Leicester, Leicestershire and Rutland

STP: Leicester, Leicestershire & Rutland

Urgent & Emergency Care Transformation Plan

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Contents

Executive Summary

Activity is rising across the whole urgent care system nationally and in LLR. Interventions are needed to manage and contain growth, in particular growth in ambulance activity and ED attendances. UHL ED attendances have risen year on year by 4.7%. Primary care is continuing to see a rise in the numbers of attendances in 18/19 there has been a 40% increase in the number of patients referred to ED compared to 17/18. As well as costing more to the LLR health economy, rising attendances cause increased pressure on UHL and result in reduced flow, longer waiting times and poor patient experience. Demand for EMAS services is also expected to rise significantly in the next two years. As well as the cost to the LLR health economy of rising growth, there is a negative impact on performance. Whilst front line staff continues to work increasingly hard to deliver effective services, growth in all parts of the urgent care system has resulted in significant challenge to meeting national and local standards.

In September 2018 the Carter Review into unwarranted variation in NHS ambulance trusts indicated that if more patients were treated at the scene by paramedics or were better assessed over the phone when dialing 999 — avoiding the need for an ambulance when it is safe to do so — the NHS could treat patients closer to home and reduce unnecessary pressure on emergency departments (EDs) and hospital beds.

More recently, the Long Term Plan challenges the NHS to reduce pressure on emergency hospital services by expanding and reforming urgent and emergency care services, including the following key objectives for 2019/20:

- To support patients to navigate the optimal service 'channel', we will embed a single multidisciplinary Clinical Assessment Service (CAS) within integrated NHS 111, ambulance dispatch and GP out of hours services from 2019/20
- Fully implement the Urgent Treatment Centre model by autumn 2020 so that all localities have a consistent offer for out-of-hospital urgent care, with the option of appointments booked through a call to NHS 111
- Implement the recommendations from Lord Carter's report on operational productivity and performance in ambulance trusts, ensuring that ambulance services are able to offer the most clinically and operationally effective response
- Implement a comprehensive model of Same Day Emergency Care, providing SDEC services at least 12 hours a day, 7 days a week by the end of 2019/20
- Provide an acute frailty service for at least 70 hours a week, working towards achieving clinical frailty assessment within 30 minutes of arrival
- Embed the Emergency Care Data Set (ECDS) into UTCs and SDEC services from 2020 to help us better understand the needs of patients accessing ED
- Further reduce DTOC, in partnership with local authorities

In order to meet these targets and deliver safe, high quality, cost effective care for LLR patients, local health and social care partners have agreed a UEC 2019/20 Transformation Plan through which we set out our plans to deliver our LLR vision for Urgent and Emergency Care. We have set our priorities into the following key work programme areas:

- Integrated Urgent Care
- Ambulance
- Urgent Treatment Centres
- Hospitals
- Reduce Length of Stay
- Digital

1. Background/Context

The LLR Vision for Urgent and Emergency Care

The LLR UEC STP vision is to create a health and care system that provides responsive, accessible person-centred services as close to home as possible. It will be a model in which services will wrap care around the individual, promoting self-care and independence, enhancing recovery and reablement, through integrated health and social care services that exploit innovation and promote care in the right setting at the right time. Patients and staff will be supported by responsive technology. As well as acute care and community services, Primary Care Networks (PCNs) and General Practice have a pivotal role to play in this ambition.

We will develop Same Day Emergency Care (SDEC) services both in hospital and in the community. In this way, we can better manage patients with long term and complex conditions reducing and better managing the demand on the Emergency Department (ED) at acute hospitals and ambulance services. Enhanced clinical assessment and navigation is a central part of the new integrated urgent care offer, so that we can direct patients into the most appropriate care setting based on need. We believe that a fully integrated IUEC system with consistency of access, allowing for local variation in the needs of patients across LLR, will make it easier for patients to navigate our system and use alternatives to acute services where appropriate.

The LLR vision is supported by the NHS Long Term Plan. Our 2019/20 Transformation Plan will ensure delivery of all the 2019/20 targets and will also position the LLR UEC system in readiness for delivery of future ambitions.

Background and Context

LLR has been an Urgent and Emergency Care Vanguard since 2015, enabling the development of a sophisticated 24/7 integrated urgent care (IUC) model that ensures seamless care of patients who enter the urgent care system. Key to the delivery of IUEC is a 24/7 telephone based clinical assessment model which supports interoperability with the wider IUC system, electronic record sharing, appointment booking, referrals and prescriptions.

These improvements have resulted in fewer ambulances dispatched and fewer patients being directed to attend ED via 111, as well as patients receiving health care closer to home. Therefore LLR already meets the requirement to **embed a single multidisciplinary Clinical Assessment Service (CAS) within 111/out of**

hours and meets the national IUC Service Specification standards.
LLR also currently has three designated Urgent Treatment Centres, providing a key element of IUC and forming a key part of our model developed in 2018.

However, we recognise that to **fully implement the Urgent Treatment Centre model by autumn 2020**, we need to review, define, improve and expand our IUEC offer.

Current Performance challenges
Overall in LLR we have seen an increase in the demand for acute services with a significant rise in A&E attends non-elective admissions and growth in ambulance activity. Although the ambulance service has maintained a good non-conveyance rate of 42%, overall activity has continued to increase which has then impacted on the overall performance. UHL performance against the national 4 hour standard has not been met with a system performance of 75.1% UHL and 82.6% LLR (national ranking 103) in March 2018/19.

In addition LLR performance against the ARP standards were not met in 2018/19 for C3 and C4 in particular. Overall Ambulance Handover delay (AHD) performance during 2018/19 improved from 2017/18. However during times of high demand and pressure on the system AHD performance standards are not met. 80% of all ambulance handovers were achieved within 30 minutes.

Demand for NHS 111 and out of hospital services such as Loughborough Urgent Care Centre have also seen an increase during 2018/19 and this trend is continuing into 2019/20. During February and March 2019 the LLR system undertook Multi-agency admission avoidance events (MAAD) to undertake a system review of understanding the level and type of demand that is coming into our emergency services and pinpointing particular areas of pressure where focussed actions are required to improve performance. Through this process a number of actions were identified some of which were short term and some that require a longer term focus. We will aim to support accelerated implementation of the highest priority scheme, based upon achievability and impact. These have been incorporated into the LLR transformation plan.

The six key areas are:

- Primary Care
- Reduce A&E attends 18-25 group
- Mental Health
- Reducing readmissions
- Redirection of ambulance conveyance into alternative pathways
- Reducing care home admissions

Our key objectives during 2019/20 are to:

- **Deliver improvements in performance in our 4 hour standard** – through improving flow and better management of demand through our acute services
- **Eliminate ambulance handover delays** – through implementing escalation protocols that support partnership working, implementing conveyance direct into pathways such as CDU, LUCC and community based step-up services
- **Improve responsiveness of services** – implementing the recommendations from the Carter Review in order to improve the ARP performance of EMAS, increasing non-conveyance through the implementation of the CAT 3&4 redirection into Clinical Navigation Hub to better manage low acuity demand
- **Reduce the demand on our acute ED service** – developing in and out of hospital same day emergency care (SDEC) pathways, improving access to extended primary care, use of digital technology that supports reducing demand on secondary care services, improving post discharge support to reduce readmissions and working with PCN development to deliver full extended primary care cover during 2019/20
- **Maintain the delivery of DTOC and achieve the standards for reducing long stay patients –** continue to implement and embed the High Impact change Model for Discharge and deliver on Red to Green and SAFER as a consistent approach across all wards at UHL and community hospitals.

Despite the challenges LLR have seen considerable improvements and success in a number of areas. During 2018/19 the LLR system has significantly reduced the number of patients whose discharge from hospital is delayed. In LLR we have achieved the standards for reducing delayed transfers of care (National DTOC Rate 10.2) and a significant improvement in delivering a reduction in the overall number of long stay patients in an acute inpatient care setting. (March 18/19 Stranded patients 14-20 day 102 patients from a target of 100 patients.) Furthermore by the end of 2018/19 less than 5% of patients underwent their CHC assessment in an acute care setting. These successes have been achieved through the delivery of a comprehensive LLR discharge plan that has been based on the delivery of the High Impact Change Model for discharge. Through the delivery of this model we have:

- Implemented an Integrated Discharge Team comprising of nurses, therapists, social workers and discharge support co-ordinators – supporting front door and base wards
- Implemented Trusted Assessment Model between Acute and community services and adult social care teams
- Implemented trusted assessor model for care homes – this includes the red bag scheme
- Implemented discharge to assess model across LLR – which better support the safe transition of patients out of hospitals

Furthermore LLR has led the development locally of digital solutions to support patient care and access such as:

- Direct electronic booking into services
- Early adoption of the Emergency Care Data Set (ECDS) at LRI ED
- Implementation of NHS.net mail with a cohort of care homes in LLR
- NHS 111 online

However there is still some way to go in order fully utilise and embed the digital solutions available that can enhance patient care. In LLR we aim to:

- Have NHS 111 booking patients into same day access for GP Practices across LLR (currently West Leicestershire have this fully implemented)
- Implement NHS.net mail across 50% of our care homes in LLR
- Pilot and test use of SystmOne Care home module for care homes so that they can access care plans for residents in their care
- Embedding the Emergency Care Data Set (ECDS) into UTCs and SDEC services from 2020 to help us better understand the needs of patients accessing ED.

Our Digital priorities section further details our plans on how we aim to utilise digital solutions available to us to enhance patient care.

In order to meet the demands of the Long Term Plan there is significant organisational change taking place within the LLR health economy. The three LLR CCGs recently appointed a single Accountable Officer and are formally considering significant governance changes to try to bring decision making closer together, focussing on the role of the strategic commissioner at system/place/neighbourhood levels. At the same time system partners are working together to ensure success within an Integrated Care System (ICS). These developments bring both opportunities and challenges as the LLR health economy adapts and changes to meet the demands of the changing health landscape and the Long Term Plan.

Furthermore with the development and implementation of Primary Care Networks (PCN) there is a significant role for PCNs in shaping and supporting the development of out of hospital SDEC services, in particular access to diagnostics. However there is significant work that needs to be done to develop PCNs in order to support the work programme. The LLR Primary Care Strategy details the priorities and key actions from a UEC perspective.

Workforce is a significant challenge to delivery in all areas of the 2019/20 UEC Transformation Plan and we will work closely with our system partners to complete and refresh the draft UEC workforce plan that was initiated in 2018.

2. Governance of the Programme

The LLR A&E Delivery Board (AEDB) brings together on a monthly basis the local statutory organisations to oversee the development, agreement and implementation of the UEC Transformation Plan. The AEDB provides a multi-agency forum for planning, discussion and oversight of the delivery of integrated urgent care services resulting in improved A&E performance delivery. It is the senior executive group for the delivery of improvement across the LLR Urgent & Emergency Care system, and members represent their organisations in holding others to account for delivery of agreed actions. The Board is the STP programme lead for Urgent & Emergency Care for LLR. Our clinicians are engaged directly into the work of the Delivery Board either directly or through the working groups such as Integrated Urgent & Emergency Care group, Demand Management Group, Clinical Ideas Factory group Engagement takes place on a weekly/monthly basis. Clinical colleagues both lead the development and/or co-design developments/interventions to support improvements. AEDB will also agree relevant performance metrics and receive performance reports to measure progress and identify variance from plan, to ensure that performance improvement is in line with agreed milestones and targets and agree recovery actions where performance does not match plan.

The Board is chaired by the Chief Executive Officer of University Hospitals of Leicester. Vice Chair is provided by the West Leicestershire CCG Accountable Officer. SRO Director Support is provided by the Director of UEC.

Reporting into AEDB are three key groups which provide recommendations to AEDB and are responsible for the implementation of the work programme of the LLR UEC transformation plan.

These are:

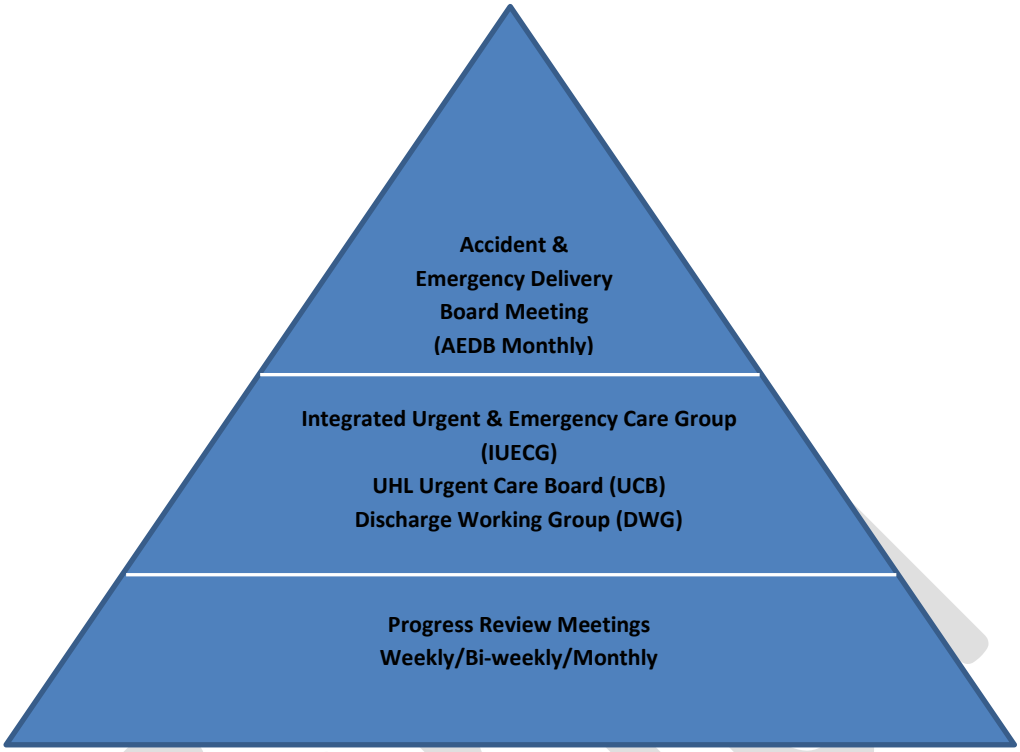
- Integrated Urgent and Emergency Care Group (fortnightly)
  Focus: Integrated Urgent Care and Urgent Treatment Centres Priorities

- UHL Urgent Care Board (Monthly)
  Focus: Ambulance and Hospitals Priorities

- Discharge Working Group (Monthly)
  Focus: Reduce Length of Stay and Digital Priorities

The management of the urgent and emergency care across LLR has been identified as a key priority and as such we are committed to supporting the work required to deliver the implementation of the plan.

In addition, a number of task and finish groups report into the above three groups, for example LLR SDEC Task and Finish Group, which reports to Integrated Urgent and Emergency Care Group. Please see Appendix A for a detailed governance chart. The diagram below illustrates high level governance.



Stakeholders

Stakeholders and partners in the delivery of the 2019/20 UEC Transformation Plan include:

- LLR Clinical Commissioning Groups (CCGs)
- University Hospitals of Leicester (UHL)
- East Midlands Ambulance Service (EMAS)
- Thames Ambulance Service Ltd (TASL)
- Regional EMAS and 111 commissioners – Hardwick CCG and other regional partners
- DHU Healthcare
- Leicestershire Health Informatics Service (LHIS)
- Care Homes (nursing and residential)
- Leicestershire Partnership Trust (LPT)
- Leicester City Council
- Leicestershire County Council
- Rutland County Council
- GPs and Primary Care Networks
- Healthwatch

Public involvement development

The CCGs will use existing public involvement tools/channels to influence the development of the plan. Health representatives sit on a number of UE workstreams. We will also use evidence from a series of Healthwatch focus groups to evaluate winter messaging to determine our approach to communication with the public.

We will establish an LLR – wide communications and engagement network to develop the detailed delivery plan, including all NHS organisations, NHS111, Healthwatch and local authorities. The lead for the network also sits on the LLR Local Resilience Forum to ensure we are linked in and respond to the broader events that can impact on demand for Urgent and Emergency services e.g. severe weather.

The communication network is also connected to the escalation process in terms of A&E demand to ensure we respond to the need for public information.

Public Involvement - delivery

The CCG will take a targeted approach to its communications and engagement on urgent and emergency care, as in previous years. Specifically this will involve:

- An evidence – based approach to communications using A&E attendance data to focus on particular groups of service users and conditions
- This year the focus will be on 18 – 25 year olds and in particular exploiting the links established with the three universities in LLR. This will involve outreach work with identified university staff who can direct students to the most appropriate service following awareness raising sessions
- We will again target large employers as a way of amplifying local the national messages with employees. This will involve outreach work and briefing employer HR teams on services for cascading to colleagues
- Using our well established links with the voluntary and community sector we will provide communications packs to help spread the message locally
- We run appropriate supporting campaigns e.g. in particular we will participate in self-care week
- We will work with local Patient Participant Groups (PPGs) to support us to ensure public information is available at practice level and to ensure campaigns e.g. flu are delivered at practice level

3. Process for monitoring and reporting

Project and Programme Management

Project and programme leads meet regularly with SROs to update on progress, risk and issues. SROs are ultimately responsible for the delivery of projects. In addition project leads meet informally on a regular basis with the LLR UEC PMO and Delivery Manager to ensure that progress against the overall UEC programme is monitored and understood. Progress against the plan is reported and discussed at the relevant working group, for example Discharge Working Group.

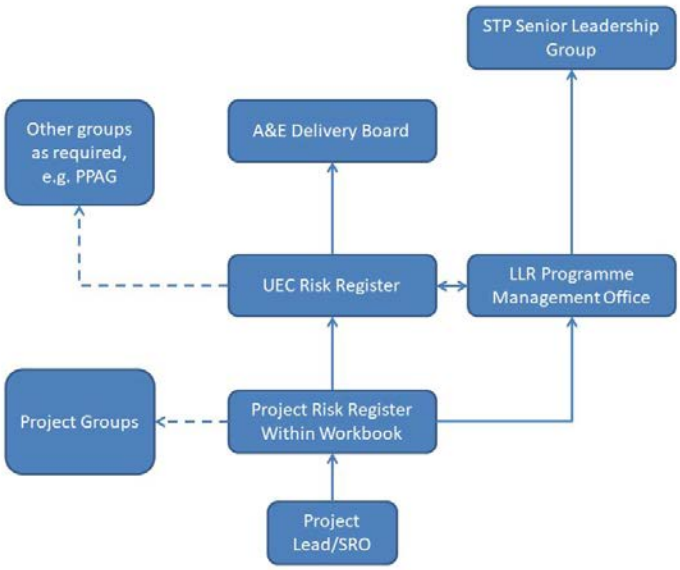
Formal monitoring of projects and the overall UEC transformation programme is reported within a programme workbook, which is completed monthly by project leads and submitted to the LLR PMO team. The workbooks contain PID and business case as well as information on progress against key milestones, project plan, risks and issues and, where relevant, financial information. Before submission to the PMO workbooks are reviewed internally by the UEC PMO and Delivery Manager and approved by the relevant SRO. Following submission PMO leads meet monthly with project leads to review progress and provide further clarity where required. Highlight reports containing key progress, risks, issue and high level finance are presented to the STP Senior Leadership Group.

Risk and Issue Management

Project leads identify risks and issues on an as-and-when basis and maintain a live risk register which forms part of the project workbook. These are agreed with the SRO. Key risks form part of the STP highlight report. Risks are reported using the following format and are reviewed/actions updated by project leads at least monthly.

Risk Number	Risk Description: describe the cause (hazard), and effect (risk)	Original Likelihood Score	Original Impact Score	Original Risk rating	Risk Level	Date Added to Risk Register	Mitigating Actions/Controls Required	Responsible Person	Reviewed Likelihood Score	Reviewed Impact Score	Reviewed Risk rating	Risk Movement from last assessment ◄►/▼/▲	Risk Status	Date Reviewed
CNH005	**CAUSE** Adequate IM&T not in place **EFFECT** Unable to transfer calls from EMAS to DHU, delay to project & benefits reduced.	4	4	16	Significant	08.01.19	(1) LHIS have initiated IM&T review and existing work taking place within EMAS to be aligned to CNH needs. (2) The project now confirmed to align to IM&T STP strategy and has access to funding stream.	Yasmin Sidyot	3	2	6	◄►	open	05/06/2019

UEC Risk Register may also be shared with the relevant project group if appropriate. Otherwise, risks are reviewed and captured for the UEC Risk Register as part of the monthly workbook submission. The UEC Risk Register is reported monthly at AEDB but risks are also reported and escalated as required at key meetings for example Provider Performance and Assurance Group. The diagram below illustrates how risks are escalated.



In addition to the workbooks a detailed presentation focused on one area per month is provided by SROs to AEDB. Key risks or issues for escalation are highlighted on the AEDB presentation are raised and discussed. Following this the workbooks and UEC risk register are updated.

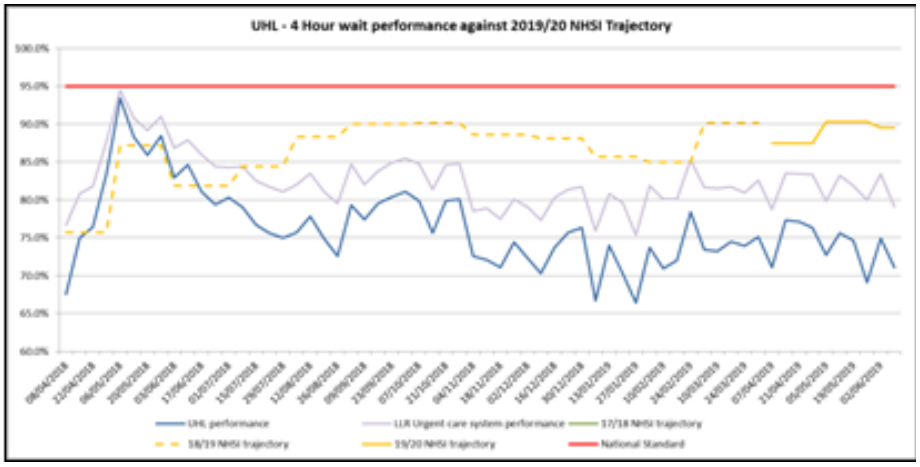
Monitoring of progress and tracking performance

In LLR we have developed our service heat map which enables the system to have an overview of the overall performance of the system and keep a track of impact of interventions and early recognition of over performance or challenges including risks at a system level. This report is reported to AEDB and Integrated Urgent Care Group. Below is an example of our heat map:

4. Monitoring the UEC Programme Plan

Please find below trajectories for the following standards:

4 Hour A&E Performance Trajectory for LLR



19/20 Trajectory

Month	National Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
UHL ED 4 hr	95%	83.1%	86.9%	85.8%	83.9%	84.1%	85.1%	83.8%	82.4%	81.2%	77.7%	82.5%	82.8%
UHL/LLR ED 4hr wait	95%	87.5%	90.3%	89.5%	88.3%	88.4%	88.6%	87.5%	86.2%	85.3%	84.0%	87.1%	87.4%

Ambulance Handover

19/20 - Trajectory (updated 15th May 19)

Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Arrivals (CAD)	5893	5662	5429	5506	5393	5532	6089	6130	6241	6108	5518	6194
Handover delays 15-30 mins CAD	1879	2222	2295	2477	2466	2644	2888	2960	2769	2616	2236	2455
Handover delays 30-60 mins CAD	728	550	393	340	288	170	142	0	310	569	399	402
Handover delays 60+ minutes CAD	263	110	45	0	0	0	0	0	0	0	0	0

Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
% Handover delays 15-30 mins (CAD)	31.9%	39.2%	42.3%	45.0%	45.7%	47.8%	47.4%	48.3%	44.4%	42.8%	40.5%	39.6%
% Handover delays 30-60 mins (CAD)	12.4%	9.7%	7.2%	6.2%	5.3%	3.1%	2.3%	0.0%	5.0%	9.3%	7.2%	6.5%
Handover delays 60+ minutes CAD	4.5%	1.9%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Ambulance Handover Performance

19/20 - Trajectory

Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Arrivals (CAD)	5458	5662	5429	5506	5393	5532	6089	6130	6241	6108	5518	6028
Handover delays 15-30 mins CAD	1999	2222	2295	2477	2466	2566	2666	2431	2448	2616	2236	2455
Handover delays 30-60 mins CAD	665	550	393	340	288	278	289	455	420	569	399	402
Handover delays 60+ minutes CAD	235	110	45	0	0	0	0	0	0	0	0	0

Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
% Handover delays 15-30 mins (CAD)	37%	39%	42%	45%	46%	46%	44%	40%	39%	43%	41%	41%
% Handover delays 30-60 mins (CAD)	12%	10%	7%	6%	5%	5%	5%	7%	7%	9%	7%	7%
Handover delays 60+ minutes CAD	4%	2%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Long Stay Patients

UHL SUPER STRANDED (21+ days)
TRAJECTORY - ADULTS

TARGET:
135

Month	Mar -19	Apr -19	May -19	Jun -19	Jul-19	Aug -19	Sep -19	Oct -19	Nov -19	Dec -19	Jan-20	Feb -20	Mar -20
Patients 21+ days	172	152	162	151	166	161	152	147	143	149	156	143	135

DTOC – BCF guidance just released and now awaiting technical guidance to setting trajectories from NHSE/I

NHS111 Standards

	Target	18/19 Outturn	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	YTD / Mean
Call Handling															
Total Calls Answered		88.00%	90.1%	84.4%	86.4%	83.1%	82.6%	86.2%	85.2%	85.0%					85.3%
Calls Answered within 60 seconds %		76.80%	94.3%	86.9%	90.5%	90.7%	90.5%	96.2%	96.3%	96.6%					92.8%
Calls abandoned after 30 seconds	<4%	5.60%	1.2%	2.7%	2.5%	2.0%	1.9%	0.9%	0.9%	0.7%					1.6%
Average Answer Time (seconds)	<27 secs	00:00:34	00:00:11	00:00:21	00:00:16	00:00:17	00:00:16	00:00:08	00:00:08	00:00:07					00:00:13
Final Disposition															
Emergency Ambulance dispatch	≤ 9%	13.1%	15.8%	16.3%	14.9%	15.3%	14.4%	14.3%	12.8%	13.4%					14.7%
Attend A&E	≤ 8%	5.2%	5.8%	5.8%	5.9%	6.3%	6.2%	6.7%	6.8%	6.9%					6.3%
Attend Primary Care	≥ 55%	59.0%	55.5%	57.3%	59.6%	57.9%	59.0%	58.5%	60.1%	59.3%					58.4%
Self Care	≥ 17%	16.0%	18.1%	17.1%	15.6%	16.1%	16.4%	16.4%	16.0%	16.0%					16.5%
Triage Rate															
Answered calls that are triaged	80%	92.4%	90.9%	90.5%	91.7%	90.5%	93.3%	93.3%	94.5%	93.9%					92.3%
Warm Transfers															
Calls either warm transferred or called back within 10 mins	≥ 50%	49.3%	57.6%	57.7%	60.5%	58.6%	58.9%	56.8%	59.0%	61.7%					58.9%
Warm Transfers to clinician when required	n/a	41.0%	22.0%	16.4%	18.1%	17.2%	14.3%	16.3%	18.5%	16.9%					17.5%
Person called back within 10 minutes	n/a	26.7%	20.3%	12.3%	22.3%	19.1%	21.2%	21.8%	25.1%	21.1%					20.4%

SDEC Standards

UHL have confirmed that they are already meeting the standard for 100% of trusts are providing Same Day Emergency Care (12 hours day / 7 days week) by September 2019

UHL current performance stands at a minimum of 34% against the standard of delivering 30% reduction in non-elective admissions from SDEC. We are working with UHL to develop a more ambitious trajectory of achieving 40% reduction in Non-elective admissions by March 2020. We are working with the national accelerator team with regards to this.

See separate project tracker worksheet :

(a) Helps to track progress

(b) Helps to develop better plans, showing where the gaps are, and what extra resource/support may be required

The sheets aim to bring together the strands of

- Monitoring and Control
- Benefits Management
- Risk Management

This will help create a coherent and effective action plan.
NHSEI to provide this at a later date which we will utilise to report back to NHSEI

5. UEC Plan 2019/20

The 2019/20 LLR UEC Transformation Plan outlines how we aim to deliver all of the national, regional and local transformation priorities for urgent and emergency care. In addition, system agreement on local priorities for improvements has also been achieved. A high level diagram of the UEC Transformation plan broken down by key priority areas including national and local priorities is attached as Appendix B. As outlined in section 2 our plan is developed to support the system to achieve the following key objectives:

- Deliver improvements in performance in our 4 hour standard
- Eliminate ambulance handover delays
- Improve responsiveness of services
- Reduce the demand on our acute ED service
- Maintain the delivery of DTOC and achieve the standards for reducing long stay patients

Our objectives are then subsequently delivered through the following Priority Programme Areas:

Transformation Priority 1: Integrated Urgent Care

Our plan for delivering Integrated Urgent Care focuses on reducing demand on our acute ED service. In order to this we will need to:

- develop in and out of hospital same day emergency care (SDEC) pathways,
- improving access to extended primary care,
- use of digital technology that supports reducing demand on secondary care services,
- improving post discharge support to reduce readmissions
- working with PCN development to deliver full extended primary care cover during 2019/20
- Improve access to out of hospital Mental Health Crisis – delivering the Core 24 and extending access to MH crisis services through our CNH service.
- Enhance the clinical assessment of low acuity ambulance (CAT 3&4) activity in order to divert from originating in 999 calls so that over 50% of NHS 111 calls are receiving a clinical assessment
- Reduce 'A&E by default' to less than 1%
- Focus on reducing demand on A&E attends in the younger population group (18-25)
- Implement MiDOS in LLR in order to improve access to alternatives to ED
- Review professional advice and guidance for GPs – improving the offer and linking this to the development of PCNs.
- Increase the use of step-up referrals to community services through the redesign of our community services

- Use of PCNs and ILTs to deliver evidence based care for LTC/multi morbid patients in primary care

- Integrating the out of hours face to face service into the UTC offer in LLR

- NHS 111*6 – The process across LLR was driven by the Care Homes Sub-Group (CHSG) and the various quality teams. Care homes have been advised to follow a process for emergency and urgent care situations. If it is an emergency then they call 999. If it is urgent, then they call the resident's GP Practice. If the urgent situation is outside the opening hours of the practice or the practice suggests they are unable to link the clinicians with the care home, then they call the Health Care Professional number that links them directly to the Clinical Navigation Hub. If this number is engaged or unavailable, they then call 111 *6. Our local solution of direct access into our Clinical Assessment Service (LLRCNH) is much more effective and enables direct access to a clinician 24/7.

NHS Mail

A recent NHS Digital Demonstrator project has funded work to engage with up to 28 care homes and work with them on a number of elements that enhance their digital capability. Each of the care homes was supported to work through the accreditation for the Data Security and Protection Toolkit and achieves the "entry level" accreditation that permits them to apply for access to use the NHS Mail service. The process of administration to set-up NHS Mail has taken place with 26 care homes and 22 now have access to NHS Mail. Of the 26 care homes that are accredited to entry level, 21 progressed towards "standards met". This standards met level demonstrates a commitment to compliance that enables these care homes to have access to the care home module for SystmOne. Information Sharing Agreements need to be signed by all parties before SystmOne can be set-up for the care home. To date we have 10 care homes that have now gone live with the SystmOne module.

The table below outlines how we plan to deliver the above improvements and for some of these areas we are working through what the impact will be for LLR in reducing the demand on our acute services. (Full plan available in Appendix C)

	Priorities	Impact Area	Actions	Timeline
Integrated Urgent Care	LOCAL: Increased clinical assessment of low acuity of 999 activity	Redirection of CAT 3&4 Calls to CNH – testing in Aug-Sept will inform the quantifiable impact	Pilot implementation to test model agreed ahead of implementation in Q4. Testing to start on 19/08/19 – 02/0919. Following actions to be undertaken: Staffing the admin position – all agreed to look at potential staffing Confirmation of retesting Consider the electronic route back into EMAS Review process map	August – September 19 January 2020
	LOCAL: Clear specification & offer across the LLR IUEC tiers of care Model	Increase use and offer of Extended primary care in line with the PCN ambitions – Increase uptake of extended access to over 80% across LLR (MADD event findings – Circa 10% of walk ins advised by their GP to go to A&E) -	Updated primary care offer Senior clinical review which provides link to consult connect and bed bureau	September 2019

Integrated Urgent	Priorities	Impact Area	Actions	Timeline
		Specifications: Emergency Front door Community based Access	Specification agreed Agree UTC offer CCG	July March 2020
	LOCAL: Better targeting of patients straight to SDEC	Direct access to Clinics (MAAD event findings – Circa 15% ambulance conveyances potentially unnecessary) LOS on the SDEC Pathway in line with national ambition	Develop Service Spec for SDEC UCC conveyance mandated (EMAS/LLR) Review of 10 cases per week (over 3 months) on non-admitted ambulance conveyance to understand cases and learning for clinical feedback ID Pathways & KPI's for each unit UHL planning commenced 25th July 2019	September 19
		SDEC acute and out of hospital offer to be developed to increase community based access for diagnostics (Currently in PDSA phase)	Develop Model for diagnostic offer across out of hospital sites - LuCC Re-launch of 10 ambulatory care pathways to LUCC and mandated EMAS conveyance to LUCC goes live 5th Aug 2019	September 19
	LOCAL: clinical advice & Guidance	Direct access to Clinics	Review current clinical Advice and guidance offer	February 2020

Integrated Urgent	Priorities	Impact Area	Actions	Timeline
		Increase use of SDEC Pathways	Develop new model for clinical advice and guidance that fits with the development of PCNS across LLR UHL planning commenced 25th July 2019	
		(MAAD event finding's – Circa 20% of walk ins did not consider alternatives to A&E)	Injuries – ambulatory pathways to focus on 18/25 age group – targeted communications (fresher's week)	December 2019
	LOCAL: Reduce length of Stay SDEC Pathway	Increase in 0 LOS Reduction in NEL Admissions	Implement actions as identified by through the National Acceleration Programme provided by NHS Elect - Next visit on 24th October2019 UHL planning commenced 25th July 2019	September 19
	Local: Primary Care	Ensure that all extended access capacity is utilised to reduce demand on ED Accessing City Hubs Targeted demand management with GP Practices – LLR approach Demand Management	West – implement agreed operational delivery changes to ensure optimised appointment availability and provision – work with referring practices to ensure optimised and strategic use of available capacity Agree a population health based demand mgt approach – June completed Discuss the approach with localities – June completed	October 19

Integrated Urgent	Priorities	Impact Area	Actions	Timeline
		group set up with clinical representative	Test approach with one outlier practice and develop action plan – June/July completed Feedback progress to F&P and West GB July 19 Completed Present and discuss approach at West ACD meeting – 6 Aug – in progress Visit remaining outlier practices Aug-Mid Oct 19 In progress	
	Local: Reduce A&E attends 18-25 group	Reduce A&E attends 18-25 group. High volume of patients leaves before treatment/ do not need treatment. Injuries – ambulatory pathways use for this age group – role of	To reduce: 20% by 2019/20 50% by 2020/21	December 2019 December 2020

Integrated Urgent	Priorities	Impact Area	Actions	Timeline
		SDEC and the redirection to LUCC		
	Local: Mental Health support	Currently 111 dispositions into ED is 34% Reduction 1429 DX92 dispositions from 111 into ED Increase referral flow into CNH Reduce EMAS conveyance for low level into ED	To provide MH support to CNH. – MH Practitioner into CNH – test phase to commence in Late September Options appraisal during mobilisation Implement additional support Improve Access into crisis team for CNH, EMAS and GP without GP face to face review dispositions (34% June 18-May 19) Frequent attenders work to develop shared care plans for known cohort impacting on attendances for VB11Z and VB09Z Implementation of the CORE 24 standards	Sept 2019 testing to commence April 2020 – although would be able to implement this earlier if the MH crisis funding is available in Q3 2019/20 April 2020 onwards – the funding to support this is released in April 2020
	Local: Reducing Care Home Admissions	Reducing 1000 patients on a 7 day stay	Accelerate the enhanced health in care homes plan by CH Subgroup to achieve a further reduction in care home admissions based on the success in 18/19	December 2019

Integrated Urgent	Priorities	Impact Area	Actions	Timeline
			Implementation of the digital solutions – extending the current work further Delivery of telemedicine and scoping further ways in which this can be used to better manage patients living in care homes	October 19 March 20
	Local: LLR Falls Programme	A reduction in FEMUR fracture acute interventions and a reduction in consultant led first out-patient appointments where patients are triaged assessed and managed within a community setting	Postural Stability Exercise Programme – embedded in County and Rutland. City – went live 1st April 2019 with non-recurrent funding for 12 months Electronic Falls Risk Assessment – phased implementation commences in Aug. Non Blue Light Service Response – Coalville PDSA commenced 10th July 2019 Therapy Triage Service – embedded in County and Rutland Training & Equipment in Care Homes	Completion June 2020 Aug 2019 Aug 2019 July 19

	Priorities	Impact Area	Actions	Timeline
Integrated Urgent			– PDSA to commence Autumn 2019	Sep 19
	NATIONAL: Maintain a 50%+ proportion of NHS 111 calls receiving clinical assessment.	Increase in proportion of 111 calls receiving clinical assessment Increase activity in CNH	Enhance the clinical assessment of low acuity ambulance activity Review DoS to identify further opportunities for clinical assessment rather than A&E by default	October 2019
	NATIONAL: Increase the percentage of people triaged by NHS 111 that are booked into a face-to-face appointment, where this is needed, to greater than 40% by 31st March 2020. By 31st March 2020, reduce 'A&E by default' selections on the Directory of Services (DoS) to less than 1% by the commissioning of appropriate services that are accurately recorded on DoS	Increase in percentage of patients booked into face to face consultation to over 40% from 37%	review our model of booked appointments vs walk in access across LLR implementing 1 GP appointment available to NHS111 for every 3000 patients across LLR Implementation of MiDoS	December 2019

In addition to the above we have developed our plan to manage demand in our system more effectively and have identified key actions that we will accelerate in 19/20 to reduce A&E attends and non-elective admissions focussing on the following 6 key areas:

- Primary Care
- Reduce A&E attends 18-25 group
- Mental Health
- Reducing readmissions
- Redirection of ambulance conveyance into alternative pathways
- Reducing care home admissions

Growing demand for care in all settings is continuing to increase; a demand management group has been set up with clinical representative to focus on the following areas:

- Federation QIPP
- Referral Support Service
- Planned Care - pathology
- Same Day Emergency Care – managing more care as 0LOS, shifting demand from LRI to Loughborough UCC
- Meds management
- Respiratory rapid response service, virtual clinics
- CHC savings
- Community Hospital repatriation

In addition to the above actions and plans in place further work is being carried out by the demand management group to focus on:

Maximising delivery of existing QIPP and 19/20 plans

- Working with outlying practices to address variation in levels of access to secondary care services
- Commissioning response - identifying pathways that could manage demand in different settings or at lower cost
- Additional NEL demand management savings identified
- Asking UHL to manage Elective activity within Plan

The following deliverables are in place or have been completed:

- Agree a population health based demand management approach – June completed
- Discuss the approach with localities – June completed
- Test approach with one outlier practice and develop action plan – June/July completed
- Feedback progress to F&P and West GB – July completed
- Present and discuss approach at West ACD meeting – 6 Aug – in progress
- Visit remaining outlier practices – Aug to Mid Oct – in progress

Transformation Priority 2: Urgent Treatment Centres

In 2019/20 we will review the LLR Urgent Treatment Centre offer as part of our tiers of care review. We will reach LLR wide agreement on future plans for our three designated UTCs by December 2019 including any changes to services necessary to fully implement the UTC model. The table below outlines our plan including our timeline.

	Priorities	Impact Area	Actions	Timeline
Urgent Treatment Centres	NATIONAL: Designate the majority of urgent treatment centres (UTC) by December 2019, with any exceptions to be agreed with the Regional Director.	Designation of UTCs in LLRs	Review the current designated sites and determine whether these remain as the designated UTCS for LLR and they can continue to fit into the LLR IUEC Model	December 2019

Currently in LLR we have the following 3 sites that are designated as UTC sites:

- Loughborough Urgent Care Centre (LUCC) – West Leicestershire
- Merlyn Vaz Hub – Leicester City
- Oadby Urgent Care – East Leicestershire & Rutland

LUCC is the only site in LLR that fully meets the national UTC specification and is LLR's 24/7 walk-in service that offers booked appointments. Merlyn Vaz is predominantly a booked appointment hub service and therefore partially meets the national UTC Specification. Oadby is a walk-in and booked appointment service and again partially meets the UTC specification.

UHL provide a front door primary care streaming offer and currently this is not designated within the UTC Spec offer as all activity that goes through this service is recorded as Level 1 A&E attends.

Currently LLR CCGs have agreed that LUCC will remain as a designated UTC. In relation to Oadby there are ongoing discussions taking place with a view to agree the position by early September.

In relation to the City Merlyn Vaz UTC, there is further analysis required of the activity that goes through the hub and what goes through UHL's front door primary care streaming to then inform what type of UTC offer is required in the City and how and where that is best placed. All potential changes that are being considered will go through an engagement and consultation with City residents. We will work to the December 2019 deadline of designation.

Transformation Priority 3: Ambulance

Over 40% of LLR 999 calls are not conveyed to ED with positive use of alternatives to ED. Regionally EMAS performs well for LLR on non-conveyance. We want to add to this success and increase our opportunity to deliver a safe reduction in ambulance conveyance, building on our low acuity ambulance clinical assessment pilot and development of alternative pathways for specific cohort of patients such as chest pain and injuries and to redirect conveyances straight to CDU as part of the RightCare opportunities.

The LLR planning function has actively utilised RightCare benchmarking and the NHSE released data packs to drive the 2019/20 LLR Commissioning Intentions, Operational Plan and system efficiency programme. The RightCare opportunity analysis highlights that there is a notable patient improvement & cost reduction opportunity for the LLR system from the improved management of patients with multi-morbidity (five or more long term conditions). It is anticipated that better case finding and subsequent prevention/crisis management for the following conditions would reduce urgent care and Non-Elective activity & spend:-

DISEASE AREA	**NON-ELECTIVE**
Gastrointestinal	£3,497,000
MSK	£00
Problems Of Circulation	£4,052,000
Trauma & Injuries	£1,878,000
Neurology	£1,878,000
Respiratory	£7,804,000
Cancer & Tumours	£340,000
Endocrine, Nutritional And Metabolic Disorders	£421,000
Genitourinary	£1,783,000
2019/20 TOTAL LLR OPPORTUNITY	**£21,653,000**

In-line with the release of the NHS England Long Term Plan, LLR have submitted plans to re-design service provision and release the opportunities within Gastrointestinal, Respiratory as well as Problems of circulation. The RightCare process, principles and analysis have guided the development of the LLR Urgent Care Transformation plan and will support the delivery of the identified opportunity.

Commissioners, UHL and EMAS will work together effectively to identify the causes of local ambulance handover delays and to resolve issues. We will ensure that 100% of ambulance handovers occur within 30 minutes.

Building on work begun in 2018/19, we will increase the digital maturity of EMAS so that clinicians on scene and working in the CAT team have access to patient information (SCR, PDS and EPR) and electronic prescribing. We will review options for providing access to service information at scene including MiDoS and Pathways Service Finder and will implement an effective solution for EMAS, taking into consideration our regional partners.

In regards to ambulance services to meet as a minimum a baseline level of digital maturity, discussions between EMAS and NHSEI took place to agree and to consider a local variation to National CQUIN 10 as long as the outcomes were still achieved. A variation proposal was sent to NHSEI by EMAS.
The coordinating commissioner view is that the national CQUIN is quite clear in terms of what is expected and although the rationales for the proposed exclusions are understood, the target for Q3 and Q4 is only 5%.
NHSEI have advised target of 5% should be a cumulative position over Q3 and Q4 and agree that this should be achievable without any delay in timeline or exclusions.

Further information and trajectories to be provided once confirmed.

(Refer to Appendix D to view proposal)

	Priorities	Impact Area	Actions	Timeline
Ambulance	LOCAL: Redirection of ambulance conveyance into alternative pathways	MADD event findings - paramedics decision-making not always consistent or protocols not consistent in and out of hours Improve consistency of protocols Increase non-conveyance by 1% in Q3 and 1.5% in Q4	Same day access to chest pain clinic – 24 hour pathway – learning from Notts and Northants Implement mandated conveyance to LUCC by EMAS – commences 2nd August Implement pathways to redirect conveyance straight to CDU Access to Health Care professional line (HCP) Implementation of MiDoS Training EMAS staff around mental health crisis/emotional distress	October 2019 August 2019 August 2019 In Place – monitoring use through failed pathways data TBC once agreed by partners October 2019
	NATIONAL: All ambulance services to meet, as a minimum, a baseline level of digital maturity including access to and usage of patient information at scene (e.g. Summary Care Record, Patient Demographic Service, Electronic Patient Record),	Improved clinical decision making Improved patient outcome Decreased EMAS on scene	Improve use of system one Potential of MiDOS EMAS ePRF already widely used	December 2019 December 2019 completed

২ ৩ — ৪	Priorities	Impact Area	Actions	Timeline
	access to service information at scene (e.g. DoS) and establishing Electronic Prescribing.	time Conveyance avoidance due to improved overall clinical picture		
	NATIONAL: Ensure 100% of ambulance handovers occur within 30 minutes	4 hr standard Ambulance handover turnaround performance Improved Quality of care MADD event findings - Handover delays occur when there are 4-5 ambulances arrive within 15 minutes	Improve Fit to sit Direct to clinic Transport Improved collaborative escalation procedure Mapped LLR Against NHSE/I Guidance and tailored to suit the locality Fit to sit Send EMAS straight to clinic Escalation procedure – improve communication between operational levels Nurse co-ordinator Operational group now meets every 2 weeks to enable continuous	Fit to sit – **Complete** Direct access to clinic – **Complete** however looking into further opportunity Learning visits **complete** Action Plan to developed post learning visit by 9th August 2019

২ ৩ — ৪	Priorities	Impact Area	Actions	Timeline
		More available resources to serve unseen patients in the community - (Matthews story) MADD event findings – Ambulance assessment inconsistent and variation between process and workforce	oversight and improvement Visits arranged to Newcastle and Leeds to investigate learning opportunity Shared EMAS/UHL conveyance modelling to enable awareness of potential peak activity AHD group work – tracker in department role. UHL and EMAS will evaluate the requirement of a HALO and a nurse co-ordinator in ambulance assessment role Fit to sit Send EMAS straight to clinic Escalation procedure – improve communication between operational levels Nurse co-ordinator	Conveyance modelling by the end of July

Transformation Priority 4: Hospitals

Improving Flow and delivering the 4 hour standard is a key objective in 2019/20. In order to do this successfully we will deliver SDEC services within UHL that operate at least 12 hours a day, 7 days a week by September and enhance our frailty service so that it operates effectively and for a minimum of 70 hours a week by December.

We will deliver 30% of non-elective admissions via SDEC by March 2020. We know that our hospital Bed Bureau service has worked very hard to keep pace with the many changes to the UEC system over the past years – in 2019/20 we will review this function and ensure that it meets the current needs of patients and staff and effectively supports maintaining system flow and direction of patients to the most appropriate services within UHL through better clinical decision making.

Our hospitals will share information more effectively with partners and agencies and we will carry out 'perfect ward' MADE (multi-agency discharge) events. We will reduce the number of aborted non-emergency patient transport journeys by improving discharge processes, and we will achieve >50% discharge across the whole of Medicine before 12pm. A Transport Improvement Group has been established. The primary purpose of the group is to focus on improving discharge flow overall, to enable TASL to respond appropriately to UHL's and LPT's needs in a timely manner in line with contract KPI's. This work has been given a priority status from the Integrated Urgent and Emergency Group which reports to the LLR A&E Delivery Board.

We will also be reviewing our overall medical and assessment bed capacity to ensure that we have sufficient capacity to meet demand and that the interventions to reduce demand are effective in managing the flow through our hospitals. We will be undertaking this review ahead of winter so that we are able to ensure we have sufficient capacity to manage increased demand over periods of surge in activity during that time.

	Priorities	Impact Area	Actions	Timeline (END Date)
Hospitals	LOCAL: Bed Bureau	Improve sign posting and utilisation of alternative ambulatory pathways Management of GP referrals for patient transport MAAD event findings – Bed Bureau relay function and acceptance is GP referral led as opposed to access criteria led	Task and Finish Group established Revised Model developed and agreed by partners Test of revised model Project group and lead to be set up working with consult connect and aligning with transport improvement group	Aug 2019 Sept 2019 Dec 2019
	LOCAL: Review of Bed Capacity – in particular Medicine and Assessment	Improve flow through Majors into medicine Improved usage of available bed capacity Early identification of gaps and plans developed to mitigate these Review of assessment beds	Task and Finish Group set up to undertake the review Undertake Bed Audit to understand bed usage Options appraisal for use of ward 7 as extension of AMU (direct admitting bed capacity)	August 2019

	Priorities	Impact Area	Actions	Timeline (END Date)
Hospitals	LOCAL: Transport (Non-emergency) – Reduce the number of aborts for transport , Up to 2 patients identified each day across 5 wards in medicine who will have criteria led discharge by the nurse	Increase flow of discharge earlier in the day – Increase number of discharges that occur before 12pm – currently approximately 30% discharges occur before 12 – to increase to more than 50% discharges across all of Medicine to occur before 12pm Reduce the number of aborts for transport	LLR Transport Improvement Group will lead on developing the plan for Priority 1.(what is referred to as priority 1) UHL, LPT and TASL to ensure that the transfer of patients from UHL to community Hospital are planned the previous day so that those patients are transferred by 10 am	September 2019
	LOCAL: Discharge before midday – "Go Green" - more than 50% discharges across all of Medicine to occur before 12pm	Up to 2 patients identified each day across 5 wards in medicine who will have criteria led discharge by the nurse	Tiger Team to be set up by Lead Nurse for Medicine to identify the 5 wards. Develop PDSA and evaluate the impact	June 2019 First PDSA August 2019
		Summary TTOs ready for each patient day in advance of discharge date	Tiger Team to be set up by Lead Nurse for Medicine to identify the 5 wards. Develop PDSA and evaluate the impact	September 2019
	LOCAL: Information	Transfer of clinical information electronically without	UHL Team to liaise with LLR IM&T	August 2019

Hospitals	Priorities	Impact Area	Actions	Timeline (END Date)
	sharing with partners and agencies	need for discharge summary.	team to ensure that this is part of the Digital Strategy.	
		Digital solution implementation: increase use of SCR and SystmOne which is already available	Implementation of Remote access for community clinicians to Nerve Centre	TBC
	LOCAL: Perfect ward – focused MADE. (Multi Agency Discharge Event)	Minimise number of medicine outliers Aim for no outlying after 9pm Implementation and embedding consistent and safe practice of SAFER and R2G	2 wards in Medicine - focussed MADE to create flow and embedding culture, practice, behaviour that supports good and safe practices - planned discharges	September 2019
	LOCAL: Reducing readmissions	Reducing readmissions from frequent flyers Reduction in readmission – further analysis of the data planned to set trajectory 6th August	Frequent flyers – to focus on individual patients. Top 10 between UHL, Community and EMAS Implement post discharge support best practice as per the Aston University research – adopt into LLR https://www2.aston.ac.uk/news/?simple-aftercare-slashes-nhs-hospital-readmissions	December 2019 October 2019
	NATIONAL: Ensure	Deliver the standard for SDEC	Participate in the National	September 2019

	Priorities	Impact Area	Actions	Timeline (END Date)
Hospitals	100% of trusts are providing Same Day Emergency Care (12 hours day / 7 days week) by September 2019	Increase usage of GPAU and CDU	Acceleration Programme for SDEC with NHS Elect Expand the scope of GPAU and review CDU	
	NATIONAL: Delivering 30% of non-elective admissions via SDEC by March 2020	30% reduction in non-elective admissions Increase in 0 LOS	UHL currently deliver same day emergency care via GPAU, TIA, and DVT. SDEC Pathway for GP referred patients in place on the Emergency floor (GPAU) monitor LOS on this unit to ensure the pathway is efficient as possible	March 2020
	NATIONAL: Providing a frailty service (70 hours a week) by December 2019.	Increase in Frailty provision by 70% Increase in activity through AFU and EFU	The Frailty Emergency Squad (FES) operates in the Emergency Department and in the Emergency Frailty Unit 08:00-18:00 7/7. This MDT team include a consultant geriatrician, Advanced Nurse Practitioner, pharmacist, discharge unit, OT and physio	December 2019

Transformation Priority 5: Reduce Length of Stay

LLR has made significant improvements is reducing delayed transfers of care and reducing the number of long stay patients in inpatient settings. We want to build on that success and continue to maintain the positive progress we have made by ensuring that we maintain our level of performance and deliver a 40% reduction in long stay patients and long stay beds by March 2020. LLR has made excellent progress in reducing DTOC over the past two years and in 2019/20 we will continue to perform well against our local targets.

We will continue to deliver our local targets by our continued roll out and use of the care home bed state tracker. Our local priorities for reducing length of stay include early discharge planning, supported by multidisciplinary/multi-agency discharge teams and Trusted Assessors. We will help patients to get home quicker and stay at home for longer through our Home First and Discharge to Assess (D2A) offer and we will help people who live in care homes to stay healthier at home through our enhancing health in care homes work. This includes increasing the number of care homes with access to nhs.net email and ensuring that care home staff use our dedicated 24/7 HCP telephone line service to access advice and help patients avoid unnecessary admissions to hospital.

In addition we aim to reduce our readmissions in order to reduce our non-elective demand further by implementing evidence based practice as recommended in the link below.

https://www2.aston.ac.uk/news/?simple-aftercare-slashes-nhs-hospital-readmissions

	Priorities	Impact Area	Actions	Timeline (END Date)
Reduce Length of Stay	LOCAL: Early Discharge Planning	Improve Discharge Co-ordination within Adult and older people MH services	Develop model for discharge co-ordination based on the IDT principles Adapt the IDT principles from UHL to implement into AMH and MHSOP	October 2019
		Improve Self-Funder – Support to patients, their families and staff	Appoint joint post across LLR for Self-Funder Project Lead Develop an LLR Self Funder Information advice and guidance strategy and process	April 2019 June 2019
		Improve Discharge planning in electives – particular focus on orthopaedics	Implementation of LLR process across all acute and non-acute sites in LLR	October 2019
	LOCAL: Systems to Monitor Patient Flow	Implementation and roll out of Integrated Needs Assessment Tool	Roll out of INAT tool across all discharge pathways and into community hospitals	July 2019
		Increase the Utilisation of care home bed tracker from 60% to 80%	Care home bed tracker currently 67% Engagement of care homes to utilise the tracker to update their bed state Engagement of IDT and discharge teams across acute and non-acute	Ongoing Ongoing

	Priorities	Impact Area	Actions	Timeline (END Date)
			including ASC to utilise the tracker to find suitable homes	
		Roll out of red bag scheme across all care homes in LLR	Roll out to all care homes to utilise red bag. LLR 28% complete (City 50% complete, 100% by end of Aug 19. West 50% by the end of Aug 19. East 25% complete)	August 2019
		Development of Local Decisions Unit (LDU) to support information flow from hospital to community services	Development of the service offer blueprint for Leicester, Leicestershire and Rutland Finalisation of service offer and model	June 2019 August 2019
	LOCAL: Multidisciplinary/multi-agency discharge teams	IDT – embedding culture and behaviour	Review and redefine case management across the pathways for LLR Expansion of Housing Enablement Team	August 2019 August 2019
	LOCAL: Home First/D2A	Increase the use of Discharge to Assess Home Pathway across City and County	Review access to D2A Home pathways in line with the community service redesign work Implementation of the Pull Model as part of CSR Review and develop therapy model that better supports D2A home	August 2019 Sept – Oct 2019 Sept 2019

	Priorities	Impact Area	Actions	Timeline (END Date)
			Implementation of NWB action Plan	Dec 2019
	LOCAL: Trusted Assessors	Increase utilisation of trusted assessment and assessors to support transfer and discharge of patients across acute and non-acute	Implementation of Trusted Assessment Model for Care Homes Evaluation of the impact of the model in reducing delays and LOS Embedding TA principles and competencies to support IDT	May 2019 September 2019 August 2019
	LOCAL: Enhancing Health in Care Homes	Reduce the number and length of delay relating to awaiting care homes to assess and accept patients for long-term placements	Rollout of INAT with Care Homes – using the TA to support this	August 2019
		Improve the sharing of information between care homes and hospitals to facilitate and support more timely and safe discharges.	Implementation of digital solutions with care homes to support better exchange of information – NHS.net email account and implementation of EPR- NHS Digital funding supporting the implementation and roll out of this across a number of care homes in LLR	December 2019
	NATIONAL: Nationally, deliver a 40% reduction in long stay patients (and long stay beds) from the March 2018 baseline by March 2020.	40% reduction in long stay patients by March 2020 – trajectory to be developed	Utilisation of regular MADE to embed changes in practice and consistency of Red to Green Embed long stay Wednesdays and system escalation calls to support safe	March 2020

	Priorities	Impact Area	Actions	Timeline (END Date)
			and timely discharge of patients	
	NATIONAL: Continue to make progress on reducing delayed transfers of care (DTOC) to achieve and maintain a national average DTOC position of 4,000 or fewer daily delays, with local targets to be set for 2019/20 through Better Care Fund (BCF) plans. Further detail on these expectations as well as wider requirements for BCF plans will be published later in 2019	Delivery of BCF Standards	See above local actions under the delivery of high impact actions	TBC – guidance just published awaiting technical guidance
	NATIONAL: Ongoing implementation of the Care Home Bed State Tracker, including embedding into Acute Trusts	Increase participation to 70% Increase usage 50%	See LOCAL Enhancing Health in Care Homes that outlines the actions to deliver this standard	March 2020

Transformation Priority 6: Digital

Our digital priorities will help us to deliver many of our other five priorities. In 2019/20 we will complete work begun in 2017 to ensure that our IUC system is fully interoperable, with electronic appointment booking available for all face to face consultations in urgent care settings. In 2019/20 we will go further and ensure that our ED is fully resourced and able to implement direct electronic appointment into extended primary care appointments. This is now a key KPI in the GMS contract for GP practices.

Record sharing is also a key priority. We want to build on past success by increasing the number of patients who consent to share additional information through e-SCR. In addition we plan to make the records accessible to UHL and EMAS of any patient with a frailty score of 7 and above.

The LRI ED and every e-prescribing pharmacy in LLR will have access to extended patient data via the SCR. Our UTCs and LRI ED will also have access to primary care records, mental health crisis records and end of life plans.

Finally, we will ensure that the Emergency Care Data Set is implemented in all our T1 and T3 departments. We have commenced working with our UTC and extended access provider to implement technical solutions that will support this. However it is important to note that currently not all of the technical solutions are readily available especially with SystmOne TPP community module. TPP is currently working on a technical solution.

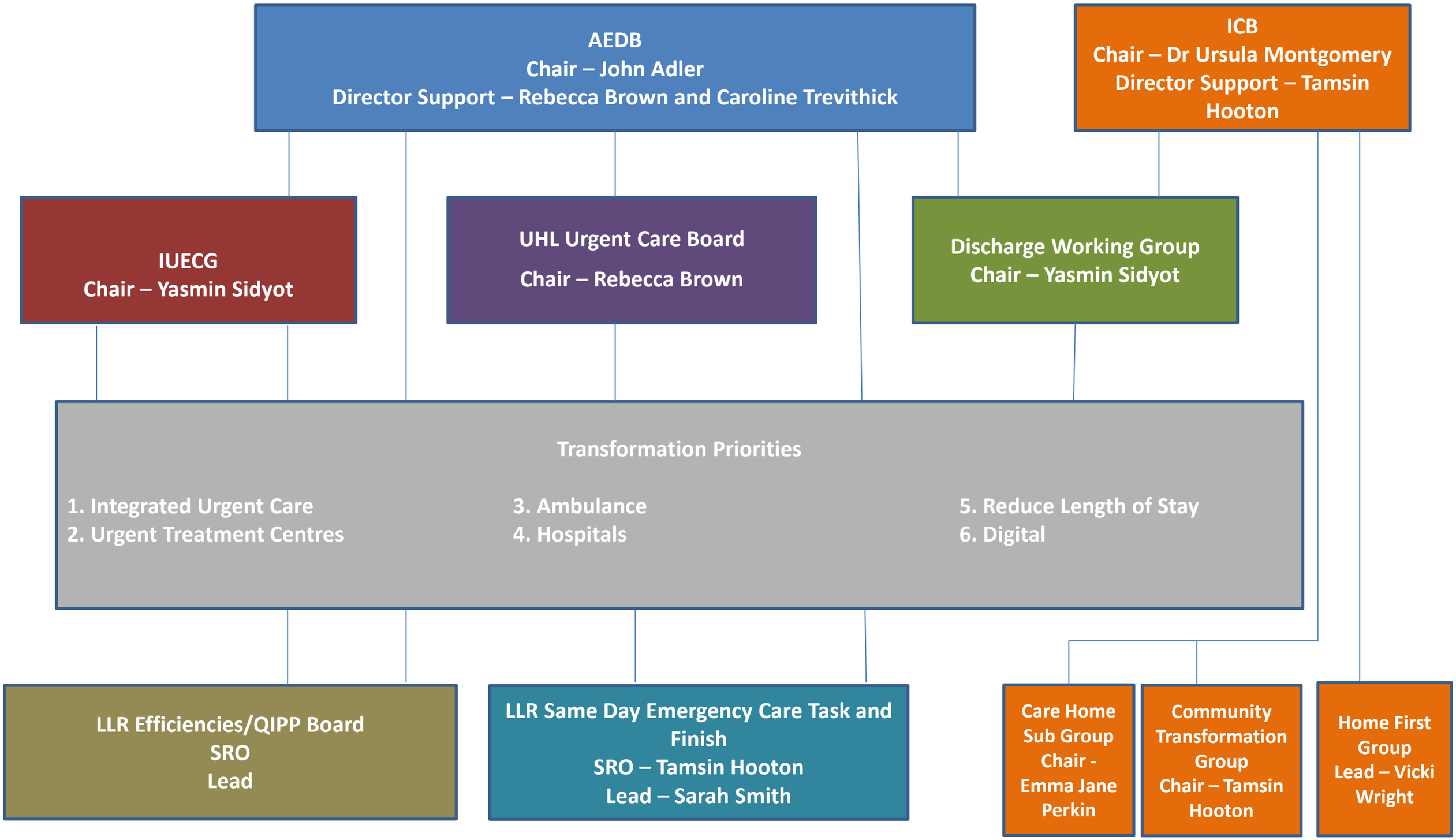
	Priorities	Impact Area	Actions	Timeline (END Date)
Digital	NATIONAL: Implementation of ECDS into T1 / T3 departments (where not already implemented)	UTC's	Rectify issues around data extraction of ECDS from Adastra	Oct 2019
	NATIONAL: UTC and IUC/CAS that have appointment booking capability	Improved booking capability across all practices in LLR	Configure remaining 50% of practices across LLR	Oct 2019
	NATIONAL: Increase the number of patients who have consented to share their additional information through the extended summary care record (e-SCR)	LLR Patients A&E UTC / CNH /Social Care / Community Pharmacy	Clinical System Searches for EOL and Frailty cohorts with no consent preference IM&T Comms drive to public to consent to share eSCR Protocols for Practice Staff on to support consent uptake on patient contact Workstreams to support drive for Consent – Long Term Conditions and Community Service Redesign	Ongoing
	NATIONAL: Every A&E, and ePrescribing pharmacy will have access to extended patient data either through the Summary Care Record or local care record sharing	Community Pharmacy	UHL Adults and Children's ED has access to TPP EPR Core (for S1 patients and SCR for EMIS patients) and can access Integrated Care Plan which	March 2021

	Priorities	Impact Area	Actions	Timeline (END Date)
Digital	services		includes EOL,LTC, Cancer and frailty data – actions around appropriate access for clinicians and clinical facilitation Liaison with local Pharmacy system suppliers/LPC and NHS Digital to establish issues with enhanced data items not being visible Currently 98% of Community Pharmacy has access to SCR. Engagement with remaining 3%	 Oct 2019 June 2020
	NATIONAL: Access to primary care records, mental health crisis and end of life plan information available in 40% of A&Es and Urgent Treatment Centres	A & E / UTC's	UHL Adults and Children's ED has access to TPP EPR Core (for S1 patients and SCR for EMIS patients) and can access Integrated Care Plan which includes EOL,LTC, Cancer and frailty data – actions around appropriate access for clinicians and clinical facilitation 3 X LLR UTC's use S1 TPP and SCR	Ongoing

	Priorities	Impact Area	Actions	Timeline (END Date)
Digital		A & E / UTC's	for (EMIS patients) and can access Integrated Care Plan which includes EOL,LTC, Cancer and frailty data Gap with MH see below.	Complete
		A & E / UTC's UTC's	MH Crisis information available in S1 record when MH services migrate to S1 (Current Gap all above) Implementation of Standards based structured info (FHIR HL7) for MH Crisis (EMIS patients) into S1 record	June 2020 June 2020
	NATIONAL: NHS 111 will be able to book people into urgent face to face appointments where this is needed.	UTC's	Resolve EMIS and BlackPear interoperability issues (Remaining circa 15% practices)	August 2019
	LOCAL : Record Sharing between Health and Social Care Proof of Concept	Integrated Discharge Team (Social Care) DTOC	Structured transfer specification for INAT data items to Local Authority Case Management systems (Liquid Logic) eSCR in Local Authorities	March 2020 July 2020

	Priorities	Impact Area	Actions	Timeline (END Date)
Digi tal	LOCAL : Digitisation Care Homes (Inc. NHS Mail, DSPT compliance and EPR implementation)	Social Care Primary Care Networks	DSPT compliance, NHS Mail and EPR capability x 10 Care Homes Establish Project development and governance Further 119 Care Homes DSPT and NHS Mail 40% of LLR care homes have EPR capability Further homes DSPT and NHS Mail	June 2020 Oct 2019 March 2021 March 2021 Ongoing
	LOCAL: EMAS Record Sharing	Paramedics Patients CAT Team	Rollout Mobile Record Viewing Capability Implement OOH SystmOne Unit in CAT team	March 2021 Dec 2019
	LOCAL: ED deflection	UTC Patients	Supplier engagement and options appraisal development for decision on approach	Oct 2019
	LOCAL: EMAS Transfers of Care to ED	ED Patients	Develop specification for EMAS structured assessment data into Nerve Centre ED	March 2020

Appendix A



Final - Governance Structure UEC

Appendix B

Transformation Plan – National and Local priorities 19/20

Integrated Urgent Care

National priorities

- Maintain a 50%+ proportion of NHS 111 calls receiving clinical assessment.
- Increase the percentage of people triaged by NHS 111 that are booked into a face-to-face appointment, where this is needed, to greater than 40% by 31st March 2020.
- By 31st March 2020, reduce 'A&E by default' selections on the Directory of Services (DoS) to less than 1% by the commissioning of appropriate services that are accurately recorded on DoS

Local priorities

- Increase clinical assessment of low acuity of 999 activity (CAT 3 and 4)
- Clear specification & offer of different tiers of care
- Better targeting of patients straight to SDEC
- Reduce length of stay on SDEC pathway
- Clinical advice and Guidance

Ambulance

National Priorities

- Deliver a safe reduction in ambulance conveyance to EDs with trajectories to be agreed between services and their lead commissioners.
- All ambulance services to meet, as a minimum, a baseline level of digital maturity including access to and usage of patient information at scene (e.g. Summary Care Record, Patient Demographic Service, Electronic Patient Record), access to service information at scene (e.g. DoS) and establishing Electronic Prescribing.
- Ensure 100% of ambulance handovers occur within 30 minutes.

Hospitals

National Priorities

- Ensure 100% of trusts are providing Same Day Emergency Care (12 hours day / 7 days week) by September 2019
- Delivering 30% of non-elective admissions via SDEC by March 2020
- Providing a frailty service (70 hours a week) by December 2019.

Local Priorities

- Bed Bureau
- Transport (Non-emergency) – Reduce the number of aborts for transport , Up to 2 patients identified each day across 5 wards in medicine who will have criteria led discharge by the nurse
- Discharge before midday – "Go Green" - more than 50% discharges across all of Medicine to occur before 12pm
- Information sharing with partners and agencies
- Perfect ward – focused MADE. (Multi Agency Discharge Event)

Urgent Treatment Centres

National priorities

- Designate the majority of urgent treatment centres (UTC) by December 2019, with any exceptions to be agreed with the Regional Director.

Reduce Length of Stay

National Priorities

- Nationally, deliver a 40% reduction in long stay patients (and long stay beds) from the March 2018 baseline by March 2020.
- Continue to make progress on reducing delayed transfers of care (DTOC) to achieve and maintain a national average DTOC position of 4,000 or fewer daily delays, with local targets to be set for 2019/20 through Better Care Fund (BCF) plans. Further detail on these expectations as well as wider requirements for BCF plans will be published later in 2019.
- Ongoing implementation of the Care Home Bed State Tracker, including embedding into Acute Trusts

Local Priorities

- Early Discharge Planning
- System to monitor patient flow
- Multidisciplinary/multi-agency discharge teams
- Home First/D2A
- Trusted Assessors
- Enhancing health in care homes

Digital

National Priorities

- Implementation of ECDS into T1 / T3 departments (where not already implemented) Implementation of any digital elements not delivered in 2018/19 such as:
- UTC and IUC/CAS that have appointment booking capability
- Increase the number of patients who have consented to share their additional information through the extended summary care record (e-SCR)
- Every A&E, and ePrescribing pharmacy will have access to extended patient data either through the Summary Care Record or local care record sharing services
- Access to primary care records, mental health crisis and end of life plan information available in 40% of A&Es and Urgent Treatment Centres
- NHS 111 will be able to book people into urgent face to face appointments where this is needed.

Local Priorities

- Record Sharing between Health and Social Care
- Digitisation Care Homes
- EMAS Record Sharing
- ED deflection EMAS
- Transfers of Care to ED

UEC Detailed National and Local Priorities

Appendix C

	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
Integrated Urgent Care	LOCAL: Increased clinical assessment of low acuity of 999 activity	Redirection of CAT 3&4 Calls to CNH - testing in Aug-Sept will inform the quantifiable impact	Elizabeth Amias	Pilot implementation to test model agreed ahead of implementation in Q4 Testing to start on 19/08/19 – 02/0919. Following actions to be undertaken: Staffing the admin position – all agreed to look at potential staffing Confirmation of retesting Consider the electronic route back into EMAS Review process map	August – September 19 January 2020	EOL Home First IM&T Discharge Programme IM&T HVS EMAS (Regional) Primary Care WLCCG UCCs/EPC ELRCCG UCCs/EPC LCCG Primary Care Hubs UEC DoS
	LOCAL: Clear specification & offer across the LLR IUEC tiers of care Model	Increase use and offer of Extended primary care in line with the PCN ambitions - Increase	LLR CCG Primary Care Leads	Updated primary care offer	September 2019	EOL Home First IM&T

d Ur ge nt Car	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
		uptake of extended access to over 80% across LLR				
		Specifications: Emergency Front door Community based Access	Vicki Enright Lead TBC	Specification agreed Agree UTC offer CCG	July March 2020	Home First Paediatrics IM&T
		(MADD event findings – Circa 10% of walk ins advised by their GP to go to A&E) -		Senior clinical review which provides link to consult connect and bed bureau		
	LOCAL: Better targeting of patients straight to SDEC	Direct access to Clinics LOS on the SDEC Pathway in line with national ambition	Sarah Smith SDEC group	Develop Service Spec for SDEC ID Pathways & KPI's for each unit UHL planning commenced 25th July 2019	September 19	SDEC Programme 111 (regional) CNH
		SDEC acute and out of hospital offer	SDEC Group	Develop Model for diagnostic offer across out of hospital sites - LuCC	September 19	SDEC Programme 111 (regional)

d Ur ge nt Car	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
		to be developed to increase community based access for diagnostics (Currently in PDSA phase)		Re-launch of 10 ambulatory care pathways to LUCC and mandated EMAS conveyance to LUCC goes live 5th Aug 2019		
		(MAAD event findings – Circa 15% ambulance conveyances potentially unnecessary) LOS on the SDEC Pathway in line with national ambition SDEC acute and out of hospital offer to be developed to increase community based access for diagnostics (in PDSA phase)		UCC conveyance mandated (EMAS/LLR) Review of 10 cases per week (over 3 months) on non-admitted ambulance conveyance to understand cases and learning for clinical feedback ID Pathways & KPI's for each Unit UHL Planning commenced 25th July 2019 Develop Model for diagnostic offer across out of hospital sites - LuCC Re-launch of 10 ambulatory care pathways to LUCC and mandated EMAS conveyance to LUCC goes live 5th Aug 2019	Sept 19	

d Ur ge nt Car	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
	LOCAL: clinical advice & Guidance	Direct access to Clinics Increase use of SDEC Pathways	TBC	Review current clinical Advice and guidance offer Develop new model for clinical advice and guidance that fits with the development of PCNS across LLR UHL planning commenced 25th July 2019	February 2020	SDEC Programme Primary Care Networks Community Service Redesign
		(MAAD event finding's – Circa 20% of walk ins did not consider alternatives to A&E)		Injuries – ambulatory pathways to focus on 18/25 age group – targeted communications (fresher's week)	December 2019	
	LOCAL: Reduce length of Stay SDEC Pathway	Increase in 0 LOS Reduction in NEL Admissions	SDEC Group	Implement actions as identified by through the National Acceleration Programme provided by NHS Elect . – next visit on 24th October 2019 UHL planning commenced 25th July 2019	September 19	SDEC Programme UHL Flow

d Ur ge nt Car	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
	Local: Primary Care	Ensure that all extended access capacity is utilised to reduce demand on ED Targeted demand management with GP Practices – LLR approach Accessing City hubs	David Muir – West Paula Vaughan – ELR Arlene Neville – West City and East - TBC	West – implement agreed operational delivery changes to ensure optimised appointment availability and provision – work with referring practices to ensure optimised and strategic use of available capacity Agree a population health based demand mgt approach – June completed Discuss the approach with localities – June completed Test approach with one outlier practice and develop action plan – June/July completed Feedback progress to F&P and West GB – July completed Present and discuss approach at West ACD meeting – 6 Aug – in progress Visit remaining outlier	October 19	

d Ur ge nt Car	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
				practices – Aug to Mid Oct – in progress		
	Local: Reduce A&E attends 18-25 group	Reduce A&E attends 18-25 group. High volume of patients leave before treatment/ do not need treatment. Injuries – ambulatory pathways use for this age group - Role of SDEC and the redirection to LUCC	Vicki Enright Sarah Smith	To reduce: 20% by 2019/20 50% by 2020/21	December 19 December 2020	

d Ur ge nt Car	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
	Local: Mental Health support	Currently 111 dispositions into ED is 34% Reduction 1429 DX92 dispositions from 111 into ED Increase referral flow into CNH Reduce EMAS conveyance for low level into ED	Elizabeth Amias /DHU &LPT Sarah Warmington (MH Commissioning Team) Matt Pickard & Alyson Taylor	To provide MH support to CNH.- MH Practitioner into CNH – test phase to commence in Late September Options appraisal during mobilisation Implement additional support Improve Access into crisis team for CNH, EMAS and GP without GP face to face review dispositions (34% June 18-May 19) Frequent attenders work to develop shared care plans for known cohort impacting on attendances for VB11Z and VB09Z Reduction of 1429 DX92 dispositions Implementation of the CORE 24 standards	October 19 April 2020 Sept 2019 testing to commence April 2020 – although would be able to implement this earlier if the MH crisis funding is available in Q3 2019/20 April 2020 onwards – the funding to support this is released in April 2020	

d Ur ge nt Car	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
	Local: Reducing Care Home Admissions	Reducing 1000 patients on a 7 day stay	Vicki Enright & Emma Jane Perkins	Accelerate the enhanced health in care homes plan by CH Subgroup to achieve a further reduction in care home admissions based on the success in 18/19 Implementation of the digital solutions – extending the current work further Delivery of telemedicine and scoping further ways in which this can be used to better manage patients living in care homes	December 19 October 19 March 20	
	Local: LLR Falls Programme	A reduction in FEMUR fracture acute interventions and a reduction in consultant led first out-patient appointments where patients are triaged assessed and managed within a community setting	Sarah Smith	Postural Stability Exercise Programme – embedded in County and Rutland. City – went live 1st April 2019 with non-recurrent funding for 12 months Electronic Falls Risk Assessment – phased implementation commences in Aug. Non Blue Light Service Response – Coalville PDSA	Completion June 2020 Aug 2019 Aug 2019 July 19	

d Ur ge nt Car	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
				commenced 10th July 2019 Therapy Triage Service – embedded in County and Rutland Training & Equipment in Care Homes – PDSA to commence Autumn 2019	Sep 19	
	NATIONAL: Maintain a 50%+ proportion of NHS 111 calls receiving clinical assessment.	Increase in proportion of 111 calls receiving clinical assessment Increase activity in CNH	IUEC Group Elizabeth Amias	Enhance the clinical assessment of low acuity ambulance activity Review DoS to identify further opportunities for clinical assessment rather than A&E by default	October 2019	IUEC Programme CNH Development Regional 111 Programme
	NATIONAL: Increase the percentage of people triaged by NHS 111 that are booked into a face-to-face appointment, where this is needed, to greater than 40% by 31st March 2020. By 31st March 2020, reduce 'A&E by default' selections on the Directory of Services (DoS) to less than 1% by the commissioning of appropriate services that are accurately recorded on DoS	Increase in percentage of patients booked into face to face consultation to over 40% from 37%	IUEC Group Elizabeth Amias	review our model of booked appointments vs walk in access across LLR implementing 1 GP appointment available to NHS111 for every 3000 patients across LLR Implementation of MiDoS	December 2019	IUEC Programme Primary Care Networks

	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
Urgent Treatment Centres	NATIONAL: Designate the majority of urgent treatment centres (UTC) by December 2019, with any exceptions to be agreed with the Regional Director.	Designation of UTCs in LLRs	IUEC Group Yasmin Sidyot	Review the current designated sites and determine whether these remain as the designated UTCS for LLR and they can continue to fit into the LLR IUEC Model	December 2019	SDEC Programme IM&T/LHIS LLR Primary Care Strategy Extended Primary Care Access

	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
Ambulance	LOCAL: Redirection of ambulance conveyance into alternative pathways	MADD event findings - paramedics decision-making not always consistent or protocols not consistent in and out of hours Improve consistency of protocols Increase non-conveyance by 1% in Q3 and 1.5% in Q4	Jade Atkin Sarah Smith and Dan Webster Dan Webster, Julie Dixon and Russ Smalley	Same day access to chest pain clinic – 24 hour pathway – learning from Notts and Northants Implement mandated conveyance to LUCC by EMAS – commences 2nd August Implement pathways to redirect conveyance straight to CDU Access to Health Care professional line (HCP) Implementation of MiDoS Training EMAS staff around mental health crisis/emotional distress	October 2019 August 2019 August 2019 In Place – monitoring use through failed pathways data TBC once agreed by partners October 2019	

ɔ — ɑ	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
	NATIONAL: All ambulance services to meet, as a minimum, a baseline level of digital maturity including access to and usage of patient information at scene (e.g. Summary Care Record, Patient Demographic Service, Electronic Patient Record), access to service information at scene (e.g. DoS) and establishing Electronic Prescribing.	Improved clinical decision making Improved patient outcome Decreased EMAS on scene time Conveyance avoidance due to improved overall clinical picture	EMAS SLT Lead & regional commissioning	Improve use of system one Potential of My DOS EMAS ePRF already widely used	December 2019 December 2019 completed	System one Nerve centre EMAS ePRF
	NATIONAL: Ensure 100% of ambulance handovers occur within 30 minutes	4 hr standard Ambulance handover turnaround performance Improved quality of care More available resources to serve unseen patients in the community -(Matthews story) MADD event findings – Ambulance assessment inconsistent and variation between process and workforce	AEDB LLR CCG UEC EMAS GM/SDM UHL COO	Improve Fit to sit Direct to clinic Transport Improved collaborative escalation procedure Mapped LLR Against NHSE/I Guidance and tailored to suit the locality Operational group now meets every 2 weeks to enable continuous oversight and improvement Visits arranged to Newcastle and Leeds to investigate learning opportunity Shared EMAS/UHL conveyance modelling to enable awareness of potential peak activity AHD group work – tracker in department role. UHL and EMAS will evaluate the	Fit to sit – **Complete** Direct access to clinic – **Complete** however looking into further opportunity Learning visits complete Action Plan to developed post learning visit by 9th August 2019	UHL EMAS

	Priorities	Impact Area	Lead	Actions	Timeline	Interdependencies
		MADD event findings - Handover delays occur when there are 4-5 ambulances arrive within 15 minutes		requirement of a HALO and a nurse co-ordinator in ambulance assessment role Fit to sit Send EMAS straight to clinic Escalation procedure – improve communication between operational levels Nurse co-ordinator	Conveyance modelling by the end of July	

	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
Hospitals	LOCAL: Bed Bureau	Improve sign posting and utilisation of alternative ambulatory pathways Management of GP referrals for patient transport MAAD event findings – Bed Bureau relay function and acceptance is GP referral led as opposed to access criteria led	Sarah Smith Elizabeth Amias Dan Webster Julie Dixon Joanna Clinton DHU	Task and Finish Group established Revised Model developed and agreed by partners Test of revised model Project group and lead to be set up working with consult connect and aligning with transport improvement group	August 2019 September 2019 December 2019	Primary Care IUC IM&T

Hospitals	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
	LOCAL: Transport (Non-emergency) – Reduce the number of aborts for transport , Up to 2 patients identified each day across 5 wards in medicine who will have criteria led discharge by the nurse	Increase flow of discharge earlier in the day – Increase number of discharges that occur before 12pm – currently approximately 30% discharges occur before 12 – to increase to more than 50% discharges across all of Medicine to occur before 12pm Reduce the number of aborts for transport	Joanna Clinton	LLR Transport Improvement Group will lead on developing the plan for Priority 1. UHL, LPT and TASL to ensure that the transfer of patients from UHL to community Hospital are planned the previous day so that those patients are transferred by 10 am	September 2019	
	LOCAL: Discharge before midday – "Go Green" - more than 50% discharges across all of Medicine to occur before 12pm	Up to 2 patients identified each day across 5 wards in medicine who will have criteria led discharge by the nurse	Sharon Harding Rachel Marsh – Clinical Leadership	Tiger Team to be set up by Lead Nurse for Medicine to identify the 5 wards. Develop PDSA and evaluate the impact	June 2019 First PDSA August 2019	
		Summary TTOs ready for each patient day in advance of discharge date	Sharon Harding Rachel Marsh – Clinical Leadership	Tiger Team to be set up by Lead Nurse for Medicine to identify the 5 wards. Develop PDSA and evaluate the impact	September2019	
	LOCAL: Information sharing with partners and agencies	Transfer of clinical information electronically without need for discharge summary.	LLR IM&T UHL medicines CMG reps	UHL Team to liaise with LLR IM&T team to ensure that this is part of the Digital Strategy.	September 2019	

	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
Hospitals		Digital solution implementation: increase use of SCR and SystmOne which is already available	LLR IM&T UHL medicines CMG reps	Implementation of Remote access for community clinicians to Nerve Centre	TBC	
	LOCAL: Perfect ward – focused MADE. (Multi Agency Discharge Event)	Minimise number of medicine outliers Aim for no outlying after 9pm Implementation and embedding consistent and safe practice of SAFER and R2G	UHL to lead Requires strong clinical leadership, Jackie Wright, Ashraf Osman, Rachel Marsh (to identify the who), Sue Burton (nursing perspective), Sharon Harding Chrissie David King (pharmacy)	2 wards in Medicine - focussed MADE to create flow and embedding culture, practice, behaviour that supports good and safe practices - planned discharges	August 2019	
	LOCAL: Reducing readmissions	Reducing readmissions from frequent flyers Reduction in readmission – further analysis of the data planned to set trajectory 6th August	Mark Pierce & Alyson Taylor UHL LPT CCG – DWG	Frequent flyers – to focus on individual patients. Top 10 between UHL, Community and EMAS Implement post discharge support best practice as per the Aston University research – adopt into LLR	December 2019 October 19	

	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
Hospitals				https://www2.aston.ac.uk/news/?simple-aftercare-slashes-nhs-hospital-readmissions		
	NATIONAL: Ensure 100% of trusts are providing Same Day Emergency Care (12 hours day / 7 days week) by September 2019	Deliver the standard for SDEC Increase usage of GPAU and CDU	LLR SDEC Group UHL – Rebecca Brown	Participate in the National Acceleration Programme for SDEC with NHS Elect Expand the scope of GPAU and review CDU	September 2019	
	NATIONAL: Delivering 30% of non-elective admissions via SDEC by March 2020	30% reduction in non-elective admissions Increase in 0 LOS	LLR SDEC Group Sarah Smith	UHL currently deliver same day emergency care via GPAU, TIA, and DVT. SDEC Pathway for GP referred patients in place on the Emergency floor (GPAU) monitor LOS on this unit to ensure the pathway is efficient as possible	March 2020	
	NATIONAL: Providing a frailty service (70 hours a week) by December 2019.	Increase in Frailty provision by 70% Increase in activity through AFU and EFU	LLR SDEC Group Julie Dixon	The Frailty Emergency Squad (FES) operate in the Emergency Department and in the Emergency Frailty Unit 08:00-18:00 7/7. This MDT team include a consultant geriatrician, Advanced Nurse Pracititioner, pharmacist, discharge unit, OT and physio	December 2019	

	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
Reduce Length of Stay	LOCAL: Early Discharge Planning	Improve Discharge Co-ordination within Adult and older people MH services	LPT – AMH and MHSOP	Develop model for discharge co-ordination based on the IDT principles Adapt the IDT principles from UHL to implement into AMH and MHSOP	October 2019	DWG IDT UHL LPT AMH
		Improve Self-Funder – Support to patients, their families and staff	Leicester City Council	Appoint joint post across LLR for Self-Funder Project Lead Develop an LLR Self Funder Information advice and guidance strategy and process	April 2019 June 2019	IDT DWG
		Improve Discharge planning in electives – particular focus on orthopaedics		Implementation of LLR process across all acute and non-acute sites in LLR	October 2019	Planned Care NWB DWG IDT
	LOCAL: Systems to Monitor Patient Flow	Implementation and roll out of Integrated Needs Assessment Tool	LLR Tiger Team for IDT	Roll out of INAT tool across all discharge pathways and into community hospitals	July 2019	IM&T Home First DWG
		Increase the Utilisation of care home bed tracker from 60% to 80%	LLR Project support hosted by Rutland County Council	Care home bed tracker currently 67% utilised Engagement of care homes to	Ongoing	Flow IDT Home First Care Home Sub

	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
				utilise the tracker to update their bed state Engagement of IDT and discharge teams across acute and non-acute including ASC to utilise the tracker to find suitable homes	Ongoing	Group ICB ASC
		Roll out of red bag scheme across all care homes in LLR	LLR	Roll out to all care homes to utilise red bag. LLR 28% complete (City 50% complete, 100% by end of Aug 19. West 50% by the end of Aug 19. East 25% complete)	August 2019	Flow IDT Home First ASC
		Development of Local Decisions Unit (LDU) to support information flow from hospital to community services	Community Services Redesign LPT & LA's	Development of the service offer blueprint for Leicester, Leicestershire and Rutland Finalisation of service offer and model	June 2019 August 2019	Home First CSR DWG IDT ASC
	LOCAL: Multidisciplinary/multi-agency discharge teams	IDT – embedding culture and behaviour	LLR Discharge Working Group (DWG)	Review and redefine case management across the pathways for LLR Expansion of Housing Enablement Team	August 2019 August 2019	
	LOCAL: Home First/D2A	Increase the use of	LLR DWG and	Review access to D2A Home	August	Community

	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
		Discharge to Assess Home Pathway across City and County	Community Transformation Group	pathways in line with the community service redesign work Implementation of the Pull Model as part of CSR Review and develop therapy model that better supports D2A home Implementation of NWB action Plan	2019 Sept – Oct 2019 Sept 2019 Dec 2019	Service Review ICB Care Home Sub Group IDT ASC LPT
	LOCAL: Trusted Assessors	Increase utilisation of trusted assessment and assessors to support transfer and discharge of patients across acute and non-acute	Leicestershire County Council UHL&LPT	Implementation of Trusted Assessment Model for Care Homes Evaluation of the impact of the model in reducing delays and LOS Embedding TA principles and competencies to support IDT	May 2019 September 2019 August 2019	Community Service Review ICB Care Home Sub Group IDT
	LOCAL: Enhancing Health in Care Homes	Reduce the number and length of delay relating to awaiting care homes to assess and accept patients for long-term placements		Rollout of INAT with Care Homes – using the TA to support this	August 2019	Trusted Assessment Home First CSR
		Improve the sharing of information between care homes and hospitals to facilitate and support	LLR & IM&T	Implementation of digital solutions with care homes to support better exchange of information – NHS.net email account and implementation	December 2019	

	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
		more timely and safe discharges.		of EPR- NHS Digital funding supporting the implementation and roll out of this across a number of care homes in LLR		
	NATIONAL: Nationally, deliver a 40% reduction in long stay patients (and long stay beds) from the March 2018 baseline by March 2020.	40% reduction in long stay patients by March 2020 – trajectory to be developed	LLR DWG	Utilisation of regular MADE to embed changes in practice and consistency of Red to Green Embed long stay Wednesdays and system escalation calls to support safe and timely discharge of patients	March 2020	
	NATIONAL: Continue to make progress on reducing delayed transfers of care (DTOC) to achieve and maintain a national average DTOC position of 4,000 or fewer daily delays, with local targets to be set for 2019/20 through Better Care Fund (BCF) plans. Further detail on these expectations as well as wider requirements for BCF plans will be published later in 2019	Delivery of BCF Standards	LLR DWG	See above local actions under the delivery of high impact actions	TBC - guidance just published awaiting technical guidance	
	NATIONAL: Ongoing implementation of the Care Home Bed State Tracker,	Increase participation to 70% Increase usage 50%	LLR Care Homes Sub Group	See LOCAL Enhancing Health in Care Homes that outlines the actions to deliver this standard	March 2020	

	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
	including embedding into Acute Trusts					

	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
Digital	NATIONAL: Implementation of ECDS into T1 / T3 departments (where not already implemented)	UTC's	DHU	Rectify issues around data extraction of ECDS from Adastra	Oct 2019	Supplier technical data extraction capability
	NATIONAL: UTC and IUC/CAS that have appointment booking capability	Improved booking capability across all practices in LLR	DHU	Configure remaining 50% of practices across LLR	Oct 2019	Supplier Technical
	NATIONAL: Increase the number of patients who have consented to share their additional information through the extended summary care record (e-SCR)	LLR Patients A&E UTC / CNH /Social Care / Community Pharmacy	CCG's	Clinical System Searches for EOL and Frailty cohorts with no consent preference IM&T Comms drive to public to consent to share eSCR Protocols for Practice Staff on to support consent uptake on patient contact Workstreams to support	Ongoing	Patients wanting to Consent Community Services Redesign and all other SCR workstreams Target to achieve - all people with LTC to have access to eSCR: LTC Baseline With access : 86,000 (LLR) LTC Target by Dec 2020:

Digital	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
				drive for Consent – Long Term Conditions and Community Service Redesign		296,888 (LLR) LTC Additional 210,888 to consent
	NATIONAL: Every A&E, and ePrescribing pharmacy will have access to extended patient data either through the Summary Care Record or local care record sharing services	Community Pharmacy	UHL	UHL Adults and Children's ED has access to TPP EPR Core (for S1 patients and SCR for EMIS patients) and can access Integrated Care Plan which includes EOL,LTC, Cancer and frailty data – actions around appropriate access for clinicians and clinical facilitation	March 2021	Future reliance on GP connect to support contextual view within NC
			Local Pharmaceutical Committee (LPC)	Liaison with local Pharmacy system suppliers/LPC and NHS Digital to establish issues with enhanced data items not being visible	Oct 2019	Pharmacy System Supplier capability
				Currently 98% of Community Pharmacy has access to SCR. Engagement with remaining 3%	June 2020	Prioritisation due to release of new pharmacy contract

Digital	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
	NATIONAL: Access to primary care records, mental health crisis and end of life plan information available in 40% of A&Es and Urgent Treatment Centres	A & E / UTC's	UHL	UHL Adults and Children's ED has access to TPP EPR Core (for S1 patients and SCR for EMIS patients) and can access Integrated Care Plan which includes EOL,LTC, Cancer and frailty data – actions around appropriate access for clinicians and clinical facilitation	Ongoing	UHL RA services HSLI Funding
		A & E / UTC's	DHU	3 X LLR UTC's use S1 TPP and SCR for (EMIS patients) and can access Integrated Care Plan which includes EOL,LTC, Cancer and frailty data Gap with MH see below.	Complete	LPT Strategic Direction to consolidate to a single EPR (S1) Current MH EPR migration to S1 June 2020
		A & E / UTC's	UHL	MH Crisis information available in S1 record when MH services migrate to S1 (Current Gap all above)	June 2020	Supplier led Interoperability Programme – FHIR standards signed off
		UTC's	DHU	Implementation of Standards based structured info (FHIR HL7)	June 2020	Gap area MH – all others ok

Digital	**Priorities**	**Impact Area**	**Lead**	**Actions**	**Timeline (END Date)**	**Interdependencies**
				for MH Crisis (EMIS patients) into S1 record		
	NATIONAL: NHS 111 will be able to book people into urgent face to face appointments where this is needed.	UTC's	DHU	Resolve EMIS and BlackPear interoperability issues (Remaining circa 15% practices)	August 2019	DHU resources

	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
Digital	LOCAL : Record Sharing between Health and Social Care Proof of Concept	Integrated Discharge Team (Social Care) DTOC	Leicestershire County Council	Structured transfer specification for INAT data items to Local Authority Case Management systems (Liquid Logic) eSCR in Local Authorities	March 2020 July 2019	HSLI System Funding Supplier capability – LL and NC Nottingham LA team
	LOCAL : Digitisation Care Homes (Inc. NHS Mail, DSPT compliance and EPR implementation)	Social Care Primary Care Networks	Leicestershire County Council	DSPT compliance, NHS Mail and EPR capability x 10 Care Homes Establish Project development and governance Further 119 Care Homes DSPT and NHS Mail 40% of LLR care homes have EPR capability Further homes DSPT and NHS Mail	June 2019 Oct 2019 March 2021 March 2021 Ongoing	HSLI Funding Digital Social Care Pathfinders Funding Care Homes Infrastructure
	LOCAL: EMAS Record Sharing	Paramedics Patients	EMAS	Rollout Mobile Record Viewing Capability	March 2021	National SCR programme NHSD Identify Management Service

Digital	Priorities	Impact Area	Lead	Actions	Timeline (END Date)	Interdependencies
		CAT Team		Implement OOH SystmOne Unit in CAT team	Dec 2019	Future of RBACS smartcards
	LOCAL: ED deflection	UTC Patients	UHL	Supplier engagement and options appraisal development for decision on approach	Oct 2019	NC GP Connect Assurance for Direct Appointment booking as consumer HSLI Funding
	LOCAL: EMAS Transfers of Care to ED	ED Patients	EMAS	Develop specification for EMAS structured assessment data into Nerve Centre ED	March 2020	Medusa approval to release data extracts National Ambulance Spec for TOC GP and Care Connect Programme HSLI Funding

Appendix D

EMAS variation Proposal to NHSEI

10a Assurance

The national CQUIN specifies four nationally approved systems. The proposal from EMAS is to access the patient record via the ***GP Connect System***, which is not one of the four systems.

Crews will use their GETEC devices (the handheld devices that electronically record and submit patient record forms (ePRF)) to enter the web based system which is compatible with other systems to allow their crews to view the patient record.

This will allow EMAS to view the record only, they will not be able to edit any patient record. The crews will be able to see patients medications, allergies etc, their current health and wellbeing, any current or outstanding issues, details of any referrals, observations or immunisations, and also view the last three contacts with healthcare professionals.

The system will allow EMAS to store a copy of the record so it will be possible to identify if the crews access the records or not, and through the ePRF record, the GP will also be able to see what information the crews accessed.

The coordinating commissioning team view is that this proposal will allow EMAS to demonstrate that they can access the patient record, and therefore achieve the outcomes specified within the national documentation, and therefore recommend that this proposal is agreed as a local variation.

10b Demonstration

The second half of the CQUIN is for EMAS to then demonstrate that they have accessed the patient records. The national CQUIN milestone states 5% during Q3 and Q4. This CQUIN is not applicable for Q1 and Q2.

EMAS have confirmed that there is no technical reason why this system cannot be implemented for 1st October however they will need GPs to grant access for crews. EMAS have confirmed that they have begun to link in with local PCNs, however may need commissioner support in this area.

EMAS have proposed two variations to this part of the CQUIN;

1. EMAS have proposed that Q3 should commence once the system is fully implemented. For example, if the system isn't fully implemented until 10th November, then Q3 demonstration would only count for the period 10th November – 31st December.

2. EMAS have also proposed that there are some exclusions to the count (contrary to the national CQUIN which clearly defines the count). The four proposed exclusions are;
    a. C1 calls
    b. HCP calls

c. VAS/PAS crews - EMAS have stated that VAS/PS crews wouldn't be able to access the patient record as they do not have the GETEC devices – VAS/PAS PRFs are completed on paper.
d. Where no NHS number is identified.

The coordinating commissioner view is that the national CQUIN is quite clear in terms of what is expected and although the rational for the proposed exclusions are understood, the target for Q3 and Q4 is only 5%.
We have sought advice from NHSE, and they too have stated that the target of 5% should be a cumulative position over Q3 and Q4 and agree that this should be achievable without any delay in timeline or exclusions.