with social services managers on a monthly basis. Patient information on interim bed provision to be produced, in partnership with Social Care to address the challenges of "patient choice". Review process for issuing section 2 and 5 with Social Care to ensure these are always submitted promptly and with the correct information within them	Matrons UHL/LPT Matrons/ Ward Managers UHL/LPT Matrons UHL/LPT Matrons/ Ward Managers UHL/LPT	Increase discharge rate before 1pm to 29.8% by YE Increase discharge rate before 11am to 14.6% by YE	July April October July	Completed Completed. Information completed awaiting feedback from reader's panel. Social care attending ward manger community hospital meetings to update on process
Communication: Patient and Carer Information Ref 118	"Ready Steady Go" letters to be re-introduced on all wards. These will support discharge planning with families/carers from admission. Re-introduction of 'local guide for patients/ carers following discharge' to be given to all patients on discharge.	Ward Managers UHL/LPT Ward Managers	Increase discharge rate before 1pm to 29.8% by YE Increase discharge rate before 11am to 14.6% by YE	July July	Completed Completed. This is a guide on who to

		UHL/LPT			contact when at home to prevent readmission
Communication: Monitoring and Review Ref 6, 108-118	Monthly thematic review of all delays will be undertaken at the LPT DTOC meeting. Areas of concern will be identified and work streams initiated if not already contained within the existing development work Hospital Matrons involved in the daily conference calls and report patient transfer and delay challenges to the wider LLR Community to facilitate resolutions. Development of templates for shared drive identifying reason for delays across all community hospitals to support daily conference calls	DTOC Chair Matrons UHL/LPT Matrons UHL/LPT	Reduction in DTOC rate to 5.2/100,000 Increase discharge rate before 1pm to 29.8% by YE Increase discharge rate before 11am to 14.6% by YE	Monthly Daily October	All continuing health care delays identified on shared drive. Will expand to include all other delays
Technology to improve discharge: Maximise use of current IT systems	Review use of current systems i.e. Patient Centre, ICE etc. Ensure essential information e.g. ADT, EDD, MFFD is inputted accurately and within agreed timescales Develop electronic clinical handover Review/re-enforce ward clerk role re. data input Review performance re: accuracy / timeliness of data input and communicate to CBU/Wards	Andy Jones UHL	Reduction in DTOC rate to 5.2/100,000 Increase discharge rate before 1pm to 29.8% by YE Increase discharge rate before 11am to 14.6% by YE	Pilot Electronic handover - Oct 12 Roll out/pilot use of electronic white board - Oct 12 Ward clerk management of Change (medicine) Oct 12 Circulate data inputting	Patient Centre review complete Ward clerk allocation complete (Medicine) Roll out to all wards
Onward referral post-discharge: Access to reablement and Domiciliary care Ref 117	Improving Domiciliary capacity and quality in Leicestershire 1. Incentive payments to providers in hard to recruit and retain areas. 2. Up-rating payments to all dom care agencies to a minimum payment of £13.25 3. Increased HART investment to increase capacity. Recruitment of staff underway	Jackie Wright (Leics County Council) Ashraf Osman (Leic City Council)	Reduction in DTOC rate to max 5.2/100 000	Through 2013/14	**Cross ref to each LA's plans with CCG SDG's**

	4. Work with domiciliary providers and HART to map packages that need move from reablement to long term packages. 5. Reduce need to hold open retainer period for cases for people in hospital from 28 days to 14 days to free up capacity. 6. Prioritise available domiciliary care for key interventions such as personal care. Use Assistive Technology, Extended Icare provision for other needs. 7. Greater flexibility in time windows care for required 8. Prioritise reviews to release care that is committed to other service users but not needed or could be reduced. 9. Integration with Intermediate care. 10. Recruitment campaigns for care staff across the sector 11. Growing the Personal assistants market. 12. Greater use of Personal Budgets which offer more choice of provider and solution				