Report to:	**Public Board of Directors**	**Agenda item:**	**10**
Date of Meeting:	**22 February 2017**		

Title of Report:	**Urgent Care Collaborative Board Update**
Status:	**For Discussion**
Board Sponsor:	**Francesca Thompson, Chief Operating Officer**
Author:	**Suzanne Wills, Divisional Manager Medicine** **Sarah Hudson, Deputy Divisional Manager Medicine**
Appendices	**None**

1. Executive Summary of the Report

To update the Management Board on the 2016/17 RUH Urgent Care Collaborative Board programme performance. The report reflects information up to and including the 31st January 2017.

2. Recommendations (Note, Approve, Discuss)

The Management Board are asked to note the following:

- 4 Hour performance did not meet STF trajectory or the internal improvement trajectory.
- Delivery of the identified schemes to improvement performance in month
- Factors affecting performance include significant increase in ambulance conveyance activity (+16.8% variance) and Emergency Department attendances and presentation increases (+12.2% and 8.2% respectively)

Areas for improvement in February 2017:

- Frailty direct admissions with ongoing support of Frailty Flying Squad.
- MAU direct admits
- Active Recovery Team (ART)
- Embedding the SAFER principles
- Relaunch of the Specialty Group

3. Legal / Regulatory Implications

Care Quality Commission (CQC) Registration 2016/17

4. Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)

The 4 hour performance is currently on the risk register ID: 634

5.	Resources Implications (Financial / staffing)
Any requests for investment linked to this programme will continue to be reviewed monthly by the Urgent Care Collaborative Board and as directed by the Board, business cases taken through the usual Trust process. Operational Resilience and Capacity Funding 2016/17 monthly monitoring. The Urgent Care Improvement Board will review progress monthly against the National Frailty CQUIN to support successful implementation and milestone attainment.	

6.	Equality and Diversity
All services are delivered in line with the Trust's Equality and Diversity Policy.	

7.	References to previous reports
Monthly 4 hour performance reports and ECIST Recommendations.	

8.	Freedom of Information
Public	

Royal United Hospitals Bath NHS
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Urgent Care Improvement Programme: 4 Hour Performance Report February 2017
1.0 Overview - Executive Summary

Current Performance

- January 2017 four hour performance was not achieved: **73.7%** (All Types)

Improvement Trajectory

- Performance did not achieve the revised internal trajectory: **81.5 %** (All Types)

4 Hour Improvement Programme

The RUH 4 hour improvement programme has been developed considering the following;

1. Emergency Care Improvement Programme (ECIP) diagnostic supported by the RUH Business Intelligence Unit (BIU)

2. RUH Urgent Care Nine Point Plan for improvement 2016/17

3. National ECIP Rapid Improvement Guides. A series of practical rapid improvement guides for health and social care staff to improve urgent and emergency care:

    - Making internal professional standards work for you
    - Identifying and managing frailty at your front door
    - Optimising medicines discharge to improve patient flow
    - Red and Green bed days
    - Multi-agency Discharge event
    - Expected date of discharge and clinical criteria for discharge
    - Maximising AEC services
    - 6As of managing emergency admissions
    - Safer Patient Flow bundle
    - Reviewing stranded patients

4. NHSI recommendations
5. ECIP recommendations
6. A&E local delivery board improvement plan
7. STP Urgent Care Subgroup
8. CQC feedback
9. Winter planning - including capacity and demand

Programme Key Deliverables

The 4 hour improvement programme focuses on the following key areas

1. Ambulatory Care
2. SAFER
3. Discharge

Delivery will be via the Front Door Group, Specialty Group and Discharge Board.

Key performance indicators (KPIs) have been considered for each of the three key delivery areas and schemes within these. In addition the NHS Improvement KPIs for daily reporting have been included for daily, weekly and monthly monitoring (page 1).

Factor Affecting Performance (Appendix 1)

- Ambulance conveyance rates in January peaked at +16.8% above five year range
- Weekly attendance and emergency admissions +8.2% and 12.2% respectively above the last financial years activity.
- Negative impact on bed capacity due to high numbers of influenza and noro-virus
- Delays in discharges / increased length of stay

Governance and Assurance

- Weekly Urgent Care Action and Review Group – aim to provide challenge and pace to delivery of the agreed actions within the improvement programme
- The RUH Urgent Care Collaborative Board is responsible for the programme and reports monthly to both Management Board and Board of Directors
- Fit for the Future Board provides detailed additional Non-Executive Director level challenge to the improvement programme
- A&E Delivery Board focus and implementation of the national A&E improvement plan required to support performance recovery; BaNES CCG leading an improvement plan support by NHS England
- ORCP funding - impact assessment required by the A&E Delivery Board
- Monthly Tripartite meetings, ceased following NHS Improvement review of RUH Governance rating. Monthly NHS Improvement oversight meetings are in place

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At a Glance Weekly Scorecard

Key Area	Description	Metric	Target	Dec-16	Jan-17					Feb-17	Current Trend
				25/12/2016	01/01/2017	08/01/2017	15/01/2017	22/01/2017	29/01/2017	05/02/2017	
Trust	ED 4 Hour Breaches			147	228	445	379	355	428	451	
	ED 4 Hour Performance		95.0%	89.5%	86.3%	70.6%	74.4%	76.3%	72.4%	71.6%	
	Minors Performance	4 Hour Non Admitted Minors Performance	96.0%	97.3%	95.7%	91.8%	94.5%	94.2%	93.3%	93.1%	
Ambulatory Care Pages 5-7	Increase non-elective ambulatory activity	Ambulatory Care Admitted Activity	108	110	72	91	107	103	93	120	
	Direct Admissions	ESAC Activity	31	41	22	12	25	37	28	26	
		GP Direct Admissions to SAU	40	37	40	23	17	10	9	14	
		GP Direct Admissions to MAU	20	20	5	2	27	0	17	0	
	Frailty Pathway	ED and GP Direct Admissions to ACE	5	1	3	3	3	9	7	0	
	Hot Clinics	Ambulatory Cardiac Hot Clinic Attendances	7	0	4	1	4	11	12	8	
SAFER Pages 8-12	Senior Review	ED Specialty 4 Hour Breaches	4	8	10	9	6	15	9	10	
	>7 Day LoS Review	Patients with a >7 Day LoS - *"Stranded Patient"*	261	302	310	334	336	336	325	329	
	Early Discharge	% Discharges Before Midday	33.0%	18.4%	16.9%	13.1%	16.8%	15.8%	18.7%	17.1%	
	Flow of Patients	MAU Transfers by 10am	20	4	13	23	18	14	13	10	
		SAU Transfers by 10am	5	4	8	5	9	7	13	16	
		Average Daily Medical outliers	15	22	25	46	56	52	60	67	
Discharge Pages 13-15	Integrated Discharge Service (IDS)	IDS forms completed		136	123	137	113	116	139	113	
	Silver Patients	Silver Patients identified on discharge tracker	75	52	26	38	32	48	54	43	

2.0 Current Performance Against Trajectory

National target 95%

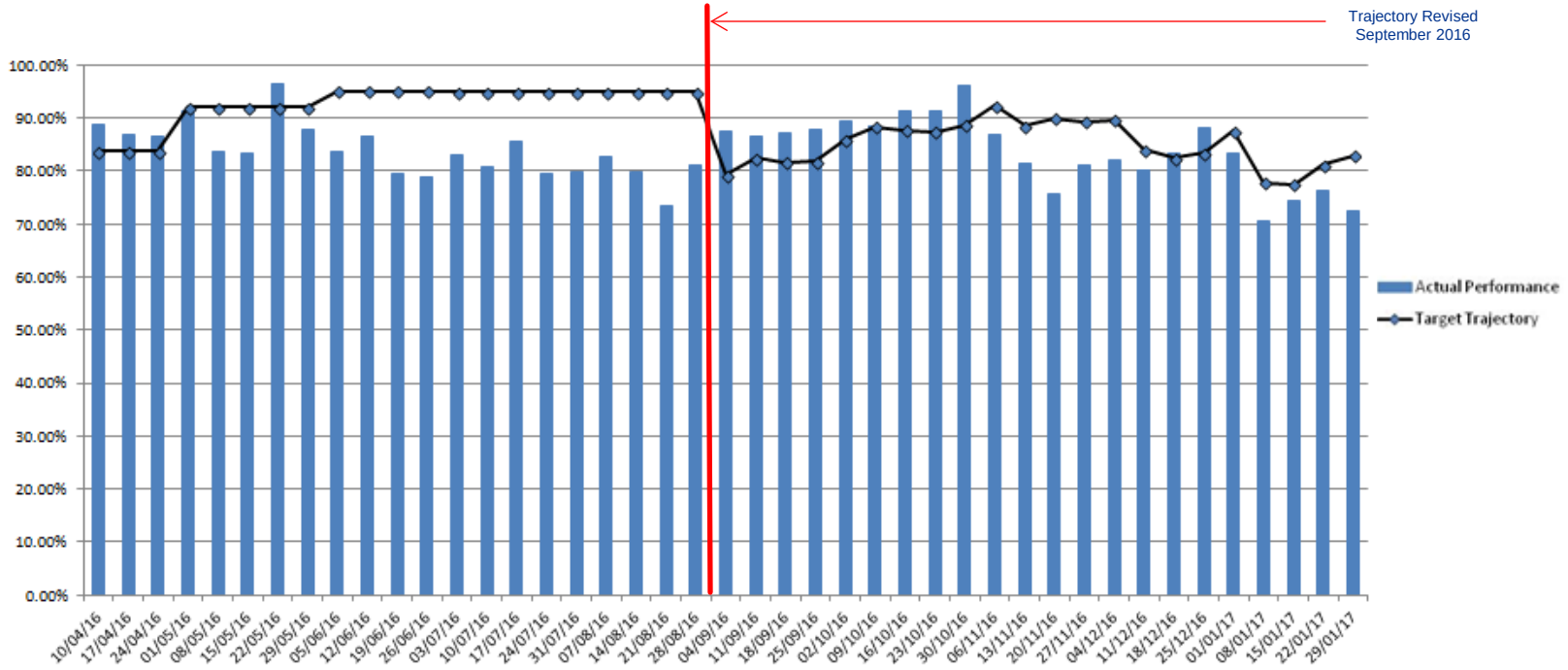
RUH 4 hour performance trajectory revised from September 2016

- Target 81.5% January 2017

The graph and tables show the current trajectory performance which is updated daily with actual performance

Key action to continue to review 4 hour performance daily linking the 4 Hour Improvement Programme

A&E Delivery Board ORCP actions are included in the trajectory



Month	Attendances	4 Hour Breaches	Performance
April 2016	6809	890	86.9%
May 2016	7107	880	87.6%
June 2016	6972	1299	81.4%
July 2016	7477	1322	82.3%
August 2016	7006	1428	79.6%
September 2016	6979	832	88.1%
October 2016	7238	625	91.4%
November 2016	6855	1281	81.3%
December 2016	7067	998	85.9%
January 2017	6755	1777	73.7%

3.0 Trajectory Performance and Delivery

4 Hour performance was 73.7%, not achieving the internal trajectory target of 81.5% in January 2017

Diagnostic key messages;

Factors affecting Performance;

- **Urgent connect in place, GP uptake less than predicted**
- **Direct admissions to MAU limited due to flow out of the unit**
- **Additional Cardiac Hot Clinic capacity in place**
- **Successful introduction of ART (Active Recovery Team)**
- **Increasing >7 day length of stay**
- **DTOC improvements not sustained and continues to rise across all CCG's**

The table below details the calculated 4 hour performance benefit from RUH identified schemes and system wide reduction in DTOC.

		Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
3 Year Range	Max Performance	94.7%	98.2%	98.00%	94.4%	91.1%	89.3%	94.3%
	Min Performance	85.5%	93.4%	87.7%	84.2%	76.1%	83.3%	82.1%
Agreed Trajectory		95.0%	95.0%	94.6%	90.9%	84.5%	90.6%	89.0%
Revised Trajectory (1) with Performance Impact	**Forecast**	**83.7%**	**86.5%**	**85.6%**	**81.0%**	**76.3%**	**78.2%**	**78.9%**
	Frailty Direct Admits	0%	0%	0.05%	0.17%	0.17%	0.17%	0.17%
	Medical Ambulatory Care - Medical Nurse Practitioner Model	0%	0.7%	0.9%	0.9%	0.9%	0.9%	0.9%
	Medical Ambulatory Care - Additional Capacity and Waiting Area	0%	0%	0%	0.2%	0.4%	0.4%	0.4%
	Medical Assessment Unit Direct Admissions	0%	0.2%	1.3%	1.4%	1.4%	1.4%	1.5%
	Internal Professional Standards	0%	0%	0.2%	0.3%	0.3%	0.3%	0.3%
	Urgent Connect	0%	0.2%	0.4%	0.8%	0.8%	0.8%	0.8%
	Active Recovery Team (Phase 1)	0%	0%	0.7%	0.8%	0.8%	0.8%	0.8%
	Surgical Direct Admits	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
	Weekend Discharges	0%	0.1%	0.3%	0.3%	0.3%	0.3%	0.3%
	MADE Event	0%	0%	0.1%	0.1%	0.1%	0.1%	0.1%
	Performance Trajectory with Impacts	**87.8%**	**88.1%**	**90.0%**	**85.9%**	**81.5%**	**83.2%**	**84.2%**
Revised Trajectory (2)	Best Case Performance Trajectory with DTOC Reduction (Max 45 DTOCs)	**90.0%**	**89.8%**	**91.8%**	**87.7%**	**83.3%**	**85.0%**	**86.0%**
	Best Case Performance Trajectory with DTOC Reduction (Max 30 DTOCs)	**91.0%**	**90.7%**	**92.7%**	**88.6%**	**84.1%**	**86.0%**	**86.9%**
	Best Case Performance Trajectory with DTOC Reduction (Max 15 DTOCs)	**91.8%**	**91.6%**	**93.6%**	**89.5%**	**85.1%**	**86.8%**	**87.8%**
Actual 4 Hour Performance	4 Hour Performance (all types)	**88.1%**	**91.4%**	**81.3%**	**85.9%**	**73.7%**		

4.0 Four Hour Improvement Programme

Three key areas delivered via the Front Door, Specialty and Discharge Groups.

These priorities will develop and evolve as the programme delivers and new schemes identified for action

A weekly 'Big Room' methodology has been successfully introduced for Medical Ambulatory Care

Launch of the Bath Faculty FLOW Programme in February 2017 in collaboration with Sheffield, Health Foundation and AHSN. 8 of the delegates are RUH staff being taught co-coaching skills to implement the "Big Room" methodology for sustainable change. Builds on the 6 existing coaches who completed cohort 1.

Front Door Group awarded the RUH *"Team of the Year 2016"* for its work

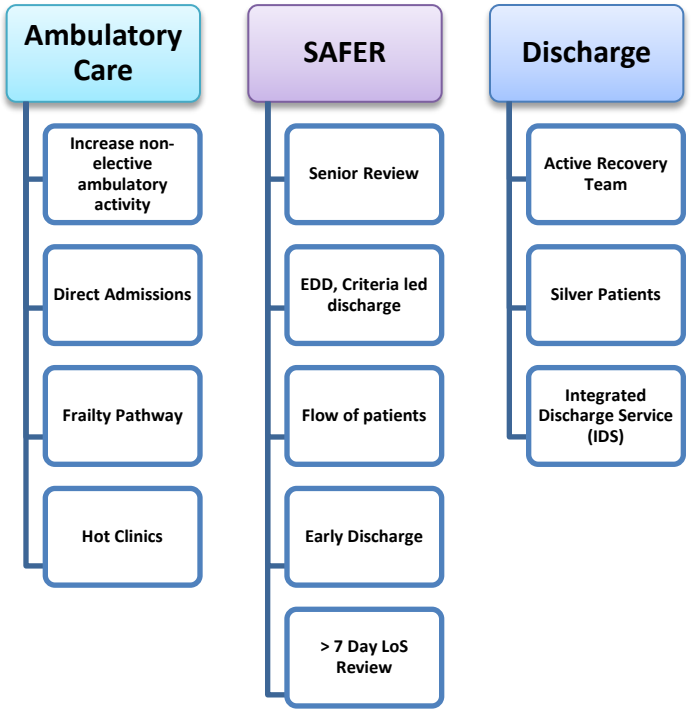
This approach will be applied to the Specialty Group from February 2017 to include multi-disciplinary, cross-divisional teams.

The 4 hour improvement programme focuses on the following key areas for delivery

1. Ambulatory Care
2. SAFER
3. Discharge

Delivery will be via the Ambulatory Care Group, Front Door Group, Specialty Group and Discharge Board.

Key performance indicators (KPIs) have been considered for each of the three key delivery areas and schemes within these. In addition the NHS Improvement KPIs for daily reporting have been included for daily, weekly and monthly monitoring. The following schematic shows the current workstreams underpinning the key areas, which will change as the schemes deliver and new schemes are added.



Key to trend for KPIs			
▲	Improvement in performance and within plan	▼	Deterioration in performance but still within plan
▲	Improvement in performance but still slightly off plan	▼	Deterioration in performance and slightly off plan
▲	Improvement in performance but off plan	▼	Deterioration in performance and off plan
▲	Improvement in performance	▼	Deterioration in performance

5.0 Ambulatory Care – Increasing Medical Ambulatory Care Activity

Delivery Group

Front Door

Project Leads

Dr Anu Garg
Dr Sarah Gillett
Matron Mandy Rumble
Sarah Hudson

Success In Month

Maintained trend of increasing activity with 441 patients in January an increase of 7 on the previous month.

Highest number of non-elective attendances recorded in one day 35 (26 attendances equates to a mean 30% of the medical take)

Activity increase in ambulatory care supported by extension of Consultant hours Monday to Friday

Big Room continues to meet weekly. Robust work plan in plan

Recruitment underway to appoint to 2 Band 5 nurse posts to enable medical nurse practitioners to focus on the medical take

1 WTE Band 4 extended HCA role commenced in post to oversee infusion activity and support registered nurse activity in amb care

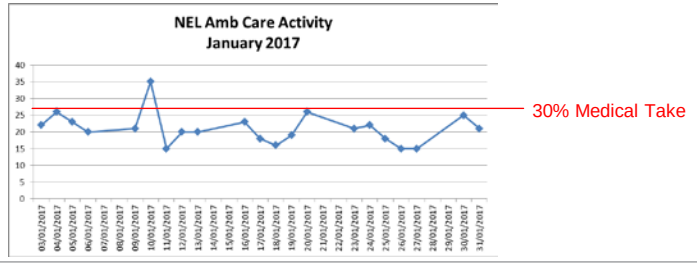
Next Steps

•Trajectory for activity to be matched to the actual take to monitor 30% of medical take
•Urgent Connect
•Extra hot clinics to manage demand
•Advertising for an acute care physician interview booked 28 March 2017

Aim Increase the non-elective activity through medical ambulatory care, trajectory to achieve 30% of the medical take via this pathway. Key actions detailed below for delivery within the next 60 days.

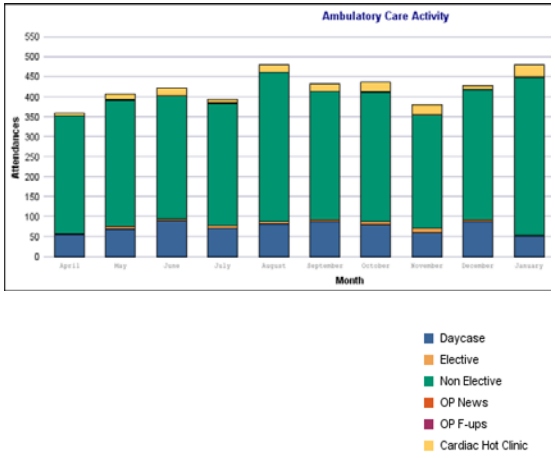
Action / Milestone	By who	By when	Delivery Confidence
Acute Medicine Consultant Replacement; to ensure adequate ambulatory care cover. Mitigation in place with Consultant team to ensure the majority of clinical duties for this vacancy are covered to provide consistency within the service 7 days. *Action updated as recruitment not successful, advertised twice and no suitable candidates*	Anu Garg	Plan to advertise again in February 2017. Interview date 28th March 2017. Candidates have expressed an interest.	
Medical nurse practitioner model and role over 7 days; proactive pull from the Emergency Department and discharge support at the weekends from Front Door – 24 direct admits from ambulatory care w/c 28 over 5 days trajectory to continue increase.	Mandy Rumble	31st December 2016	Action complete
Increase hours of consultant presence in Ambulatory Care out of hours – review of rotas and possible options to support extension of hours with a medical presence. *Action update: Big Room topic 19 January to agree required changes and timeline*	Sarah Gillett	1st November 2016	
Launch of the Ambulatory Care referral proforma in the Emergency Department 1st December 2016 and revised referral process and pathway. Review in weekly Big Room meeting and formal review Mid January 2017	Terri Bentley	19th January 2017	Action complete
Nurse recruitment to an addition 2 WTE Band 5 and 1 WTE Band 3 ward clerk. Aim to provide a consistent nursing workforce in amb care to deliver an 8am to 8pm service without dependence upon medical nurse practitioners. Interviews planned January 2017. Band 4 advanced practitioner already recruited and due to commence in post 30 January 2017.	Helen Jeffcoat	27th February 2017	
Daily monitoring of the ambulatory care activity – trajectory to achieve 26 non-elective attendances per weekday equivalent to 30% of the mean medical take. In place and reviewed weekly at the Amb Care BIG Room	Sarah Hudson	18th January 2017	Action complete

Non-Elective Ambulatory Care Daily Activity January 2017



KPI

Number of patients seen in ambulatory care per month



4 Hour Improvement Trajectory % Forecast

Scheme	4 Hour Improvement Trajectory Contribution						
	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Medical Ambulatory Care - Medical Nurse Practitioner Model	0%	0.7%	0.9%	**0.9%**	0.9%	**0.9%**	0.9%
Medical Ambulatory Care - Additional Capacity and Waiting Area	0%	0%	0%	**0.2%**	0.4%	0.4%	0.4%

5.1 Ambulatory Care – Frailty Pathways

Delivery Group

Front Door

Project Leads

Dr Chris Dyer
Matron Anita West
Sarah Hudson

Success In Month

- Weekly Big Room continues with excellent attendance
- New consultant rotas implemented on the 3rd January to provide front door frailty flying squad which is Consultant led until 6pm daily
- Therapy and Medical nurse practitioners also identified to support the Frailty Flying Squad
- Significant change in how patients are managed non-electively
- ACE LoS reduced by 1day since April 2016 sustained

Next Steps

- Q4 CQUIN milestones
- Continuation of Frailty Scoring and CGA embedding
- Daily and weekly review of Frailty Flying Squad KPIs including direct admissions
- "March on Frailty" month

Aim Shortest possible length of stay for frail older patients, increasing the number of patients discharged in <72 hours, direct admissions to ACE and the implementation of Clinical Frailty Score and Comprehensive Geriatric Assessment (CGA) to support overall length of stay reduction .

Action / Milestone	By who	By when	Delivery Confidence
Increase Geriatrician of the day presence in the Emergency Department PDSA 2: new rota based upon South Warwick model to commence 3rd January 2017 for a 2 month period. This model also includes additional medical nurse practitioner support "Frailty Flying Squad" providing a front door service until 6pm daily and continuity throughout early stages of admission	Dr Chris Dyer	3rd January 2017	Action complete
Delivery of the Frailty CQUIN deliverables including frailty scoring, completing of CGA and inclusion of CGA in discharge summaries. Milestones across Q1, Q2, Q3 and Q4	Sarah Hudson	Programme of FY 2016/17 quarter delivery In place	
PDSA direct admission to MAU for assessment +/- discharge home to support time for assessment, reduction in 4 hour breaches and reduction in LoS if admitted. Action to be closed as incorporated and a key KPI for PDSA 2 and the introduction of the Frailty Flying Squad	Dr Sarah Gillett	26th October 2016	Action complete
Weekly review of Frailty Flying Squad KPIs in the Frailty Big Room, agree any changes and next steps. Aim to provide a review to the Head of Division by 24th February with regard to outcome and recommendations to continue the service.	Dr Chris Dyer	24th February 2017	
Phlebotomy service in the Emergency Department supporting patient flow and expected patient management – supporting earlier access to diagnostics in preparation for Consultant review. Commenced 19th December 2016. 6 Month pilot.	Dr Nickie Jakeman	31st March 2017	
Frailty Big Room to lead a month of Trust wide events to promote frailty Promotion of movement and activity, decomposition, getting people dressed, frailty impact Delirium, falls, iimpact of increased LOS in hospital, education lying and standing BP to dip or not to dip, advanced care planning conversation project and 1st March pyjama day.	Anita West	1st March 2017	

4 Hour Improvement Trajectory % Forecast

Scheme	4 Hour Improvement Trajectory Contribution						
	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Frailty Direct Admits	0%	0%	0.05%	0.17%	0.17%	0.17%	0.17%

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* Number of <72 hour discharges from ACE reduced due to closed beds on ward associated with Influenza

Metric	Baseline	Target	Trend	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17
Number of patients discharged <72 hours ACE	29	50	▼	43	47	55	44	50	67	37	49	65	54*
Direct Admission from ED or GP Expected to ACE OPU	12	25	▲	13	5	20	12	9	10	9	12	13	22

5.2 Ambulatory Care – Direct Admissions

Delivery Group

Front Door

Project Leads

Dr Anu Garg
Ms Sarah Richards
Matron Mandy Rumble
Head of Nursing Ana Gleghorn
Sarah Hudson

Success In Month

ED and SAU agreement supporting clinical decision making and flow of surgical flow; in place and embedded

Direct admissions to MAU when flow allows assessment capacity to be held for expected patients. Note when flow poor patients can be admitted directly from ED to a ward

Number of Urgent Connect Calls to Acute Medicine and Ambulatory Care continue to increase; averaging 1 call per day to each service

Next Steps

PDSA required to support protection of direct admit capacity in MAU – early flow out of MAU

Movement to all Silver declared beds , linked to discharge tracker monitoring work led by the Deputy Director of Nursing and Midwifery

Aim to admit all medically and surgically expected patients through MAU and SAU respectively, without the need for an Emergency Department attendance unless clinically required

Action / Milestone	By who	By when	Delivery Confidence
Operational policy for direct admissions to MAU and SAU. Review progress and operational challenges out of hours and at times of high pressure	Anu Garg Sarah Richards	19th January2017	Action completed
PDSA to increase hours of consultant presence in ED and MAU – senior decision maker presence supporting admission avoidance , referral to Ambulatory Care and reduction in LoS. To commence w/c 31st October 2016 and continue for 4 months	Anu Garg	28th February 2017	
Proactive move before 10am to all Silver declared beds to support the creation of assessment capacity. *Action update work linked to discharge tracker monitoring process*	Mandy Rumble	1st November 2016	
Development of an Acute Medicine Big Room to focus on short stay and direct admission pathways to find a sustainable solution. Individuals identified to undertake the Sheffield FLOW programme due to commence 8th February 2017	Anu Garg Jennifer Jones	28th March 2017	
Emergency Department PDSA Cycle 2 – Rapid Assessment and Treatment (RAT) to include expected medical patients starting 9th January 2017	Nickie Jakeman	7th February 2017	Action completed

4 Hour Improvement Trajectory % Forecast

Scheme	4 Hour Improvement Trajectory Contribution						
	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
MAU Direct Admits	0%	0.2%	1.3%	1.4%	1.4%	1.4%	1.5%
SAU Direct Admits	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%
Urgent Connect	0.0%	0.2%	0.4%	0.8%	0.8%	0.8%	0.8%

KPI

Metric	Baseline	Target	Trend	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17
Number of GP direct admits to MAU	73	121	▼	22	111	12	23	30	90	56	24	52	47
Number of Patients transferred from MAU by 10am	0	87	▲	45	24	38	29	51	44	41	68	45	76

Metric	Baseline	Target	Trend	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17
Number of patients seen in ESAC	0	130	▼	116	137	131	133	118	159	140	165	149	130
Number of GP direct admits to SAU	0	130	▼	50	172	115	78	84	164	233	234	188	63

6.0 SAFER – Senior Review

Delivery Group

Specialty Group

Project Leads

Heads of Division
Heads of Nursing
Divisional Managers

Success In Month

National 7 day service audit completed and reported.

Baseline of availability of senior decision makers per specialty completed

Review of consultant job plans continues

Board round checklist in place across all ward areas

Next Steps

Planned visit to West Sussex NHS trust to review *"Emergency and Medical Floor"* principles

Review of board round checklist aim to promote discussion and support reduction in unnecessary delays and earlier discharge

Bullet round audits to assess effectiveness by "critical friend"

PDSA in ED of Rapid Assessment and Treatment (RAT) to support early senior decision maker inputs and improved time to assessment

Use of the National 7 day audit outcomes to identify SAFER "hotspots"

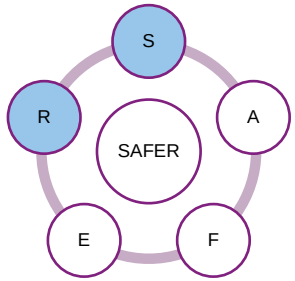
Aim All patients will have a senior review before midday by a clinician able to make management and discharge decisions.

Action / Milestone	By who	By when	Delivery Confidence
Decision hour – every specialty to commit to providing senior opinion; aim to reduce unnecessary delays and reduce time to respond to "pink slips". *Action updated to review progress and agree actions at the Specialty Group throughout January 2017*	Heads of Division	1st November 2016	Action completed
MADE event feedback positive for board rounds, plan to maintain momentum across all wards. Presentation at the Divisional Board meeting 6th December 2016. to agree next actions.	Robin Fackrell	6th December 2016	Action completed
Job plans have been amended to include increase ward presence and time for SAFER. *Action updated: Bi-weekly review of progress in place with Head of Division to be completed 10th January 2017*	Robin Fackrell	30th November 2016	
Review outcomes of the national 7 day service audit at the Front Door and Specialty Group – focus on time to senior review	Sarah Hudson	19th January 2017	Action completed
Specialty Group to be reframed and relaunched in January 2017 in line with the FLOW Big Room methodology to drive forward in a sustained way the specialty elements of the SAFER Bundle. To be led by the Heads of Division and to have in place by the end of February 2017 a clear workplan	Robin Fackrell Jon McFarlane Sarah Hudson	24th February 2017	

4 Hour Improvement Trajectory % Forecast

Scheme	4 Hour Improvement Trajectory Contribution						
	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Internal Professional Standards	0.0%	0.0%	0.2%	0.3%	0.3%	0.3%	0.3%

SAFER Bundle Scheme Impact



Metric	Baseline	Target	Trend	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Number of Specialty Breaches	41	0	▲	57	39	59	67	78	54	25	35	31	41

6.1 SAFER - All Patients will have an Expected Discharge Date and Clinical Criteria for Discharge

Delivery Group

Specialty Group
Discharge Board

Project Leads

Dr Robin Fackrell
Heads of Nursing
DM Suzanne Wills

Success In Month

Escalation to matron of the day improving including escalation re medical outliers

Weekend discharge team in place until March 2017

Junior Doctor engagement. Weekend planning stickers in place across OPU wards

Weekend discharge registrar in place throughout the month delivering an average of 8 discharges on a Saturday, reduced on a Sunday but provides preparation for Monday discharges.

Next Steps

Define weekend discharge target and set improvement trajectory including weekend resilience planning process

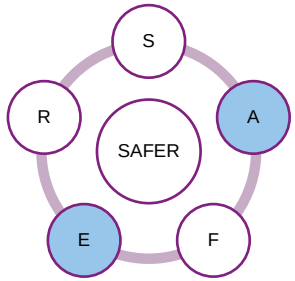
Aim **All** patients will have an Expected Discharge Date and Clinical Criteria for Discharge This is set assuming ideal recovery and assuming no unnecessary waiting.

Action / Milestone	By who	By when	Delivery Confidence
All new medical admissions to have an EDD recorded within 24 hours. audit planned January 2017 to assure compliance	Sarah Hudson	26th January 2017	
Communication cascade to ward teams and junior doctors regarding SAFER and discharge criteria . Update: meetings arranged in December with Head of Medicine	Robin Fackrell	1st November 2016	Action completed
Medical clerking proforma to be updated to include EDD instead of options for LoS	Sarah Hudson	31st December 2016	Action completed
Thursday "Weekend Resilience Planning" with the junior doctors to support weekend discharges including weekend discharge planning "sticker" process	Robin Fackrell	31st December 2016	
Junior Doctor Feedback. Comments box has been placed in the Doctors Mess for open comments about what we do well, what we could do better and what "drives them nuts". Senior Registrar to be the link between Juniors and Heads of Division to act upon information received. To be taken through as appropriate each Urgent Care Group for review and action.	Robin Fackrell Bernie Marden Jon McFarlane	7th March 2017	

4 Hour Improvement Trajectory % Forecast

	4 Hour Improvement Trajectory Contribution						
Scheme	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Weekend Discharges	0.00%	0.1%	0.3%	0.3%	0.3%	0.3%	0.3%

SAFER Bundle Scheme Impact



Metric	Target	Trend	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17
Weekend discharges (Adult Elective & Non Elective)	TBC	▼	18.6%	17.2%	16.1%	18.7%	13.5%	14.6%	20.9%	17.6%	18.7%	17.6%
EDD accuracy (Adult EL &NEL)	80%	▼	62.1%	61.7%	59.8%	60.1%	63.8%	65.0%	68.8%	68.5%	67.1%	63.4%

6.2 SAFER - Flow of Patients will Commence at the Earliest Opportunity

Delivery Group

Specialty Group
Discharge Board

Project Leads

Dr Robin Fackrell
Heads of Nursing
DM Suzanne Wills

Success In Month

Increase in "pull" from MAU to Ambulatory care to create early capacity on MAU and sustaining activity

Increased reporting of silver patients using the discharge tracker – daily reporting in place with targeted actions

Next Steps

Medical outlier management embed agreed responsibilities

Weekly audit of SAFER principles following MADE event and "mini MADE" event held over one weekend

Movement to all Silver declared beds , linked to discharge tracker monitoring work led by the Deputy Director of Nursing and Midwifery

Impact of movement from ED to specialty bed, review of processes as affects overall MAU LoS

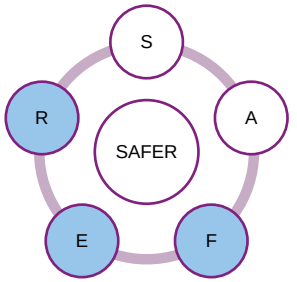
Aim flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am

Action / Milestone	By who	By when	Delivery Confidence
Support early moves out of MAU to Front Door Areas to create assessment capacity; a) Acute Medicine identification of Silver patients b) proactive sitting out c) earlier discharge via amb care and d) pull from MSS and ACE . Review at weekly Front Door Group. Formal review in January 2017.	Anu Garg	1st November 2016	
Medical outlier management to support surgical flow and earlier discharge . *Action update each specialty to commit to increased frequency of patient review- audit in place January 2017 to review compliance*	Robin Fackrell	1st December 2016	
Embed processes and robust monitoring of performance at ward level by senior nursing teams though robust escalation	Jo Miller Ana Gleghorn	1st November 2016	Action complete
Capture of themes and underlying issues which delay declaration of Silver or actual discharge from the ward areas and agree immediate actions to address – linked to discharge tracker initiative	Jo Miller Ana Gleghorn	1st November 2016	Action complete

4 Hour Improvement Trajectory % Forecast

Enabler scheme to support the creation of assessment capacity and the management of expected patients to be directly admitted to the assessment units

SAFER Bundle Scheme Impact



Reduced number of LOS <24 hours due to significant capacity pressures and impact on patient flow.

Metric	Target	Trend	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17
Number of patients moved from MAU < 10am	87	▲	45	24	38	29	51	44	41	68	45	76
Number of patients discharged from MAU with LOS < 24 hours	208	▼	168	195	166	193	202	188	243	197	185	120
Average Daily Medical Outliers	15	▲	34.6	31.8	32.1	37	29.7	21.7	22.3	43.2	29.0	54.0

6.3 SAFER – Early Discharge

Delivery Group

Specialty Group
Discharge Group

Project Leads

Dr Robin Fackrell
Heads of Nursing

Success In Month

Declaration of Silver Patients increased, however still below daily target

Reinforcement of initiative and communication of benefits

Ability to pre-empt before 10am – coupled with Front Door discharges can support early Flow and direct admissions

Next Steps

Continue to embed process and monitor KPIs daily

Ward rewards for Silver delivery

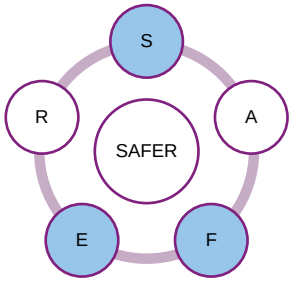
Aim early discharge; 33% of patients will be discharged from base inpatient wards before midday. Silver initiative supporting discharge of a minimum of one patient per ward before 10am to support early flow out of the assessment and short stay units to support early ED Flow and Direct Admission Capacity

Action / Milestone	By who	By when	Delivery Confidence
Embed processes and robust monitoring of performance at ward level by senior nursing teams – *in place ongoing action*	Jo Miller Ana Gleghorn	1st November 2016	Action complete
Capture of themes and underlying issues which delay declaration of Silver or actual discharge from the ward areas – *in place and ongoing action*	Jo Miller Ana Gleghorn	1st November 2016	Action complete
Deputy Director of Nursing and Midwifery to meet with all Matron on 13th January 2017 to critically review the Silver process, identified themes and agree next steps to achieve the early flow out of assessment areas and increase discharges before midday. Clear actions required. Early discharge is also linked to the success of the Silver initiative. Review at UCCB January 2017 completed. Further work required.	Lisa Cheek Jo Miller Ana Gleghorn	27th January 2017	

4 Hour Improvement Trajectory % Forecast

Enabler scheme to support the creation of assessment capacity and the management of expected patients to be directly admitted to the assessment units

SAFER Bundle Scheme Impact



KPI

Metric	Baseline	Target	Trend	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan 17
% discharges before midday	0	33%	▼	13.6%	13.8%	12.4%	14.9%	14.3%	15.3%	15.7%	15.9%	17.9%	16.0%
Total number of silver patients declared on the Discharge Tracker Board	0	325	▼	NA	NA	NA	NA	53	208	248	240	189	181
Number of Patients transferred from MAU by 10am	0	87	▲	45	24	38	29	51	44	41	68	45	76

6.4 SAFER – Review

Delivery Group

Specialty Group
Discharge Group

Project Leads

Dr Robin Fackrell
Heads of Nursing
DM Suzanne Wills

Success In Month

MADE event completed and recommendations taken through the Divisional Boards and Discharge Board

"Mini MADE" completed over one weekend

Process in place to review >6 day LoS in medicine (to focus all medical wards on the opportunity to discharge, medical LoS averages 7 days)

Next Steps

Weekly audit of SAFER principles following MADE event

Daily "Green" review throughout February 2017 with the community

Update of "Green" list to cross reference with those patients referred to the Integrated Discharge Service

Aim: Review

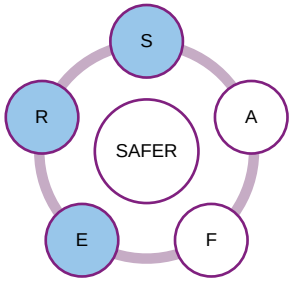
A systematic MDT review of patients with extended lengths of stay (> 7 days – 'stranded patients') with a clear 'home first' mind set.

Action / Milestone	By who	By when	Delivery Confidence
7 day LoS review processes and actions - Agree what actions are to be taken at a Trust wide and ward level with a defined escalation process to highlight delays to discharge. Linked to national stranded patient reporting	Robin Fackrell	1st November 2016	
14 day LoS review processes and actions - Agree what actions are to be taken at a Trust wide and ward level with a defined escalation process to highlight delays to discharge	Robin Fackrell	1st November 2016	
MADE event – Trust Wide November 2016 evaluation and learning from event to inform next steps and actions	Anita West	31st December 2016	Action complete
Medicine Division Stranded Patient . Weekly review of all wards and all patients with a LoS of > 6 days to be coded on a Friday . Data collated and all internal delays addressed. Weekly "Stranded patient" call in place with the community	Suzanne Wills	17th February 2017	
Daily challenge of the EDD. Matron of the day ward visits. Clinical Leads to ensure that all ward areas have robust bullet rounds in place and are challenging EDD. Review at the Weekly Urgent Care Action Group	Suzanne Wills Robin Fackrell	3rd March 2017	

4 Hour Improvement Trajectory % Forecast

Scheme	4 Hour Improvement Trajectory Contribution						
	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
MADE Event	0.0%	0.0%	0.1%	0.1%	**0.1%**	0.1%	0.1%

SAFER Bundle Scheme Impact



KPI

- Monthly reporting metrics under review as >7 day and >14 day reporting is based upon a daily midnight snapshot.

7.0 Discharge – Active Recovery Team (ART)

Delivery Group

Specialty Group
Discharge Board

Project Leads

Dr Chris Dyer
Head of Therapies G Sargeant

Success In Month

Total bed days saved exceeded the monthly target.

95% patients left hospital before 10.00 am with CGA completed by first ART community visit

Afternoon discharges introduced

Proven ability to take home at risk i.e. with no confirmed date for care to commence but an agreed plan without impacting on handover compliance.

Increased evidence of joined up working with Wiltshire Health & Care teams sharing POC and needs to achieve expedient complex discharges.

Continuous excellent patient feedback.

Family participation/friends social support with care remains higher than expected with this model.

Clear shared risk taking across a patient's journey, a better understanding of each teams challenges and working together to solve issues.

Next Steps

Presentation of ART to the Trust Board of Directors March 2017

Recruitment to extend the service into March 2017

Aim: The opportunity to establish an active recovery team to allow patients to be discharged home when limited additional home support is required.

Action / Milestone	By who	By when	Delivery Confidence
Early evaluation post implementation, series of PDSA's in place to test change. Operational KPIs agreed.	Gina Sargeant	31st December 2016	Action complete
Deliver against agreed trajectory for discharges out with the ART Team – weekly monitoring in place	Gina Sargeant	31st December 2016	Action complete
Review of services provided and patient feedback evaluate and agree actions to improve service offering	Gina Sargeant	31st December 2016	Action complete
Critical review of the 2 re-admissions in December 2016 to support ongoing service development and learning	Kerrie Hopson	3rd February 2017	
Continue with the PDSA approach with the wards increasing knowledge and experience with Home First across wards.	Kerrie Hopson	24th February 2017	
Continue to challenge and plan with Wiltshire to increase potential patient cohort and manage the flow within the care capacity in community.	Kerrie Hopson	24th February 2017	
Management Board review of ART service progress and next phase of the service	Gina Sargeant	22nd March 2017	

4 Hour Improvement Trajectory % Forecast

Scheme	4 Hour Improvement Trajectory Contribution						
	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Active Recovery Team (Phase 1)	0.0%	0.0%	0.7%	0.8%	0.8%	0.8%	0.8%

Metric	Target	Trend	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Number of patients suitable for supported discharge with ART per month (8 discharges per week)	44	▲	8	24	45		
Actual	44	▲	3	19	36		
Total bed days saved (3.4 day LoS reduction per patient)	149.6	▲	10.2	153	282		

7.1. Discharge – Integrated Discharge Service (IDS)

Delivery Group

Discharge Board

Project Leads

Deputy COO Clare O'Farrell
Head of Therapies G Sargeant
IDS Lead Lee Warner-Holt

Success In Month

KPIs show that the number of IDS referrals has increased and sustained since introduction in September RUH 65+ years and IDS referred green bed days are increased in month

Recommendations from ECIP D2A review and MADE event linked to 2017/18 programme priorities/objectives

Review planned of IDS referral form planned in 2017/18 IDS priorities/objectives

Next Steps

Recruit IDS Programme Lead. IDS Priority 1

Review IDS SOP – agree pathways and standardise across all partners. IDS Priority 2

Action / Milestone	By who	By when	Delivery Confidence
Establish new IDS team working practices – Being led by IDS Operational IDS Group. Wiltshire and BANES teams now in-place. Review in 2017/18 Q1 agreed - see appendix 3.	Gina Sargeant & Lee Warner-Holt	25th November 2016	Action completed
Introductory meetings with Virgin reablement leads booked in November and December.	Clare O'Farrell	14th October 2016	
ECIP D2A process review 9 Dec - agree key actions and delivery dates based on the review recommendations. BANES D2A meeting 12 Dec.	Clare O'Farrell & Gina Sargeant – IDS Senior Management Group	3rd February 2017 ***Completed see appendix 3***	Action completed
IDS/ Homefirst Project Lead role agreed in principle - Complete JD and advertise post	Clare O'Farrell & IDS Senior Management Group	31st January 2017	Action completed
Agree performance target for RUH Green Bed Days IDS referred. Based on 4 months of data – set at 8 days (improvement of 1.2 days required)	IDS Senior Management Group	1st February 2017	
Interview for IDS Programme Lead on 1st March 2017 – IDS Key priority 1	Clare O'Farrell & IDS Senior Management Group	1st March 2017	
IDS Pathway Agreement Meeting: Review IDS SOP and across the system confirm pathways - IDS Key Priority 2	Operational Management Group	1st March 2017	

Aim: To improve and simplify discharge processes and support the principles of 'HomeFirst' and Discharge to Assess. through the co-location of the discharge teams working at the RUH and reducing time to discharge, delays and improve quality through collaborative working.

4 Hour Improvement Trajectory % Forecast

Scheme	4 Hour Improvement Trajectory Contribution						
	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
RUH DTOC reduction	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%

Metric	Baseline	Target	Trend	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Number of IDS referral forms completed	0	500	▲	404	472	532	498	554		
RUH 0.1% reduction in DTOC (snapshot)	52	44	▲	61	53	62	39	53		
RUH Best Case DTOC reduction (max 15 DTOC)	52	15	▲	61	53	62	39	53		
RUH Green bed days 65+ years (days)	5.2	5.0	▲	5.4	4.6	4.9	5.2	6.0		
RUH Green bed days IDS referred (days)	New	8.0	▼	6.7	10.0	9.4	11.0	10.9		

8.0 Four Hour Improvement Programme and System Wide Contribution with DTOC Reduction

4 Hour Improvement plan in place with system wide contribution

Key focus area for A&E Delivery Board

Discharge to Assess (D2A) is 1 of the 5 priority areas as in the National A&E Improvement Plans

The trust anticipates that the combined key actions will reduce the number of breaches in the Trust through a combination of front door, specialty, discharge and system wide improvements

CCG and ORCP contribution to breach avoidance to be confirmed by the A&E Delivery Board

System Wide 4 Hour Breach Avoidance

The Trust has created a low, medium or high range target reduction per week based on a calculation of how many breaches the system will avoid depending upon the level of DTOC reduction. This metric does not take into account green patient numbers and any community focus on green reduction. The table below details the performance improvement trajectory including the DTOC reduction.

		Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Revised Trajectory	**RUH Performance Trajectory with Impacts**	**87.8%**	**88.1%**	**90.0%**	**85.9%**	**81.5%**	**83.2%**	**84.2%**
	LOW Performance Trajectory with DTOC Reduction (Max 45 DTOCs)	**88.5%**	**88.2%**	**90.2%**	**86.2%**	**81.6%**	**83.5%**	**84.4%**
	MEDIUM Performance Trajectory with DTOC Reduction (Max 30 DTOCs)	**89.4%**	**89.2%**	**91.1%**	**87.0%**	**82.6%**	**84.4%**	**85.3%**
	HIGH Performance Trajectory with DTOC Reduction (Max 15 DTOCs)	**90.3%**	**90.0%**	**92.1%**	**88.0%**	**83.5%**	**85.3%**	**86.2%**
Actual 4 Hour Performance	4 Hour Performance (all types)	**88.1%**	**91.4%**	**81.3%**	**85.9%**	**73.7%**		

Appendix 1: Factors Affecting 4 Hour Performance

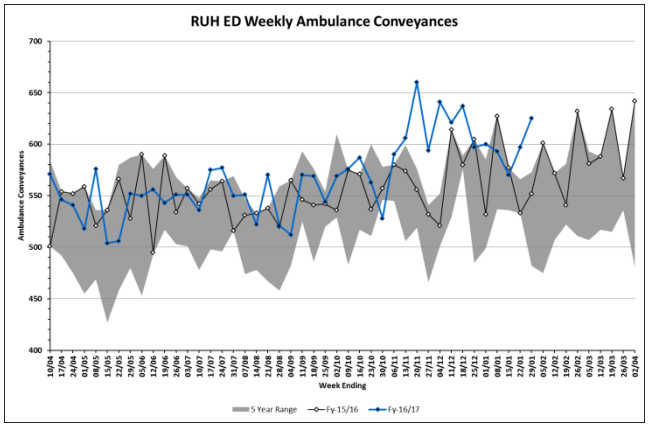
Ambulance conveyance activity +16.8% variance compared to 5 year average.

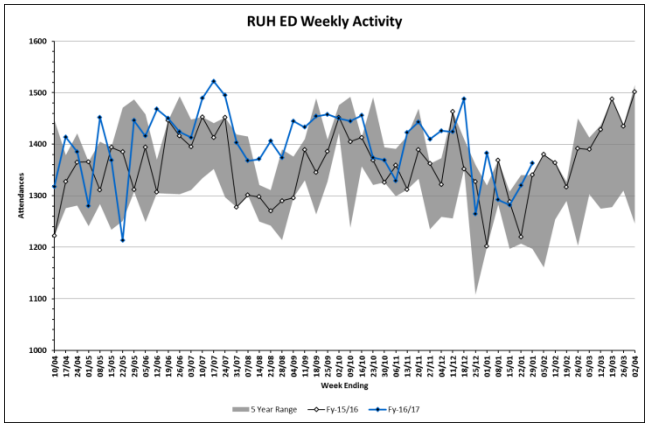
+12.2 % variance in emergency presentations compared to the last financial year at the peak week of activity

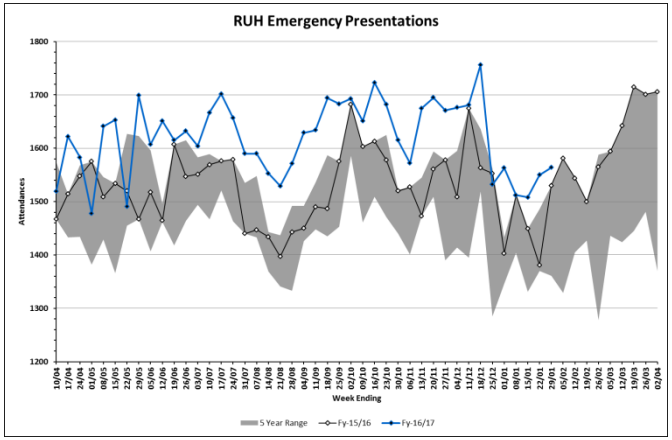
+8.2% variance in emergency department attendances compared to the last financial year in the peak week of activity

Emergency Department Activity

The Trust has seen unprecedented ambulance activity, in excess of the highest activity over the last 3 years, mirroring the increase in Emergency Department activity and Emergency presentations.







Appendix 2: Completed Actions Log

Action / Milestone	By who	By when
Ambulatory Care Big Room – support model delivery and communication strategy. *Action completed*	Sarah Hudson	29th September 2016.
Definition of % of the medical take through ambulatory care and apply to both medical and surgical pathways – to develop an activity improvement trajectory. *Action completed*	Alyssa Smith	28th October 2016
Nursing model for ambulatory care to support current activity and projected increases (in hours and out of hours). *Action completed*	Mandy Rumble	24th October 2016
Medical nurse practitioner model and role over 7 days; proactive pull from the Emergency Department and discharge support at the weekends from Front Door. *Action completed*	Mandy Rumble	24th October 2016
Capital works to increase the physical waiting areas capacity and treatment/assessment space to commence mid November 2016. *Action completed*	Helen Jeffcoat	14th November 2016
Agree Target number of patients with a 0 day length of stay to be considered for ambulatory care treatment and the associated clinical model to deliver the identification and transfer – balanced with ambulatory care activity increases. Opportunity of 3-5 patients per day identified. *Actions Completed: linked with STP Ambulatory Care work programme 8th December 2016*	Sarah Gillett	1st December 2016
Relocate existing elective ambulatory care work to other locations / services completed during refurbishment. *Actions completed plan for ongoing plan to continually review*	Sarah Hudson	14th November 2016
Increase Geriatrician of the day presence in the Emergency Department to support admission avoidance and placement onto correct pathway of care including direct admission to ACE Unit. *Action* for *PDSA completed*	Dr Chris Dyer	17th October 2016
Direct Admission to ACE Unit from the Emergency Department to support shortest possible length of stay by continuing CGA commenced in the Emergency Department. *Planned actions completed, this will be an ongoing action under daily and weekly review*	Anita West	1st November 2016
ACE Unit functioning as a short stay unit with a target maximum length of stay of <72 hours supporting Front Door Flow. *Planned actions completed review* *Year to date can demonstrate a 1 day LoS reduction and 90% of patients being discharged back to their usual place of residence. Ongoing weekly focus.*	Dr Chris Dyer	31st December 2016
Revision and communication of operational policy for direct admissions to MAU and SAU. *Action completed*	A Garg /S Richards	24th October 2016
Internal professional standards; ED to ensure robust application of the standards and exception reporting / escalation if these are not adhered to supporting early assessment and decision to admit or discharge. *Action completed and process in place, weekly monitoring continues*	N Jakeman	1st November 2016
Ward and Board Rounds embed best practice and implement a checklist to prompt action to support discharge. *Action completed.*	Robin Fackrell	24th October 2016
MADE event – Trust Wide November 2016. *Action completed*	Anita West	17th November 2016
PDSA cycles to capture learning from ward 14 day reviews. *Action completed*	Heads of Nursing	13th November 2016
All new medical admissions to have an EDD recorded within 24 hours. *Action completed*	Chris Dyer	30th November 2016
Ensure appropriate escalation via Matron of the Day to Senior Triumvirates across all clinical divisions to ensure reviews are undertaken in line with SAFER . *Planned action completed ongoing review of this action in place*	Heads of Nursing	1st November 2016
Approval of Active Recovery Team (ART) – Phase 1 (pilot to March 2017). *Action completed*	Gina Sargeant	1st October 2016
Recruitment of staff to pilot, agree start dates and induction programme. *Action completed*	Gina Sargeant	31st October 2016
Development and circulation of guidelines and protocols completed and agreed by senior RUH and community. *Action completed*	Gina Sargeant	31st October 2016
Implementation of ART; to include a series of virtual patients monitored in line with the proposed process prior to live launch underway. *Action completed*	Gina Sargeant	1st November 2016
Agree KPIs and establish KPI reporting with BIU– monthly dashboard for IDS. *Action completed*	Gi Sargeant & Lee Warner-Holt	28th October 2016
ECIP reviewing D2A progress across RUH community, visiting IDS on 9th November. Report on visit to be shared at Nov IDS Senior Management Group and A&EBD.	Clare O'Farrell & Gina Sargeant	9th November 2016

Appendix 3: Integrated Discharge Service (IDS) Programme 2017/18 Key Priorities

Area of focus and outline:	Proposed work streams:
1. Appoint IDS Programme Lead: To recruit an operational lead for the IDS Programme. To gain commitment and increase day to day drive to improve discharge pathways. Role to champion Home first – ECIP recommendations. Role developed with input from ECIP.	• Agree JD and role profile • Advertise post (Jan 2017) - • Complete recruitment (Feb 2017), involving ECIP in the selection process. • Commence in post April/May 2017 – dependent on recruitment • Re-focus and lead IDS weekly Operational Group
2. IDS Pathways & IDS Pathway Response Standards ECIP recommendation and MADE event recommendation. To work to simplify the discharge pathways and ensure that every patient discharged from the RUH is under one of the FOUR possible pathways: **IDS SDOP April 2016:** • Simple discharge – ward staff will manage discharge to home or usual place of residence • At home with support but complex (IDS Pathway 1); • In a sub-acute community step down facility with rehabilitation and reablement (IDS Pathway 2); • In a nursing or care home facility with for recovery in a Non-Acute environment with complex assessment and for probable long term care needs (IDS Pathway 3). For each pathway agree clear response standards.	• Review Pathways and agree definitions for 4 pathways • **One pathway to be clearly Home first** • **Response Standards -** Use ECIP and other system definitions – NBT. • Pathway to be added to IDS referral form • Training and education plan IDS team • Training and education plan RUH Wards • SOP and all IDS standards to promote 'Fit to Participate' not waiting until fit to assess.
3. Home First (High priority action) As one of the IDS Discharge pathways agree key actions to increase the number of patients discharged from RUH on this pathway.	• Agree process with each CCG area – BANES, Wiltshire and Somerset. What about S Glos Set up weekly Home first steering group – in-place for BANES, next step Wilts and Somerset. • Daily and weekly monitoring in-place. • PDSA process – copy ART patient report form process
4. IDS Referral is the ONE ASSESSMENT ECIP recommendation – we need to review the Millennium IDS referral and up-date this after action 2 above is completed.	• Pathways and response times used to up-date IDS referral form. • Section 5 – How can the one assessment be used to remove the need for Section 5?
5. CHOICE policy- Advice and training MADE event recommendation How to improve the management of Choice by RUH ward teams. This needs to be clearly matched to the 4 IDS pathways – what Choice options are we building in and how will IDS team support this?	Support the 4 pathways and how the wards should work to be clear on what to advice patients. IDS complete this work and handover to RUH proactive discharge group.
6. IDS One Team and 7 day working ECIP recommendation Review operational processes admin and professional and assess if moving to a single team is an option. After agreeing the operational model assess what would be required to support 7 day discharge across the system.	Clear IDS Development Plan: • *Can we move to a single team approach?* • *What are the options for 7 day working in the IDS Team?*
7. 2017/18 Discharge CQUIN Discharge mapping exercise in Q1, this will be a whole day IDS review and planning meeting to be held in June 2017.	Discharge mapping exercise in Q1 to be held – use as an IDS review and planning meeting for the 4 discharge pathways.