Overall aim	Primary drivers	Secondary drivers	Change ideas	
Increase the quality and productivity of urgent and emergency care resources by improving flow and reducing variation and waste	**Right place:** Ensure patients are cared for in the most appropriate setting for their needs	**Optimising admissions** Adopt criteria driven approach regarding decision to admit	Run **Criteria to Admit** as a live tool for confirming patient admissions	**Team job plans** that support early review of patients by senior clinician
			Extend **CTA to residents** & other HCPs with senior oversight	Ensure use of CTA by senior decision maker **at the point of attendance**
			Use **CTA audits** to confirm capacity required in alternatives to admission	Run CTA for admitted patients at 24hr to determine **fitness for discharge**
		Alternatives to admission Reduce reliance on admitted care by increasing the use and impact of alternative care models	Implement 10 core components of the **Virtual Wards Operational Framework**	Ensure virtual wards link with **SPoAs/ ICC, SDEC, UCR, 999/111, care homes**
			Scale virtual ward capacity to deliver efficiencies and meet UEC demand	Establish a **virtual hub** to manage referrals & outreach to specialist teams
			Local **profiling of SDEC demand** to ensure core service meets demand	Establish **acceptance criteria** & Include SDEC and VW on DoS
			Ensure **job plans and resource** support SDEC delivery	**Co-locate SDECs** with the emergency department
			Use self-assessment tools to benchmark & address gaps in SDEC	
	Right process: Optimise processes, making best use of resources & minimising waste	**Standardised process** Increase the use and optimise the impact of Internal Professional Standards (IPS) 7-days a week, across all services and specialities	**Establish, measure and hold** to account IPS delivery	Test IPSs during times of **crowding and increased pressure in ED**
			Implement changes to **rostering and job planning** to ensure the right resource	Use **telephone** to refer allowing conversations rather than electronic referrals
			Ensure consistent **access to diagnostics** 7 days a week	**Minimise ward moves**
			Deliver networked **rotas** to access speciality advice in low volume specialities	
	Right pathway: Ensure patients have an appropriate plan, know about it & it is enacted	**Care & discharge planning** Create and enact comprehensive care and discharge plans in partnership with patients and carers	Deliver **100% coverage of comprehensive care plans**	Ensure all appropriate patients can answer the **four patient questions** every day
			Deliver **comprehensive discharge planning**	Implement **criteria led discharge** (CLD) with a focus on facilitating weekend discharge
			Implement **reconditioning / get up get dressed** initiatives	Ensure a **'home first'** approach
			Establish **team job plans** which support early review of all patients	Implement best practice, **evidence based clinical pathways**
			Embed the **flow principles** throughout the patient pathway	Maximise use of **step-down virtual wards**
	Right people: Securing greatest value from our people	**Workforce planning and transformation**	**Job planning:** e-job planning, job planning toolkit & demand / capacity planning	**Retention:** deploy the national retention guide and toolkit
			Workforce transformation: use best practice models like CLEAR & HEE tools	**Consider new roles:** access workforce transformation case studies
		Workforce deployment	**E-rostering and e-job planning:** as an enabler for flexible working	Consider the establishment of a **digital staff passport**
			Use the nationally developed **agency rules toolkit**	
		Governance & measurement	Deploy the national **safe sustainable and productive staffing guidance**	Adopt the national **e-rostering & e-job planning meaningful use standards**
			Utilise national **workforce measurement tools, including model hospital**	

Measures

Outcome measures (Quality)	Balancing measures	Outcome measures (Productivity)
Reduction in 12-hour+ stays in ED	Readmission within 30-days	Reduction in number of NEL admissions
Reduction in time after discharge ready date for P0 patients	Re-attendance at ED within 7 days	Reduction in number of patients with 7+ day LoS
		Reduction in number of patients with 14+ day LoS
		Reduction in number of patients with 21+ day LoS