Group	Objective	Action area	Delivery description & detail	Senior accountable lead	Delivery date	Expected impact	Activity Monitoring	Delivery Status	Progress to date
Inflow	1.1 To provide consistent and useable information to enable patients to make informed choices about when and how to access the most appropriate urgent and emergency care service	1.1.1 - Targeted Patient Information campaigns	CCGs reviewing potential to increase flu vacc uptake; LC offering vaccination to patients with a BMI >40 and their care homes workforce WL / ELR to develop proposal for similar service	R Vyas (LC CCG) / I Potter (WL CCG) / D Eden (ELR CCG)	LC - Nov 2015 WL - 21/12/2015 ELR - 21/12/2015	Reduced risk of major flu epidemic	Increase in uptake of flu vaccs in targeted groups. CCGs baselines @ 31/10/2015 for Over 65y (target 75%) / Under 65y (target to increase on 2014/15 of 49.6%); LC - 61.5% / 36.6% WL - 60.6% / 32.7% ELR - 62.3% / 33.8%	3. Some delay – expected to be completed as planned	LC care homes workers initiative completed. Patients with a BMI >40 to commence (Rach to advise date) LC scheme details being reviewed by WL and ELR with a view to implementation Review completed in WL - to trial care homes workers initiative from mid-January 2016 **Update 05/01:** ELR will review potential for care home staff vacination
Inflow	1.1 To provide consistent and useable information to enable patients to make informed choices about when and how to access the most appropriate urgent and emergency care service	1.1.1 - Targeted Patient Information campaigns	To deliver Stay Well (inc Flu) outreach campaign across LLR targeting hard to reach and at risk groups, carers, parents of children 0-10y, Partnership with voluntary sector and GEM outreach - ways to stay well, appropriate attendance locally per CCG Series of local public events Dec 2015 - Feb 2016	R Crabb (LLR Urgent Care)	Dec 2015 - Feb 2016	Increase public awareness of alternatives available	Target cohorts for outreach campaign per CCG to include; Parents of 0-5y, patients 65+y, LTC, carers groups, Age UK contacts, multiple deprivations Niche voluntary sector groups will in-reach to moderate/frequent flyers who are low volume high impact users	4. On track	LC have Patient Engagement event 10/12/2015 WL have Patient Engagement event Jan 2016 ELR to advise of any planned events Outreach campaign commenced in WL Nov 2015 To undertake cross-referencing exercise during December for the identified lists with the hard to reach moderate/frequent flyers
Inflow	1.1 To provide consistent and useable information to enable patients to make informed choices about when and how to access the most appropriate urgent and emergency care service	1.1.1 - Targeted Patient Information campaigns	To develop consistent patient information for each UCC, WIC, City Hubs, ED Streaming Service, CRT, AVS, OPU To be disseminated in leaflet format; Artwork confirmed 11/12/2015 Distribution of info w/c 14/12/2015 Implement PDSA for direct public engagement @ LRI campus	R Crabb (LLR Urgent Care)	w/c 14/12/2015	All front line clinicians to hand to patients at the end of their clinical consultation Increase public awareness of alternatives available	No of leaflets handed out and patient contacts made @ LRI campus, UCC Lo, City Hubs, EMAS See & Treat calls and CRT/AVS visits Baseline - not currently monitored Aiming for 100% distribution rate Average distribution per week based on current activity circa; UCC Le - 2,000 UCC Lo - 700 EMAS S&T - TBA CRT - 600 AVS - 350 City Hubs - 850, to be 1,740	6. Complete and regular review	Discussion with printers complete and artwork confirmed GEM comms staff to undertake direct public engagement PILs distributed w/c 21/12/2015
Inflow	1.1 To provide consistent and useable information to enable patients to make informed choices about when and how to access the most appropriate urgent and emergency care service	1.1.2 - Roll out Patient service navigation app 'NHS Now'	Pilot launch and refinement in EL&R	T Sacks (ELR CCG)	30/11/2015	Increase awareness & utilisation of alternatives	ELR baseline 600 downloads in first 2w	5. Complete	Completed - roll out and refinements
Inflow	1.1 To provide consistent and useable information to enable patients to make informed choices about when and how to access the most appropriate urgent and emergency care service	1.1.2 - Roll out Patient service navigation app 'NHS Now'	Roll out to LC and WL CCGs: Review information databases Develop marketing & comms Go live	R Vyas (LC CCG) / I Potter (WL CCG)	w/c 07/12/2015 w/c 14/12/2015 w/c 21/12/2015	Increase awareness & utilisation of alternatives	Anticipating 1000 downloads per week across LLR over next four weeks	2. Significant delay – unlikely to be completed as planned	ELR to write analytics and advise of downloads as hosts of the app. Update 05/01 - analytics available from 11/1/16 WL data further updated over Christmas 2015. Now on hold for WL & LC pending resolution to inaccuracy of data Task & Finish Group post Demand Group mtg 08/01/2016
Inflow	1.1 To provide consistent and useable information to enable patients to make informed choices about when and how to access the most appropriate urgent and emergency care service	1.1.2 - Roll out Patient service navigation app 'NHS Now'	Explore link to real time waiting information for ED/UCC services	S Smith (LLR Urgent Care)	31/03/2016	Increase awareness & utilisation of alternatives	Monitoring on a weekly basis of hits per CCG	3. Some delay – expected to be completed as planned	To be added to Phase 2 as functionality not available for Phase 1 Discussions commenced with TPP re: availability of data feed - awaiting their confirmation
Inflow	1.2 To improve 7 day urgent access (same/next day) to primary care services	1.2.1 - Extended GP services	Leicester City CCG: Hubs hours of operation M-F 18:30-22:00 S-S 09:00-22:00 Increasing utilisation of City Hubs; Continue application of comms strategy Implement remote booking by EDSS Implement remote booking by NHS111	S Prema (LC CCG)	Weekly Weekly Live from 23/11/2015	Decrease in ED attendance/Increased access primary care	Current baseline for LC w/e 06/12/2015 - 782 appts booked of the 1,700 available per week (45.2%)	3. Some delay – expected to be completed as planned	Increase in weekly utilisation to be reported Sundays remain significantly more quiet than the rest of the week LC CCG to advise of EDSS remote booking functionality NHS111 direct appt booking already in place EDSS direct appt booking to be established in Jan 2016
Inflow	1.2 To improve 7 day urgent access (same/next day) to primary care services	1.2.1 - Extended GP services	West Leics CCG: Implement West Leics GP on the day access scheme	A Bright (WL CCG)	07/12/2015	Increased availability of appointments	Expected 85% uptake by general practice which would give additional 367 appointments per day	4. On track	Spec to all WL practices 03/12/2015 Confirmation of practice uptake by 14/12/2015 Current position @ 04/01/2016 48 of the 49 practices have confirmed participation, giving 1,899 additional appts per week
Inflow	1.2 To improve 7 day urgent access (same/next day) to primary care services	1.2.1 - Extended GP services	West Leics CCG: Hours of operation 08:00-22:00 Implement West Leics primary care weekend access scheme targeting 2% at risk / end of life / moderate-frequent flyer patients	A Bright (WL CCG)	05/12/2015	Reduction in ED attendance and EA for at risk cohort	Can accommodate up to 100 extra patient contacts per weekend Will monitor the number of patient passports issued	6. Complete and regular review	Federations all signed up Implemented service 05/12/2015 in conjunction with AVS @ 04/01 1000 passports issued
Inflow	1.2 To improve 7 day urgent access (same/next day) to primary care services	1.2.1 - Extended GP services	ELR CCG: Coverage of total ELR population increased from 10% to 30% (95,000 patients) in Dec 2015. This equates to 3%-5% (2,850 to 4,750) complex patients who have weekend access	T Sacks (ELR CCG)	21/12/2015	Reduction in ED attendance and EA for at risk cohort	Supporting an anticipated 50 patient contacts per weekend day	3. Some delay – expected to be completed as planned	Update 05/01 - 4 GP practice hubs to commence 9/1/16

APPENDIX 2

Group	Objective	Action area	Delivery description & detail	Senior accountable lead	Delivery date	Expected impact	Activity Monitoring	Delivery Status	Progress to date
Inflow	1.3 To extend range and timing of alternative UCC services for immediate but non-life treatening conditions	1.3.1 - Urgent home visiting service (Crisis Referral Team /Acute Visiting Service) including direct referrals from care homes	LC CCG & WL CCG: Optimise appropriateness of use of existing SSAFA CRT and AVS services by; ECPs to undertake daily audit of referrals SSAFA to inform CCGs weekly of any inappropriate use CCGs leads to contact practices directly to discuss WL to submit BCF request for funding of 1 WTE ECP for dedicated triage to allow extended daily coverage Extend AVS West Leics hours of operation at weekends	A Bright (WL CCG) / S Prema (LC CCG)	Monthly review 08/12/2015 05/12/2015	Urgent home visit requests earlier in the day, reduction in care home calls to EMAS	Monthly monitoring Current utilisation as at 31/10/2015; LC - 611 visits per month of 502 contracted capacity WL - 340 visits per month of 350 capacity Additional appoinments offered and utilised Linked to the WL Weekend Access Scheme to see 100 extra patients per weekend	4. On track	Enhanced phone system and dedicated triage within CRT & AVS Address the highest and lowest GP practice users to target both inappropriate referrals and under-utilisation ELR SSAFA service commencement 18/01/2016 TBC WL shared data on comparative usage of AVS @ Dec 2015 locality mtgs Audit to be completed by 31/01 on appropriateness of referrals to AVS SSAFA to advise of WL recruitment status
Inflow	1.3 To extend range and timing of alternative UCC services for immediate but non-life treatening conditions	1.3.1 - Urgent home visiting service (Crisis Referral Team /Acute Visiting Service) including direct referrals from care homes	ELR CCG: Establish ELR in-car visiting service by; Activity review to inform pilot area Identify level of funding to requested through BCF Identify workforce Implement for trial	T Sacks (ELR CCG)	01/12/2015 08/12/2015 09/12/2015 18/01/2016	Urgent home visit requests earlier in the day, reduction in care home calls to EMAS	Anticipated 100 patient contacts per month to Service	4. On track	An initial area of Oadby/Wigston/Blaby/LFE identified Rob has approached SSAFA Board for sign off BCF funding application approved ELR SSAFA service commencement 18/01/2016 TBC
Inflow	1.3 To extend range and timing of alternative UCC services for immediate but non-life treatening conditions	1.3.2 - Implement Loughborough UCC extended care pathways	Maximise appropriate use of increased specialist medical cover 9am - 10pm Monday-Friday, 10am - 10pm at weekends to allow increased referrals from GPs, AVS and EMAS UCC Lo clinicians to ride with EMAS crews to promote referrals to UCCs during Dec-Jan	C Tierney-Reed (WL CCG) S Court (CNCS) / Tim Slater)EMAS)	01/11/2015 31/01/2016	Reduction in referrals to ED for ambulatory conditions	Number of referrals to extended pathways; Phased trajectory of avoidable emergency attends Nov 2015 - anticipated 130, actual 30 Cumulative total of extended pathways capacity at 31/03/2016 anticipated to be 850, of which 450 would be avoidable emergency attends No. of EMAS shifts attended by UCC clinicians Utilisation of UCC Lo for Oct 2015 was 3,604 appts vs capacity of 3,750 appts	4. On track	Completed - implemented on time Updated EMAS Pathfinder and NHS111 DoS Additional GP comms to practices regarding no of cases seen during November, types of cases, case studies, match real time data during December to measure impact on acute care/999 conveyances Tim Slater has provided assurance that EMAS will provide insurance cover for CNCS staff riding with ambulances
Inflow	1.3 To extend range and timing of alternative UCC services for immediate but non-life treatening conditions	1.3.3 - Increase referrals from OOH GPs to alternative services	Communication to OOH GPs regarding UCC Lo enhanced GP pathways Weekly review of ED attendances following OOH contact within preceeding 24h Reinforce all LLR non-ED options available to OOH GPs Improve internal tracking of referrals by OOH GPs	R Haines (CNCS)	14/12/2015 15/12/2015 15/12/2015 14/12/2015	Increased use of alternatives to admission by OOH GPs	Increased utilisation of alternatives to admission above current baseline position Current baseline TBC Weekly monitoring of final patient dispositions; telephone consult face to face consult referral to OOH clinic, UCC, ED, CRT, social care	2. Significant delay – unlikely to be completed as planned	Awaiting activity monitoring
Inflow	1.3 To extend range and timing of alternative UCC services for immediate but non-life treatening conditions	1.3.4 - ELR CCGs 4 Urgent Care Centres	Deliver increased utilisation of appts Winter 2015/16 compared to Winter 2014/15	T Sacks (ELR CCG)	18/12/2015	Reduction in referrals to ED	Utilisation of 3,200 additional appointments available 18/12/2015 - 31/01/2016 than last Winter Reduction in LLR and OOA ED attendances at peripheral hospitals over the Christmas & New Year period	6. Complete and regular review	Weekly utilisation to be demonstrated within enhanced Inflow Dashboard ELR to scope potential for increased capacity @ Oadby site Update 05/01 - New Nurse triage service from 4/1 to increase throughput
Inflow	1.3 To extend range and timing of alternative UCC services for immediate but non-life treatening conditions	1.3.5 - Implementation of live waiting times data feeds for the public to access	Web page, with URL links available for other devices to use, showing the live waiting time at each LLR UCC/WIC	R Crabb (LLR Urgent Care)	11..01.16	Reduction in self-referrals to ED	Once service commenced, to monitor no. of hits	2. Significant delay – unlikely to be completed as planned	Adastra feed available UHL feed available but still outstanding TPP not willing to commit to availability or timescale of information feed for SystmOne sites Discussion to be had around manual workaround@ UCB 07/01
Inflow	1.4 To reduce EMAS conveyance to LRI	1.4.1 - Implement mobile device (smartphone) with MDoS access	Rapid roll out across LLR crews with link to live waiting times web page, 400 front line staff to have use of devices.	T Slater (EMAS)	Jan-Mar 2016	Awareness for crews of alternatives to admission	Increased utilisation of alternatives to admission above current baseline by front line staff	3. Some delay – expected to be completed as planned	Pilot testing occurred to decide device of choice
Inflow	1.4 To reduce EMAS conveyance to LRI	1.4.2 - Increase use of alternatives to admission by EMAS crews by referral to UCC Lo and OPU, ELR UCCs, LC Hubs and use of Falls Pathway	EMAS CAT to be able to directly book into City Hubs All new services to align to Pathfinder outcomes ELR UCCs to confirm that they capture direct and indirect EMAS referrals	T Slater (EMAS)	weekly review 14/12/2015	Increased use of alternatives to admission by EMAS crews	EMAS to develop own metric for reduction of conveyances to ED/UCCs Current baseline for use of alternatives by EMAS crews @ Oct 2015; UCC Le - 0 (not currently measured) WIC Le - 0 (not currently measured) UCC Lo - 33 (target 40) OPU - 4 (target 18) AVS - 1 (target 40) CRT - TBA LC Hubs - 0 (not currently measured) UCCs ELR - 0 (not currently measured) Falls Pathway - c50% (target up to 75%)	3. Some delay – expected to be completed as planned	EMAS to devlop own metric for reduction of conveyances to UHL ED. EMAS (WL) doing ground work on proposal to increase nursing capacity in CAT
Inflow	1.4 To reduce EMAS conveyance to LRI	1.4.3 - SSAFA to be reflected as a Pathfinder disposition	Include AVS/CRT as alternative service on version2	T Slater (EMAS)	14/12/2015	Referrals by EMAS to SSAFA	see above	6. Complete and regular review	Pending the new Pathfinder booklet, we have provided our crews and clinicians with a local directory of services including AVS, CRT and back-office GP numbers.
Inflow	1.4 To reduce EMAS conveyance to LRI	1.4.4 - Develop process to enable EMAS access to GP medical opinion and prescriptions; In hours Out of hours Circulate Service description to all front line staff (daily to ensure all EMAS shifts covered)	In hours via UCC Lo enhanced GP resource as a pilot (assuming CNCS CG approval) Out of hours via the CNCS HCP line	T Slater (EMAS) / S Court (CNCS)	14/12/2015	Non conveyance and increased use of alternatives to admission	EMAS use of OOH HCP line TBA No of consults to UCC Lo to be advised once commenced	2. Significant delay – unlikely to be completed as planned	Simon Court at CNCS mtg 10/12/2015 to discuss and sign off Tim Slater to advise of current EMAS contact levels with CNCS OOH HCP line

Group	Objective	Action area	Delivery description & detail	Senior accountable lead	Delivery date	Expected impact	Activity Monitoring	Delivery Status	Progress to date
Inflow	1.4 To reduce EMAS conveyance to LRI	1.4.5 - Dedicated GP patients transport as pilot extension to existing service where transport is provided for a range of clinics	Implement additional service via Bed Bureau for appropriate GP urgent transport for patients not requiring a clinical chaperone Rapid testing in Leic City with focus on LE2, LE3, LE5 to inform roll out Comms to GP practices to promote default of self-transportation where a clinical chaperone is not required	Sarah Smith (LLR Urgent Care) / Julie Dixon (UHL)	w/c 14/12/2015	Freeing up EMAS capacity/reduction in batching	No of patients transported by dedicated transport crews	2. Significant delay – unlikely to be completed as planned	RVS now unable to deliver to required specification and timetable In contact with TMAS and CNCS OOH for an immediate solution CNCS have provided costing Julie Dixon provide Trust Medical costing 10/12/2015 Comms to Bed Bureau / GPs and implementation w/c 14/12/2015
Inflow	1.4 To reduce EMAS conveyance to LRI	1.4.6 - Reduce referrals to EMAS from NHS111 and OOH	Review referral activity to identify scope for alternative dispositions to LRI ED	EMAS/CCGs	TBC				New action identified through UNIPART exercise
Inflow	1.5 To minimise the need for GP initiated/related admission to acute hospital	1.5.2 - Improve process by which GPs refer to UHL for specialist opinion/admission	Review early experience in November of Pathway Co-ordinators in Bed Bureau	Sarah Smith (LLR Urgent Care)	10/12/2015	Review has informed a discontinuation of this service	Review has informed a discontinuation of this service	7. Closed	Changes in UHL pathways have resulted in no need for clinical navigator roles. Bed Bureau Call Assessment Frameworks being written for each patient pathway to inform a gap analysis of breakdowns in patient flow
Inflow	1.5 To minimise the need for GP initiated/related admission to acute hospital	1.5.2 - Improve process by which GPs refer to UHL for specialist opinion/admission	Implementation of 'Consultant Connect' telephone advice for respiratory and gastro patients who are at risk of admission	Julie Dixon (UHL)	14/12/2015	Reductions in inappropriate emergency attends where there are suitable alternatives available	Collate nos of contacts for advice by GPs	2. Significant delay – unlikely to be completed as planned	UHL liasing with Consultant Connect to develop consultant hunt groups and agree implementation date Further update required at next EQSG. **Update on 05/01:** Consultant connect have completed set up for Endocrinology and are progressing towards Gastroenterology and Neurology. It is not currently feasible to extend this to respiratory due to the exceptionally high levels of activity. All GP numbers are with Consultant Connect. Service will start within next 7-10 days once Consultant telephone and GMC numbers are provided.
Inflow	1.5 To minimise the need for GP initiated/related admission to acute hospital	1.5.2 - Improve process by which GPs refer to UHL for specialist opinion/admission	Understanding remit and current specification of ambulatory clinics to understand appt timeframes	Catherine Free	10/12/2015	Ensure 'rapid' clinics are in fact rapid Increase utilisation of clinics by GPs and EDSS	All rapid access pathways accessible within intended timeframes. Improved utilisation of ambulatory clinics capacity by GPs and EDSS	6. Complete and regular review	Timeframes have been checked with each service and added to front of directory to facilitate feedback if issues arise with slot availability
Inflow	1.5 To minimise the need for GP initiated/related admission to acute hospital	1.5.2 - Improve process by which GPs refer to UHL for specialist opinion/admission	Implement rapid cycle testing by placing a GP in ED to observe the assessment and decision making process by ED clinicians, producing recommendations for community-based alternatives and the role of the care plan in supporting decision making	C Tierney-Reed (WL CCG)	10/12/2015	Increased utilisation of care plans to inform treatment pathway Feedback to GPs where care plans are not available for at risk patients	No of primary care records accessed, to include care plans and medications	6. Complete and regular review	Visit has been done Report produced Recommendations to be reviewed @ Demand Group mtg 08/01
Inflow	1.5 To minimise the need for GP initiated/related admission to acute hospital	1.5.2 - Improve process by which GPs refer to UHL for specialist opinion/admission	Deploy LHIS support to; Access GP care plans for ED clinicians and upskill ED ward clerks in accessing primary care information Reinstate dedicated IT support to ED	C Tierney-Reed (WL CCG) John Clarke (UHL)	14/12/2015 TBC	Increased utilisationof care plans to inform treatment pathway Feedback to GPs where care plans are not available for at risk patients	No of care plans accessed	4. On track	See above Dr Ffion Davies contacted John Clarke to request support - awaiting update Action plan developed and ongoing monitoring now required CTR to liaise with LHIS and IM&T Steering Group for progress updates
Inflow	1.6 To continuously review activity data to identify patients/groups potentially amenable to alternative care plans/services	1.6.1 - Regular attenders picked up and management plans agreed across agencies	WL to develop SOP based on current process for weekly review of real time data to share with ELR & LC Utilise review of real time data to target moderate/frequent flyers, paeds (particularly 0-10y) CCG leads to contact individual GP practices directly to discuss alternative services ELR and LC to circulate and adopt WL SOP	C Tierney-Reed (WL CCG) / D Eden (ELR CCG) / R Vyas (LC CCG)	11/12/2015 14/12/2015 14/12/2015	Reduction in frequency of attendance/admission for target patients	Target cohort is ED attends via ambulance to be reviewed Nos of patients who died in the department (consider presence of care plan) Nos of frequent attenders Nos of patients admitted where an alternative service could have been considered (UCC, OPU, AVS) Baselines per CCG; WL - circa 250 records reviewed every week with circa 110 reviewed in more detail, circa 5 GP practices contacted per week	3. Some delay – expected to be completed as planned	WL CCG system fully operational & their SOP shared LC CCG have amended and implemented from 04/01/2016 Reviewing 6y-18y and 50+y conveyed via 999 to Minors/Majors w/o Em Adm **Update 05/01:** ELR to adopt Leicester City SOP
Inflow		1.6.2 - Short stay admissions	Specific review of ED attends / Em Adms for Paeds & Gynae LC CCG to Organise Patient info sessions in high usage areas; undertake a book bag drop in every city school 'when should I worry' booklet; To Assess viability of providing community pathway at Westcotes Health Centre WL to develop targeted comms campaign as part of outreach campaign (see 1.1) re: use of UCC Lo by parents / carers ELR conducting deep dive analysis of all Em Adms	R Vyas (LC CCG) / R Mitchell (UHL) S Venables (WL CCG) / R Crabb (LLR Urgent Care) D Eden (ELR CCG)	21/12/2015 11/12/2015 14/12/2015	Detailed understanding of short stay presentations	Reductions in Paeds and Gynae short stay activity Increase in Paeds presentations to UCC Lo	4. On track	LC CCG - Data analysis complete to understand activity flow and Leaflets ordered, Book bag drop in place before by 18.12.15 GP's representatives from across the CCGs to observe in both ED and GAU/UAU/CAU to understand what primary care can do differently on Thurs 17th and w/c 21st Dec - awaiting feedback Previously written SOP for gynae community pathway being re-assessed WLCCG - Plan in place to target Surestart, Mother and Toddler groups and similar with winter messages.
Inflow		1.6.3 - UHL admission variance YTD by CCG and condition	UHL to identify key variances YTD by CCG and condition to inform development of further targeted plans	R Mitchell (UHL)	18/12/2015	Detailed understanding of presentations	Review commenced, analysis to be shared with CCG colleagues w/c 21.12.15	2. Significant delay – unlikely to be completed as planned	We are further analysing the information presented at UCB in October to identify where the greatest increases have occurred by age, presenting condition and CCG. The aim is to complete by 18th December. This has been delayed because of recent CQC requests. **Update on 05/01:** This is continuing to be worked on, but continuing CQC requests have delayed this action further

Group	Objective	Action area	Delivery description & detail	Senior accountable lead	Delivery date	Expected impact	Activity Monitoring	Delivery Status	Progress to date
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.2 - Learning from best practice elsewhere	Look at QMC systems and processes	Richard Mitchell	w/c 30/11/15		Overall improvement in key KPIs	2. Significant delay – unlikely to be completed as planned	QMC has been contacted and planning a visit w/c 21st **Update on 05/01:** Visit was cancelled due to operational pressures both at UHL and NUH. Phone conversations have taken place and the plan is to visit NUH in January.
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.3 - Pre-admission space	Transition area protocol and staffing arrangements	Richard Mitchell	w/c 30/11/15	EMAS crews freed up to respond to incoming calls in the community	Fewer lost hours and zero 2 Hr+ delays	6. Complete and regular review	Transition area protocol signed off. We are trying to staff facility every shift and this has been used 3 times in the last 14 days.
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.5 - To complete SOP supporting the streaming of patients from EMAS to the streaming service and implement		Sam Leak	31/12/2015		Increase in ambulance streaming to UCC	5. Complete	**Update on 16/12:** SOPs in place. Updates needing following latest changes. **Update on 05/01:** Completed and circulated internally and externally.
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.6 - Introduce routine flow management/co-ordination for patients arriving at LRI by ambulance to increase referrals to non-ED majors dispositions		UHL/EMAS					New action identified through UNIPART exercise
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.7 - Agree a consistent handover assessment process/approach/tool/template		UHL/EMAS					New action identified through UNIPART exercise
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.8 - Agree data and reporting to monitor impact of new arrangements and ensure operational process changes are embedded and sustained		UHL/EMAS					New action identified through UNIPART exercise
Flow	2.1 To reduce delays in ambulance handover times at the LRI site	2.1.9 - Agree and implement 'B list' of logistical issues (e.g. availability of chairs/trollies/blanket, sheet and battery replen for EMAS crews) which just need to be resolved to optimise handover slow/support multi-agency relationships		UHL/EMAS					New action identified through UNIPART exercise
Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.3 - Consider extension of current service to 12am		Richard Mitchell	Lead in time once funding has been confirmed	Reduction in number of patients attending main ED and therefore a reduction in ED occupancy	Further decrease in referral rate from UCC to ED	4. On track	RM, Julie Dixon and Lakeside have met to discuss this. Lakeside would like to extend the hours per day that the service is provided but are cautious because of challenges in fully staffing the current 0900 – 2100 rota. If authorised by the CCGs we beleive we can deliver an extension to midnight noting an extension will cost more money. A three hour extension will cost circa £87,000 per month. RM has already authorised Lakeside to look at extending the scope of their service eg increased interaction with UCC and minors and are working up a proposal at the moment. **Update 05/01:** Request submitted as part of Vanguard Bid.
Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.4 - To increase the number of patients redirected by the streaming service to community alternatives/ambulatory clinics		Julie Dixon	31/01/2016	Reduction in number of patients attending main ED and therefore a reduction in ED occupancy	Increased proportion of patients diverted to alternative services	5. Complete	Julie and Stuart Maitland- Knibb will explore this **Update 05/01:** Piloted having one of the Urgent Care GP's at the front desk screening all attendances and referrals. This was successful in diverting higher volumesof patients and the proposal is to continue this between 9am and 9pm.
Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.5 - To relocate OOH service from clinic 4 to the UCC		Julie Dixon	31/01/2016	better flow within UCC	N/A	4. On track	Julie and Stuart Maitland- Knibb will explore this. **Update 05/01:** Sarah Smith scoping current activity levels to assess capacity requirements.
Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.6 - To increase the range of near patient testing within the UCC		Julie Dixon	31/01/2016	Reduction in number of patients attending main ED and therefore a reduction in ED occupancy	Further decrease in referral rate from UCC to ED	1. Not yet commenced	New action
Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.7 - To establish pathway in UCC to assess ambulatory patients from GPs		Julie Dixon	31/01/2016	Reduction in number of patients attending main ED and therefore a reduction in ED occupancy + reduction in admissions	Reduction in volume of GP referrals needing to access ED	5. Complete	Update on 05/01: All patients asked to attend ED by GP (GP urgents) are redirected from minors reception to UCC and are seen in an ambulatory setting.
Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.8 - To establish pathway to direct OOH patients through the streaming service		Julie Dixon	31/01/2016	Reduced demand on OOH service	Reduction in OOH attendances	6. Complete and regular review	**Update on 05/01::** In which forum was this agreed? Is the purpose of this action screen all OOH referrals by another GP? Patient feedback is poor from this pathway.
Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.9 - To establish observation room in UCC to both reduce admissions and if appropriate enable direct admissions by passing ED		Julie Dixon	31/01/2016	Reduction in number of patients attending main ED and therefore a reduction in ED occupancy + reduction in admissions	Reduction in ED attendances and in majors congestion	4. On track	**Update on 05/01:** Estates have reviewed building work needed. Two rapid cycle tests have been conducted which were successful - patients were safe and some were able to be discharged. For this to run on an ongoing basis nursing cover is required. These shifts have been put out to agency.

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Flow	2.2 To ensure walk in patients at the LRI campus are assessed and streamed direct to the most clinically appropriate service	2.2.10 - To route all GP urgents through bed bureau including those with a GP letter currently presenting to minors		Lee Walker	31/01/2016	Reduction in number of patients attending main ED and therefore a reduction in ED occupancy + reduction in admissions	Imprrovement in GP referrals via ED metric	4. On track	New action **Update on 05/01:** Temporary business case (up until end of March) for extra funding in AAU has been approved pre christmas to increase direct admissions coming to AAU. This will allow: More nurses (already in place), 1 more junior in the evening (due to start in next couple of weeks), a senior in the evening (start to be confirmed as part of CESR). Longer term we are looking to further increase capacity by trying to separate the ambulatory and non-ambulatory streams with the former being directed into the UCC. In the meantime, reviewing the possibility of a least moving the follow ups down to UCC as a sort of 'separate the streams LITE'. We mat be able to do this without additional funding but reallistically will take at least a few weeks to organise IT, admin and get an agreement with the clinicians in UCC and AIM to support.
Flow	2.3 To ensure adequate ED nurse staffing levels to maintain 5/6 assessment bays	2.3.1 - Increase ED nursing establishment to 28 plus 2/3 for transition area	Agency 'long lines' increased through to 11 Jan	Julie Smith	Complete	ED assessment bays operating at full capacity	No. assessment bays and resus bays operational	6. Complete and regular review	Authorisation to long line agreed w/c 23 November. Fill rate has been marginal although has increased ability to fill the baseline staff levels.
Flow	2.3 To ensure adequate ED nurse staffing levels to maintain 5/6 assessment bays	2.3.2 - ED establishment and skill mix review	Review skill mix, numbers of staff and roles in place and refresh if indicated	Julie Smith	31/01/2016	Balance of staffing and skill mix to demand	No. assessment bays and resus bays operational	4. On track	Julie Smith and Maria McAuley are working on this as part of the establishment review process that is taking place on all wards and departments.
Flow	2.3 To ensure adequate ED nurse staffing levels to maintain 5/6 assessment bays	2.3.3 - Review impact of current nurse shift length and handover timing on clinical 'downtime' (est around 7pm) and staff productivity/safe operating							New action identified through UNIPART exercise
Flow	2.4 To accelerate the admissions process from ED to base wards	2.4.1 - Scope feasibility of introducing movement of patients from ED to base wards earlier in bed identification process to streamline admission	Development of protocol for consideration by UCB and discussion with CQC	Richard Mitchell	10/12/2015	Improved flow out of the ED	Reduced time from decision to admit to patients leaving ED	6. Complete and regular review	Draft SOP completed and signed off at EQSG. Trialed last week on Wards 37 and 38. Feedback coming to EQSG this week. Sharron Hotson discussed with CQC in November. **Update on 16/12:** Julie S, Julie D and Gill to develop short paper with summary of trial, updated protocol and next steps **Update on 05/01:** Protocol updated and summary of initial trial produced and to be discussd at EQSG on 06/01. Further trial took place 29-31st December and results being analysed.
Flow	2.4 To accelerate the admissions process from ED to base wards	2.4.2 - To consider Relocation of bed bureau to enable expansion of service-.		Julie Dixon	End of January	More efficiient working	Reduced time to bed allocation and improvement in GP refs via ED metrics	1. Not yet commenced	**Update on 05/01:** Options being considered - for this to have full benefit, move would need to involve telephone system updated and headsets to minimise noise.
Flow	2.4 To accelerate the admissions process from ED to base wards	2.4.3 - To develop patient facing script for bed bureau service re mode of transport to reduce EMAS dispatch /late arrivals		Julie Dixon	End of January	Reduction in patient trasnport demand	Reduction in number of transports booked	1. Not yet commenced	New action
Flow	2.5 To maximise availablilty/flexibility of safely staffed bed capacity	2.5.1 - Reschedule some elective activity from Monday's to weekends	Reduce elective work for 2-3 weeks in January 2016 in anticipation of the predicted spike in non-elective activity	Richard Mirchell	01/01/2016	Surgical ward capacity freed up to support medicine	Additional medical bed capacity during January	4. On track	Plans to reduce elective work between Christmas and the third week in January. However, in reality this is already taking place due to the very high cancellation rate. This means that we will not see a further benefit from this action. **Update 05/01:** We have stratified our adult elective work and only cancer, urgent and previously cancelled patients are having operations. We currently do not have paediatric capacity challenges.
Flow	2.5 To maximise availablilty/flexibility of safely staffed bed capacity	2.5.2 - Identify opportunities to deliver UHL activity away from the 3 acute sites	Scope feasibility of creating cardio-respiratory ward capacity at Loughborough	Kate Shields	TBA	Freed up acute ward capacity	No. acute hospital beds operational	7. Closed	This will not take place due to clinical suitability, however further actions are being explored.
Flow	2.5 To maximise availablilty/flexibility of safely staffed bed capacity	2.5.2 - Identify opportunities to deliver UHL activity away from the 3 acute sites	Review potential for re-comissioning space on wards used for non-clinical purposes	Darryn Kerr	04/12/2015	Physical potential to create additional bed capacity	Number of acute hospital beds	6. Complete and regular review	In the last month additional gastro, oncology and paediatric beds have been opened. A further piece of work is taking place to open additional beds and we are also confiming required bed capacity for 16/17. It is worth noting that ability to open additional beds is dependent on access to increased staffing levels.
Flow	2.5 To maximise availablilty/flexibility of safely staffed bed capacity	2.5.3 - Improve utilisation of all available and appropriate beds	Improve process for early outlying by sending out an early outlying plan with the bed state on Friday afternoon (4:30/6pm)	Julie Dixon	11/11/2015	Improved flow out of the ED	Reduced time from decision to admit to patients leaving ED	6. Complete and regular review	Outlying plan is circulated every Friday. Work is ongoing to improve process. Data request made to confirm effectiveness of process and to monitor impact on patient outcomes and surgical activity.
Flow	2.6 To speed up and bring forward (time of day) the discharge process	2.6.1 - Additional assistant capacity to support Drs in non-clinical activity	Advanced HCAs x7 on wards with highest daily discharges to support flow, admin and junior Drs in making patients ready	Julie Dixon	w/c 07/12/2015	Reduced time from decision to discharge to patients being made ready	Patients discharged by time of day	6. Complete and regular review	Trialling additional discharge coordinator on base wards with highest turnover. There is little evidence atm discharges have increased as a result.
Flow	2.6 To speed up and bring forward (time of day) the discharge process	2.6.2 - Improve utilisation of the discharge lounge between 8am and 12pm.	Review current processes and approach to utilisation of the discharge lounge	Julie Dixon	18/12/2015	Increased utilisation of the discharge lounge between 8am and 12pm Freed up acute ward capacity	Increased utilisation of the discharge lounge Patients discharged by time of day	6. Complete and regular review	Driven increased discharges to the discharge lounge on oncology and day wards by visiting outlying patients, and encouraging staff to use the discharge lounge Designed a 'meet me in the discharge lounge' project for patients. Data not available to ascertain benefit of project - awaiting information before deciding to pursue additional initiatives

Group	Objective	Action area	Delivery description & detail	Senior accountable lead	Delivery date	Expected impact	Activity Monitoring	Delivery Status	Progress to date
Flow	2.7 To ensure that the hospital responds appropriately to capacity pressures in ED	2.7.1 - Co-ordinated escalation response between ED. AMU and CDU to share risk appropriately across the areas in the safest possible way	Design and implement an escalation policy for CDU as part of the whole hospital response to improve flow through department	Sam Leak	~~01/09/2015~~ 31/01/2016	Reduced number of diverts from AMU/CDU Reduced occupancy in CDU/ED	Evidence of escalation plans being enacted in line with policy	4. On track	Initial meeting between CDU and ED has taken place. AMU and ED meeting being scheduled. Existing escalation plans on CDU and AMU are being reviewed. **Update on 05/01:** Escalation policy updated and to be circulated.
Flow	2.7 To ensure that the hospital responds appropriately to capacity pressures in ED	2.7.1 - Co-ordinated escalation response between ED. AMU and CDU to share risk appropriately across the areas in the safest possible way	Coordinated escalation process to be implemented in the ED	Richard Mitchell	19/12/2015			5. Complete	**Update on 05/01**: Implemented - please see Urgent Care policy agreed with Urgent Care Board
Flow	2.7 To ensure that the hospital responds appropriately to capacity pressures in ED	2.7.1 - Co-ordinated escalation response between ED. AMU and CDU to share risk appropriately across the areas in the safest possible way	Agree and implement escalation response between AMU and ED	Richard Mitchell	19/12/2015			5. Complete	**Update on 05/01:** Implemented - please see Urgent Care policy agreed with Urgent Care Board
Flow	2.8 To ensure that patients who do not require an admission are directed to ambulatory services where possible	2.8.1 - Implement RCT of acute physicians reviewing ED admitting decisions	Agree process for trialling + expected benefits	Ian Lawrence	~~16/12/2015~~ 25/12/2015	Reduction in admissions	Reduced admission rate from ED	5. Complete	Finalising plans **Update on 16/12:** Ian to action **Update on 05/01** - Trialled w/c 28/12 with following results: Deferred admission (discharges home) use of ambulatory pathways (particularly Acute Medical Clinic) Expedited admissions (ACB from Resus/Assessment Bay), direct admissions to SSU/speciality base wards (thus bypassing AMU/AFU) This should be continued and further actions will be added to deliver this sustainability.
Flow	2.8 To ensure that patients who do not require an admission are directed to ambulatory services where possible	2.8.2 - Increase capacity on AMU for GP access	Utilise space on UCC for ambulatory patients to increase capacity for GP direct admisisons	Lee Walker	16/01/2015	Reduced occupancy in ED	Increased number of patients going through AAU	4. On track	Steering group set up, IT and Estates work scoped. Business case for temporary additional staff completed. **Update on 05/01** Updated Version of business case will be discussed at revenue committee in January.
Flow	2.8 To ensure that patients who do not require an admission are directed to ambulatory services where possible	2.8.3 - Work with CDU to develop ambulatory clinic to streamline flow through department	Stream patients at triage who are likely to be ambulatory into separate area to facilitate rapid turnaround	Sam Leak	14/12/2015	Reduced CDU Occupancy	Increased propotion of patients with LoS on CDU of > 6 hours CDU Occupancy	6. Complete and regular review	Streaming service launched on 14/12 with comms to all CDU staff and patient information posters. Full implementation will be complete by March once all staff in post.
Outflow	3.1 To increase community 'step-down' capacity	3.1.1 - Phased increase of Intensive Community Support (ICS) capacity	Implement additional 16 ICS beds; Oct 16 Dec 16 Jan 8 Feb 40 (subject to successful staffing recruitment) Mar 50 (subject to successful staffing recruitment)	Rachel Bilsborough (LPT)	w/c 30/11/2015	Increase of alternatives to acute hospital admission	No. ICS beds operational	4. On track	Additional December capacity opened in line with plan
Outflow	3.2 To optimise use of existing community services capacity	3.2.3 - Additional Primary Care Co-ordinators to expedite identification of patients suitable for discharge to community services	LRI x2 additional to start by 21 Dec	Nikki Beacher (LPT)	21/12/2015	More patients identified as suitable for discharge to community services earlier in LOS	No. patients identified for earlier discharge	4. On track	Recruitment commenced
Outflow	3.2 To optimise use of existing community services capacity	3.2.4- Additional Primary Care Co-ordinators to expedite identification of patients suitable for discharge to community services	Additional recruitment to take full complement to 7 (inc. Glenfield)	Nikki Beacher (LPT)	31/01/2016	More patients identified as suitable for discharge to community services earlier in LOS		4. On track	Staffing for GGH and LRI are in place as per the plan
Outflow	3.3 To maintain DTOC rates at current low levels	3.3.1 - Maintaining daily multi-disciplinary partnership approach	Maintaining daily bed management and DTOC calls	Sarah Prema (City CCG) /Tracy Yole (LLR Urgent Care)	Ongoing	DTOC not being rate limiting factor in discharge flow	DTOC rate to be maintained <2%	4. On track	Current DTOC position remains low at 1.72%