Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 6 MARCH 2014 at 10.00am

Present:

Councillor Rory Palmer Chair)	–	Deputy City Mayor, Leicester City Council
Dr Avid Prasad	–	Co-Chair of the Leicester City Clinical Commissioning Group
Dr Simon Freeman	–	Managing Director, Leicester City Clinical Commissioning Group
Detective Superintendent Andy Lee	–	Leicestershire Police – attending for Chief Superintendent Rob Nixon
Elaine McHale	–	Interim Strategic Director, Children's Services, Leicester City Council
Councillor Rita Patel	–	Assistant City Mayor, Adult Social Care, Leicester City Council
Philip Parkinson	–	Healthwatch Leicester – Interim Chair Healthwatch Leicester
Tracie Rees	–	Director of Care Services and Commissioning, Adult Social Care, Leicester City Council
David Sharp	–	Director, Leicestershire and Lincolnshire, NHS England
Councillor Manjula Sood	–	Assistant City Mayor (Community Involvement), Leicester City Council
Deb Watson	–	Strategic Director Adult Social Care, Health and Housing, Leicester City Council

Invited attendees

John Adler	-	Chief Executive, University Hospitals of Leicester NHS Trust
Rachel Bilsborough	-	Divisional Director Community Health, Leicestershire Partnership NHS Trust
Dr Tony Bentley	–	GP, Leicester City Clinical Commissioning Group
Ruth Lake	-	Director Adult Social Care and Safeguarding, Adult Social Care, Leicester City Council
Dr Peter Miller	–	Chief Executive, Leicestershire Partnership NHS Trust
Richard Mitchell	–	Chief Operating Officer, University Hospitals of Leicester NHS Trust
Sue Noyes	–	Chief Executive, East Midlands Ambulance Service NHS Trust
Paul St Clair	–	Assistant Director Operations, East Midlands Ambulance Service NHS Trust

Jane Taylor	–	Urgent Care Director, Leicester, Leicestershire and Rutland, University Hospitals of Leicester NHS Trust

In attendance

Graham Carey	–	Democratic Services, Leicester City Council

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55. APOLOGIES FOR ABSENCE

Apologies for absence were received from Professor Azar Farooqi, Co Chair, Leicester City Clinical Commissioning Group and Chief Superintendent Rob Nixon, Leicestershire Police.

56. DECLARATIONS OF INTEREST

Members were asked to declare any interests they may have in the business to be discussed at the meeting. No such declarations were made.

57. URGENT CARE/A&E AT UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Councillor Palmer welcomed everyone to the meeting and outlined the practicalities and consequences of the meeting being webcast. He thanked everyone for attending at short notice to discuss the performance of the Urgent Care/A&E Department at the Leicester Royal Infirmary.

The aim of the meeting was to develop and revisit the Board's understanding of the current situation around A&E. It was important to review what had happened, what measures had been put in place and what ought to happen next. There were increasing levels of public and media interest as well as public scrutiny of A&E performance and the Board had a key role to provide collective leadership in that process.

Simon Freeman, as Chair of the Leicester, Leicestershire and Rutland Urgent Care Working Group, provided a short overview as follows:-

- All partners recognised the issues associated with urgent care and were working hard to address them together. That meant doing more to keep patients well and out of hospital where possible, and making sure that first-class systems and processes were in place within the hospital and community hospitals to ensure that patients' care could be transferred seamlessly to the most appropriate place for them.

- Other contributors would provide examples of how the challenges were being met collectively, but a few of the highlights were:-

    - The implementation of a new A&E assessment system, which sees nearly a 30% of all patients arriving at A&E on foot, assessed and treated by nurses and GPs without the need for them to ever enter

the main department.

- The launch of a team of rapid response GPs to treat elderly and vulnerable patients at home, and the trialling of putting GPs in rapid response cars with paramedics when responding to emergency calls.

- All these were designed to help reduce the number of unnecessary visits to A&E, freeing up staff to focus on what they did best – caring for patients with the most urgent need.

- UHL had also benefitted from significant additional funding during the winter to help improve the way in which the department and wider hospital operated. In particular it had focused on the flow from A&E to wards when patients need admitting, and improving discharge processes so that medically fit patients could be sent home earlier in the day so as to free up beds for other patients that needed them. The effectiveness of this had been observed through the recent 'Super Weekends'. There was now a need to ensure that those lessons were put into practice on a daily basis.

Collectively these changes had provided some positive effect, but it was recognised that there was still a long way to go to get to where the service needed to be and everyone was collectively focused on that goal. It was accepted that there would always be spikes in attendances on any particular day but the system needed to be able to cope with that appropriately. The more pressing concern was ensuring that performance within A&E was met and maintained week after week, month after month.

A collective presentation by a number of partner organisations was circulated to the meeting and is attached as Appendix A to these minutes.

Simon Freeman, introduced the presentation (slide 1) and commented upon the general overview of performance from April 2013 to March 2014 for patients treated with a 4 hour period. Performance above the 90% level had been maintained between 15 December 2013 and 2nd February 2014. However from 9th February performance had deteriorated to levels not previously seen in the preceding 6 months.

Jane Taylor, Urgent Care Director, Leicester, Leicestershire and Rutland, provided a context of the performance described what drove performance and illustrated the challenges faced by staff. (slides 2-4)

In addition to the points illustrated on the slides the following specific points were made:-

- there were not any massive swings in the levels of attendance rates and the emergency admissions through A&E and GP referrals during the period March 2013 to February 2014.

- the opening of the urgent care treatment centre in July 2013 had seen a drop in the attendance levels at A&E.

- in the last 5 weeks there had been a 9% increase in emergency admissions mainly from GP referrals, particularly from City GPs. The admissions for A&E were fairly static at approximately 1%.

- there was a move to bring discharges forward earlier in the day to create capacity at the point of need and avoid bottlenecks, particularly with weekend discharges to avoid bed shortages for the higher levels of attendance on Mondays.

- the use of locum and agency nurse and medical staff presented a challenge as it slowed down the process of change and continuity of change and the pace at which changes could be made.

- although A&E attendance had not increased significantly there was more pressure within the service to take more patients within the service which consequently impacted upon discharge and overall flow rates through the system.

Following the Chair's question on the composition of the various bodies involved in the governance arrangements, it was stated that the Urgent Care Working Group comprised Chief Officers and Senior Operational Directors together with senior medical representatives from providers. The Trust Development Authority, NHS England, Healthwatch and the 3 Directors of Adult Social Care for Leicester, Leicestershire and Rutland were also present. The "Surge & Capacity Planning" and the "Emergency Care Delivery & Improvement" groups were more junior divisional level representatives as these were planning and detailed operational groups. The Better Care Together group was in a transitional phase but from this month it would include the Chairs of the three Health and Wellbeing Boards Leicester, Leicestershire and Rutland.

Philip Parkinson, Healthwatch Leicester, presented a submission to the meeting, a copy of which is attached to these minutes at Appendix B. The submission had been informed by enquiries to the Healthwatch Information Line, comments made to Healthwatch at engagement events in the last 6 months, information from Healthwatch Participating Observers on the Urgent Care Working Group and with the Clinical Commissioning Group and University Hospitals Leicester and matters raised with Healthwatch representatives at Community Meetings.

Simon Freeman clarified the situation relating to the statement in the presentation that members of the public may find it hard to understand why the ward at Loughborough Hospital which had been closed, reopened and was about to be closed again within a space of 9 months. He stated that:-

- The City CCG, through the legacy of PCT commissioning, had commissioned 45 community hospital beds for the City. 19 of these were in the county and 16 were through local authority or privately owned premises in the City.

- Sending frail and elderly persons discharged from hospital to beds outside the City was not considered adequate.

- In partnership with the PCT, the City had not re-commissioned the 19 beds in the county this year as 48 beds were opened at the Evington Centre at the Leicester General Hospital site.

- Beds in the Ward at Loughborough Hospital were not used by the City. The Ward had been re-opened last October with the winter monies granted to the health economy which would expire at the end of March and wards could not be kept open without funding. The decision to consider closing the ward was being taken at the Urgent Care Working Group after the Board meeting.

- Since October, the City CCG and the East CCG had opened a further 72 hospital at 'home day beds' with the support of the LPT. Consequently the provision of such beds had risen by 60% in the City during the year.

- The average length of stay in a community bed was 24 days; so 12 beds provided ½ a patient a day processing power.

Following a question, Simon Freeman confirmed that in 2012/13 there had been 45 community beds and this year there were 48 plus 24 'hospital at homes' beds.

Leicester City Clinical Commissioning Group

Dr Tony Bentley GP, Leicester City CCG Board Member gave an overview of the Primary Care Access and Demand Management (slide 5). In addition to the points illustrated on the slides the following specific points were made:-

- CCG and primary care were engaged in working together to make it better as there were many conditions that were best treated in primary care.

- The CCG had progressed a number of initiatives illustrated on the slide

    - Nearly all care plans for patients with long term conditions or approaching the end of life had been completed for nursing home patients and care plans were being prepared for other residents of care homes.

    - The GP's System 1 IT software was already available to ED and the CCG were keen to work with UHL to progress that to the whole of the Emergency Floor and then the hospital as a whole, subject to patients' consents for sharing information held about them. This would provide clinicians to access a patient's history and treatment which should improve patient care and speed up

the process for a patient to receive the right care.

- Progressing a scheme to access a 'staff-bank' of staff used to working in the City to increase clinical capacity.

- The hours of the walk-in centre were being extended until 10pm as a pilot project until the end of March.

- Annual Quality Review visits were being made to all GP practices to share good practice and provide help where practice was less than desirable.

- Work was progressing on preventative care to identify patients on registers so that their care could be managed, including treating approximately 2,800 patients to prevent diseases they have not yet developed, although the results of this may not be seen for some years.

Following questions from Board members, the following statements were made:-

- There were 3 GPs in City paramedic response cars. The GPs were in the cars for 12 hours 7 days a week. The GPs were not taken away from other duties as the staffing of the cars was mainly drawn from GPs who either worked part time in surgeries or who were working additional shifts.

- All 63 City GP practices were required to offer online patient access to appointments etc by the end of the financial year as part of their contacts.

- Some practices offered Saturday extended hours but patients often preferred extended hours during the week.

- On-line access was an extra option and patients could still visit surgeries to make appointments, request prescriptions etc. if they preferred.

- Diversity issues were recognised, for example the age for national health checks for COPD was 45, whereas in Leicester this had been reduced to 40 years old in recognition of the higher prevalence rates in BME communities. Posters advising patients of the proposal to share health/data records with their consent were displayed in surgeries in 7 different languages.

<u>NHS England</u>

David Sharp, Director, (Leicestershire and Lincolnshire Area) NHS England, made a presentation to the meeting on the role of NHS England in the context of emergency care n Leicester. A copy of the presentation is attached to these minutes at Appendix C. In addition to the points in the submission the following

comments were made:-

- NHS England were the primary care contract holder for GP services, although the CCG was a primary care membership organisation GPs were not allowed to pay themselves, this was done by NHS England.

- NHS England had a role, as a contractor of primary care, to identify any weaknesses in the primary care sector and to improve the primary care sector working closely with the CCG.

- 13% of patients in Leicester received treatment from single-handed GPs, compared to a national average of 9%, and whilst this did not detract from the level and standards of clinical care given, it did cause problems for the continuity of care, access and recruitment in the context of Urgent Care/A&E.

- NHS England were investing in named GPs for patients over 75 years old as it was recognised that the frail and elderly were one of the most vulnerable groups. NHS England were working with the City CCG to provide a financial allocation to help the frail and elderly population to stay in the community and avoid acute care admission.

- NHS England had the responsibility to licence the 7 CCGs in Leicestershire and Lincolnshire to practice the commissioning of healthcare for the population in their area.

- NHS England worked with Monitor and the Trust Development Agency, as part of the Tripartite Agreement to ensure systems worked in an efficient and fair way and, to that extent, they had not helped the providers or the CCG to fulfil the obligation to patients in the community to provide safe and prompt emergency care access, which is why the meeting was currently discussing the issue because the oversight of the Urgent Care Working Group had not guaranteed prompt urgent care for the people of Leicester. The secondary role of NHS England was to work with the TDA for Tripartite oversight.

Following a question as to whether the type or volume of services to be core commissioned under the Better Care programme had been completed, it was stated that :-

- The £5s per head allocation to support people to stay out of hospital care would be implemented from April 2014. The CCG had decided to increase this amount to between £6 to £10 per head and forms the basis of the Better Care Fund jointly agreed with the Council. This represented a significant investment in Adult Social Care and Community Services in Leicester that wrapped around GP practices. Work was being undertaken with GPs to discuss the role of GPs in these services and how the GPs could be the co-ordinators of those services. The investment was approximately £3.7m.

University Hospitals of Leicester NHS Trust

John Adler, Chief Executive, UHL Leicester and Richard Mitchell, Chief Operating Officer, UHL Leicester, gave a presentation on what had been done to address the issues faced in urgent Care/A&E at the Royal Infirmary, what had worked and what hadn't and what needed to happen in the future. (slides 11 to 15). In addition to the points illustrated on the slides the following specific points were made:-

- It was devastating to be in the current position when everyone had felt that progress was being made in the right direction.

- January was usually the worst month for performance but this year had been the best; whilst February had seen a significant drop in performance resulting in serious setback in the quality of care and service for patients. UHL had focused on the cause of the issues and the significant spike in admissions levels had generated problems in the system as there was not sufficient slack in the system. Also the ability to respond was constrained by a number of factors such as staffing levels and physical capacity and the system lacked resilience to cope with the recent levels of activity. Whilst there were a range of plans in place to address these issues in the medium and long term to address activity trends under the Better Care Fund, there was a limit to what could be done in the short term as a result of limited resources and capacity and inevitably it gets to a point where the system does not work sufficiently well and that was what happened over the last few weeks.

- Four key factors could be influenced – attendances, internal processes, discharges and admissions.

- The A&E Unit was the single largest A&E site in the country, no other single site saw more patients per day than UHL. Historically the health community had performed badly against the national performance standards.

- UHL had too few beds for elective and emergency care, there was now a shortfall of 83 beds.

- The average stay in hospital for non-elective care had been reduced from 5.7 days in 20112/13 to 5.2 days in 2013/14, and no other peer organisation had levels as low as these.

- Staffing levels have been increased and nursing vacancies halved. More doctors had been employed especially in A&E.

- Internal site meetings took place 4 times a day 7 days a week and performance improved steadily from April 2013 to January 2014 when performance was 93.6% and put the Unit in the top third in the country.

- Twice daily telephone calls from 13 medical wards at the Royal Infirmary site had been put in place to review discharges on an individual basis and plan discharges over the following 2 days. The system which was in place 7 days a week had improved performance and was now being rolled out to all 3 acute sites.

- Discharges were now at the highest for the last 12 months. The super weekends had resulted in discharge rates of 153 on average per day as a result of increased ward rounds and working closely with the CCG, EMAS, Arriva and LPT. The higher discharge rates partly reflected the higher admission rates but was also partly due to the improvement in processes. This level of discharge had been around or above that level on three of the last six weeks and this needed to be embedded into standard working practices.

- Delayed Transfer of Care (DTOC) continued to present a problem. DTOC involved medically fit patients who could safely be cared for elsewhere in the health economy. The previous day there were 79 DTOC patients in beds at the hospital which represented 5.7% beds in the hospital. As of today, 15 of those patients had been delayed for 6 days.

- There had been 9.5% more admissions in February than in January. This was becoming a continuing trend. There were 5.7% more admissions from GP referrals in the first 8 weeks of 2014 compared to the same period in 2013. This represented 640 more GP referrals and 34 GP practices across the 3 CCGs accounted for 85% of that increase.

- The impact of the 9.5% increased attendances when all the beds in the hospital were full meant that patients could not be treated quickly enough. This contributed to 101 breeches in the A&E performance the previous day, which was not acceptable to patients and staff. There were 79 DTOC patients, a further 25 patients on medical assessment units waiting for transfer to bed wards and 15 patients in A&E waiting to transfer to bed wards. 128 EMAS ambulance crews attend the site before 8pm, which was more than Derby and Nottingham Hospitals with larger A&E facilities. Also 74 patients arrived in a 100 minute period after 9 pm and it was not believed that any single A&E site could cope with that level of pressure.

- Processes needed to continue to improve and the available capacity needed to be used effectively.

- If the DTOC level could be reduced from 5.7% to 3%, which was an achievable national rate, this would free up an additional 30 beds.

- Further work needed to be done to reduce A&E and GP admissions and support the GP practices which had experienced increased

levels of admission referrals.

- Nottingham Hospital has a larger A&E unit but saw less patients than UHL and the physical restrictions of the unit did not allow any operating capacity to cope with the size of surges seen recently. The proposed emergency floor scheme which would substantially increase the physical size of the department would help to make the A&E unit more resilient to these peaks in demand.

- Emergency admissions needed to be reduced and could be achieved through ambulatory care pathways to find alternative routes for caring for a patient than admission into hospital beds.

- More was needed to plan for capacity to meet the expected demand to allow for the impact of the QIPs scheme and the Better Care Fund which should reduce demand on the acute sector, through a jointly owned capacity plan.

- Intensive work had been carried out recently on a multi-agency basis to improve the discharge process, particularly around complex discharges, which was better for both patients and families and a capacity viewpoint. The responsiveness from the City's Social Care Department was towards the top end of responsiveness based upon UHL's Chief Executive's personal experience compared to other areas and places in which he had worked.

In a response to a question about the emergency floor scheme, Mr Adler stated that the preparatory enabling schemes would start later in March and, if the required approvals were received from the TDA, work would commence on the A&E part of the scheme in October 2014. The approval would be dependent upon the combined health economy 5 year strategy currently being prepared for completion in June and the approval of the Trust's financial recovery plan. There was high confidence that the approvals would be received as the importance of providing sustained high quality emergency care at UHL was widely recognised and the emergency floor scheme was an important component in achieving this. If the approvals were received then the new emergency department could be open in December 2015 with the assessments centres following after that.

Following further questions it was noted that:-

- There was a small minority of patients that frequently re-visited the A&E department but these were now being filtered through the Urgent Care Centre.

- Work was progressing with the CCG to review re-admission rates to see if there were patients being discharge too early which might result in re-admissions.

Leicestershire Partnership Trust NHS Trust

Dr Peter Miller, Chief Executive and Rachel Bilsborough, Divisional Director Community Health gave a presentation on the various clinical and community services provided by the Trust to support UHL in achieving the flows through the system. (Slides 16 to 18). The Trust recognised that the efficient and effective working of their services assisted in reducing admission rates and aided quicker discharge rates. In addition to the presentation the following comments were made:-

- Initiatives introduced and developed over the winter months included:-

    - Since mid-December a Mental Health Triage Nurse pilot to divert patients away from hospital admissions when it was safe and appropriate to do so. 242 patients with mental health conditions had been seen to date. 73 patients were triaged in January and only 7 were referred to the emergency department for further assessment.

    - Close working with UHL in the emergency department and assessment units, especially the acute frailty unit, where a number of primary care co-ordinators work collectively. They had in- depth knowledge of available community services which may not be known to UHL staff and they were able to provide a signpost function to these services. Between December and February the team prevented over 1,000 admissions of which 411 were city patients.

    - LPT staff were also working with the Integrated Discharge Team and also supported the Daily Patient Census to proactively identify patients that could be transferred in LPT services which may not have been known to UHL staff or access the services quicker than may have been anticipated to assist the discharge process. The team could also assist by diverting patients into community based services before a package of care started.

    - Since December a bed co-ordinator has been in place and had been instrumental in managing the beds available in the City and County to support the UHL bed bureaux and discharge process.

    - LPT had also adopted and rolled out the UHL patient census model in the Trust, daily ward rounds and participated in the multi-agency case conferences.

    - Patients in the community support beds received up to 4 visits a day from physiotherapists with nursing support available and the beds were led and co-ordinated by an advanced nurse practitioner and were also subject to daily ward rounds and the patient census processes.

- Geriatricians visited community hospitals twice a week to take part in the review of patient care and this has ensured that only those patients who required more acute treatment are transferred back to acute wards.

- They were working closely with the CCG, the Council and UHL on developing service provision in the Better Care Fund scheme.

In response to questions it was stated that:-

- There were now 60% more community beds in the City than last year.

- It would cost approximately 30% more to keep the 24 bed ward open at Loughborough using agency staff compared to a recurrently funded ward with permanent staff.

- There were currently 30 patients placed out of county who required an acute mental health bed and that figure had been fairly constant over the last few months.

East Midlands Ambulance Service NHS Trust

Sue Noyes, Chief Executive and Paul St Clair, Assistant Director Operations gave a presentation on the changes made in EMAS regionally and in Leicestershire and the impact of recent weeks on other work within their operating area. (Slides 6 to 10).

- EMAS had made a number of changes under the Quality Improvement Programme.

- EMAS were now part of the Urgent Care Working Groups.

- More operational hours had been introduced partly through winter funding and partly through additional recruitment.

- A Regional Surge Cell oversaw areas where there was a high pressure point and they had been intervening in Leicester frequently in recent weeks to ensure service delivery.

- A Clinical Assessment Team with access to a consultant paramedic worked within the Emergency Operational Centre to provide a triage service and provide greater clinical advice over the phone.

- An improved 'safety netting' call back service to check that a patient's condition had not deteriorated, which was especially relevant when there were high demands for ambulance services.

- EMAS had incentivised contracts which meant they received higher payment if they were able to see and treat patients and enable them to

stay at home rather than convey patients to hospitals.

- EMAS feed into a number of organisations regionally which gave them a good oversight position but equally made them susceptible when large resources were required in one locality.

- The current performance for the last quarter was 93.8% for A19 compared to a national target of 95%. The Red1 (most urgent cases) performance was 72.1% compared to a target of 75%, and Red 2 (8 minute target) was 70.4%.

- Funds were received to have a Hospital Ambulance Liaison Officer (HALO) in attendance at UHL 12 hours per day to oversee the efficient handover of patients' turnaround time to enable ambulance crews to be available for the next response call with minimum delay. The HALO also worked with clinical staff as part of this process. This was currently being funded at 12 hours a day from 7am but actually worked until midnight.

- The target turnaround times were 30 minutes, which compared well to the present arrival time to handover of 18 minutes and preparation to be 'Green' and on call again of 8-12 minutes. The balance, however, was not quite where the service wished to be.

- The impact of the handover delays on the 17 February 2014 were fully illustrated on slide 9 and the corresponding figures for the 24 February were contained on slide 10.

Following questions on the presentation it was stated that:-

- The 4 hours target period started at the handover of the patient to clinical staff or 15 minutes after the ambulance arrived if no handover had been made.

- HALOs were senior clinical managers and they had live feeds into the EMAS CAD system (the system used to log calls and responses) and they used the information to proactively liaise with UHL clinical staff to warn of expected arrivals so that they were ready and prepared to receive the patients. HALOs met the ambulance crews at the front door and could alert them to pressures in the emergency department and helped the flow of patients into the hospital. HALOs could also help in the prioritisation of patients when there were high levels of admissions.

- UHL found the HALO arrangement useful as it helped them to understand the expected flow rates through the department.

- On the 17 February 3 patients that would normally have been taken to UHL were diverted, with agreement, to Coventry and Warwick hospitals at approximately 2am and a further 2 patients diverted to Kettering.

- The Urgent Care Centre at Loughborough was used to treat patients where possible instead of the UHL A&E department. It used a bulletin board from EMAS Control to send text messages directly to ambulance crews to remind them that certain patients could be treated at the Centre rather than at hospitals.

- Approximately 70 ambulance journeys per day were being taken out of the system by directing patients who had called 999 to other places where they could receive better and safe levels of care through other routes. This was largely as a result of the work of the Clinical Assessment Teams and the EMAS target was to take this figure up to 140 journeys per day.

- 38% of all calls attended by ambulance crews resulted in the patient being treated at the scene and 62% of patients being transferred to hospital and this was the best performance in the EMAS counties. In addition to the City scheme of 2 paramedics in cars with GPs, there was a similar scheme in West Leicestershire with 4 paramedics and Emergency Care Practitioners in cars, acting as a GP visiting scheme, and in that area the non-conveyance rate was 60%.

- In relation to 17th and 24th the length of times patients had to wait in ambulances prior to being handed over was not acceptable; however, A&E consultants did work closely with the HALOs as patients arrived to determine the priority for treatment for them. A balance of risk was determined on both of the evenings and it was determined that the best and most suitable location for those patients was to wait in ambulances until they could be safely admitted to the A&E department. Also the A&E consultants did visit the ambulances to check on the condition of the patients waiting to be admitted and the HALOs were also directing the A&E consultants to vehicles if there were any concerns for the patient.

- Mondays have always been traditionally busy days. Primary care was usually busy on Mondays as GPs were not normally available at weekends except for emergency cover. Flows through hospitals slow down at weekends, both in terms of admissions and discharges, and this could lead to capacity issues on Mondays through bed shortages. This had been a universal issue in the hospitals for some time and had led to the national initiative to move to a 7 day working model. As part of this, one of UHL's current priorities was to move the acute medical wards, which included frail and elderly care to a sustainable 7 day working model, and additional medical staff were currently being recruited.

- EMAS had looked at the performance data for both the 17th and 24th February in relation to the Red 1 and Red 2 – the two highest response levels. The comparators were :-

Norm (No of calls)	17th February (No of calls)	Variance with Demand	Variance with the Prediction

			Comparator to the same time last year	model for the day's activity
RED 1	8-12	13	- 6.5%	+1.5%
RED 2	121-150	137		

12.5% of activity came from NHS 111 alerts and 67% of patients were conveyed to hospitals

	Norm (No of calls)	24th February (No of calls)	Variance with Demand Comparator to the same time last year	Variance with the Prediction model for the day's activity
RED 1	8-12	10	- 0.4%	+5%
RED 2	121-150	126		

15% of activity came from NHS 111 alerts and slightly less than average patients were conveyed to hospitals.

The figures did not show any significant skewing in variation although in general EMAS had conveyed an extra 3 patients per day over the last three months compared to the preceding three month period.

- EMAS were the only ambulance service in the country that did not operate a 111 service and it was a priority to work closely with NHS111 to understand each other's working arrangements. The average activity rate from NHS111 for ambulance services was 14% but this could fluctuate on an hourly basis to between 18-28% and the activity could arrive in large volumes especially at weekends and after 6pm each day.

- It was also noted that both 17th and 24th February had been very busy days for primary care as well. The 2004 contract arrangements for GPs made them responsible for GP services from 8am to 6.30pm, and some practices offered extended hours. When Saturday hours were offered the afternoons were usually quiet and Monday's were still busy.

Leicester City Council Adult Social Care Services

Deb Watson, Strategic Director of Adult Social Care and Health gave an overview of the role of Adult Social Care and Ruth Lake, Director Adult Social Care and Safeguarding gave a presentation of the role and contribution of the service to the Acute Care Pathway. (Slides 19 to 29)

It was noted that Adult Social Care Services had a significant role in keeping older and vulnerable people safe and well in the community and preventing their health and wellbeing deteriorating. The department undertook approximately 13,000 assessments per year and provided approximately 9,000 packages of care at any one time. The department had a wider role in preventing the need for older and vulnerable persons to call upon NHS care and had an important early intervention role, which was being further developed through the Better Care Fund (BCF) to prevent urgent hospital admissions and to assist discharges from hospital by providing social care support to those patients that needed it.

The department was proactive in its role within the urgent care system and sought to be a good responsive operating partner in helping to assist the prompt discharge of patients. For example, between mid-January and mid-February 2014, there were 127 Delayed Transfers of Care (DTOC) at Ward 2 of the Leicester General Hospital, which related to factors outside UHL's control and only 3 were attributable to the City's Adult Social Care services. As part of the department's continued development as a good partner it was conducting a peer review the following week with a visiting team from other Social Care Departments in the East Midlands. The visit will have a particular focus on the social care contribution to the urgent care system as one of the themes.

In addition to the points shown on the presentation the following issue points were also were noted that :-

- The eligibility thresholds used by the Council were the same as the majority of other local authorities and coincided with the minimum standards required in the Care Bill, which is currently before Parliament.

- The department worked 'upstream' wherever possible and regarded the statutory targets as minimums and used for reporting thresholds.

- Social care contributed greatly to hospital admission avoidance, especially through the work of the Integrated Crisis Response Service. For example, in the event of a fall, carers would be despatched to provide care and support to avoid an admission if at all possible. This contributed to relieving pressure on EMAS and UHL resources.

A general discussion followed the presentations to consider the issues that had been raised. As a result of the discussion session and the general questions raised, it was noted that:-

- In relation the number of community beds in the City, not all DTOC's were city residents and whilst the City Adult Social Care discharges worked well, UHL also dealt with two other authorities for these discharges.

- There were a variety of causes for DTOC's and these were not all

related to delays in arranging social care support packages. Factors such as family liaison, choice and Continuing Healthcare were also relevant.

- All stakeholders recognised that they had reduced financial resources available through the current economic climate whilst facing increasing demands on services. Improvements and increased capacity could only be achieved through efficiencies and re-organisations and the lack of resources should not detract from finding solutions to meet the challenges that were being faced.

- There was no single solution to the issues faced and it required a number of responses from various stakeholders to build on each other to achieve a greater synergy in response to the challenges. It was disappointing that despite a number of initiatives being implemented the 95% target had not been consistently met.

- There was an inevitable unpredictability when dealing with demands for emergency care.

- Whilst the extraordinary peaks for demand on 17 and 24 February had been analysed, it had not been possible to identify any individual definite causes.

- It used to be the case that if 95 beds were available by the 4.30pm site visit, these would be sufficient to meet the demands for admissions through the night time period, however, this number was now increasing to 105 -110 to achieve this.

- Staff morale had been generally high in A&E despite the recent setbacks. Staff felt that others recognised their work and that they were not solely responsible for targets not being achieved. The level of staff vacancies had been reduced from 25% a year ago to a current level of 5%.

- The decision to close the emergency frailty unit had arisen from recommendations of external advisers in the autumn of 2012 that it was better to have expertise spread across all assessment units. This decision had been re-evaluated and the ward was re-opened 6 months ago and additional investment had also been recently approved for the ward to go to 7 day working.

- 7 day working was a complex issue and had significant cost implications for UHL.

- There was a good interaction of stakeholders in making progress to improve the situation in the Urgent Care/A&E Department but more needed to be done.

- Although there were relatively low volumes of complaints in relation to the A&E Department it was clear that there was a shift in increased public and political interest in, and concerns about, the issues.

- It was important to demonstrate to the public that there was a clear and fully costed plan on how the issues would be addressed and be embedded in practices so that the 95% target could be achieved on a consistent basis, together with a target date on when this would be achieved.

- It was felt that the targets could be achieved but it may not be possible for everyone to continue to deliver the current portfolio of services at their current levels and much would depend on prioritising service provision.

The Board subsequently

RESOLVED:

1. That everyone be thanked for their presentations and candid contributions to the discussion.

2. That the challenges faced by the Urgent Care/A&E Department are fully recognised together with the determination of all stakeholders to resolve it.

3. The intensity and resources already committed to addressing the issue are fully recognised and supported.

4. That the work of staff providing excellent quality of care under difficult circumstances is acknowledged and appreciated.

5. That the Implementation Plan be revisited and revised and be reconsidered by the Board.

6. That a further meeting of the Board be convened in the near future to review the Implementation Plan and to understand how it related to the broader context of the Better Care Fund and the policy issues in which all stakeholders were operating.

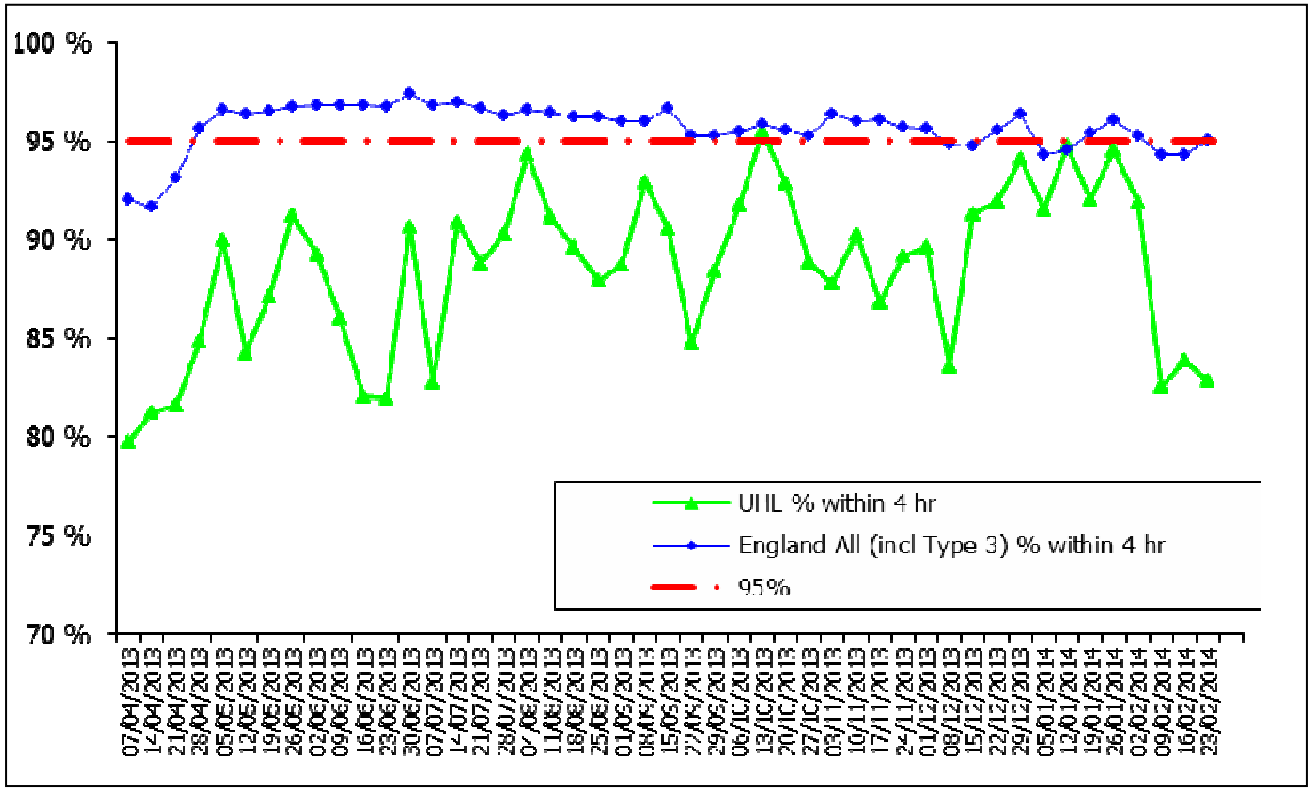
58. CLOSE OF MEETING

The Chair declared the meeting closed at 5.30pm

Note: This meeting was webcast live and can be viewed at the following link:-

http://www.leicester.public-i.tv/core/portal/webcast_interactive/129586

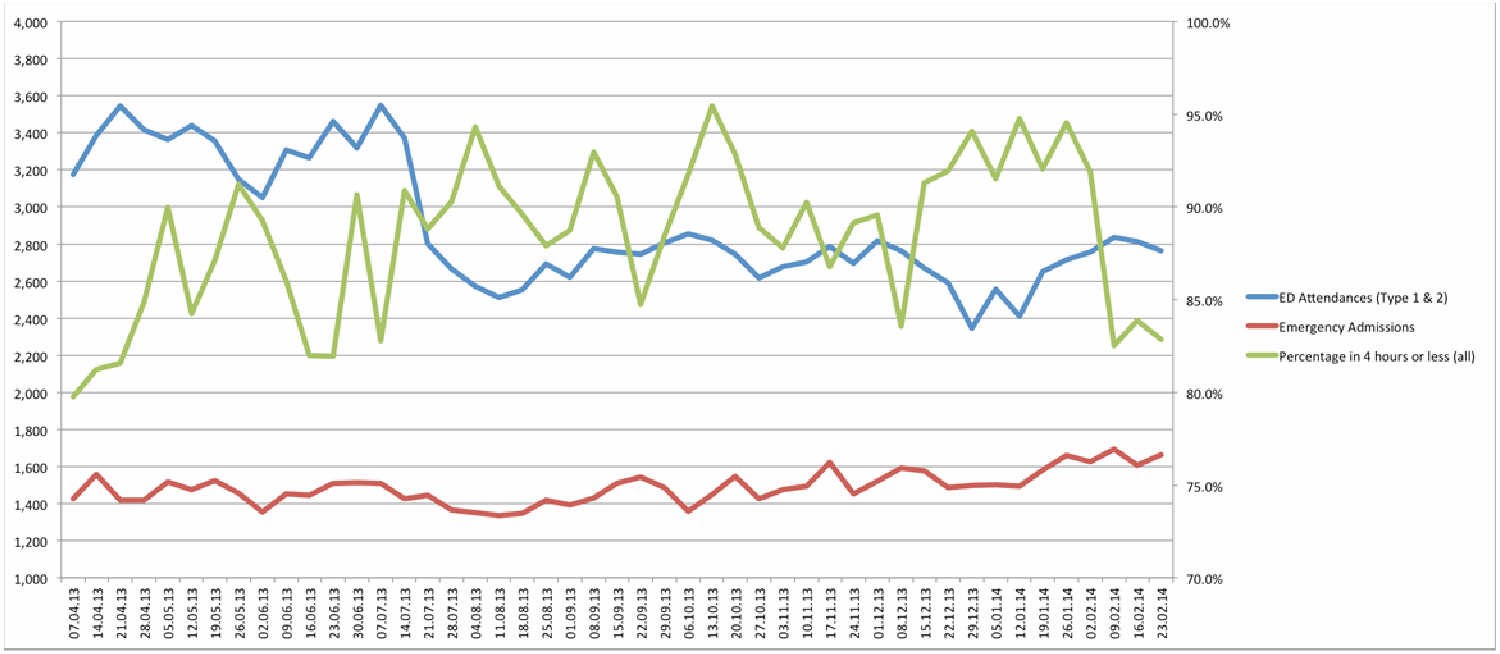
Overview of Performance and Governance



For a period of 8 weeks between 15th December 2013 – 2nd February 2014 performance was maintained over 90% , from the 9th February performance has deteriorated to levels not seen in the last 6 months.

Minute Item 55

Activity and Performance



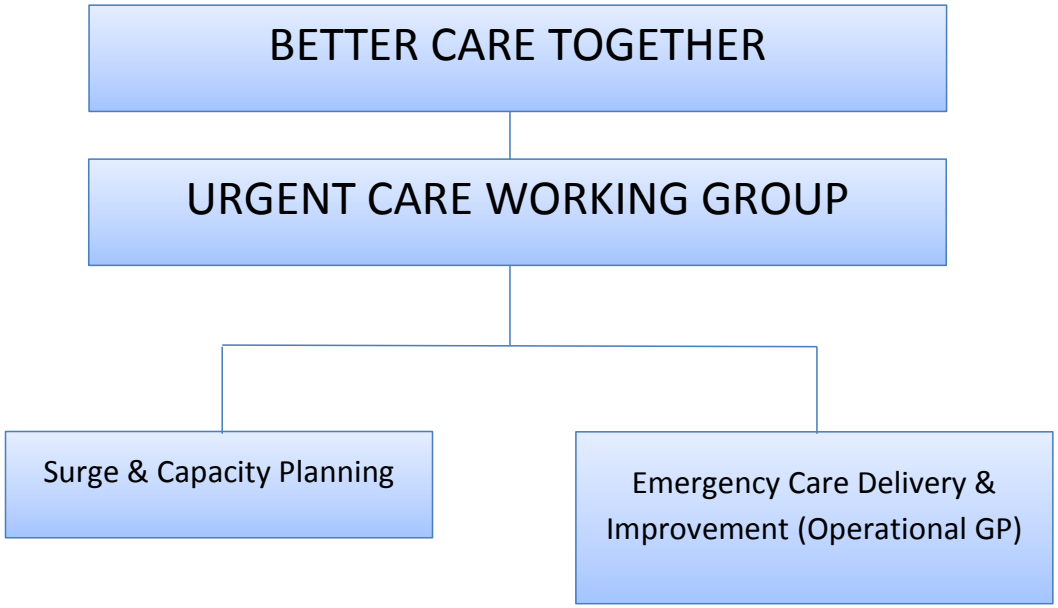
A&E attendance (blue line) dropped in July following the implementation of the single front door into the Urgent Care Centre for ambulatory patients. This reduced attendance by about 30%. Activity over the week has been reasonably consistent during over the last 6 months but the graph doesn't portray the daily variation – It is noted that over Christmas and new year period that Attendance dipped.

Emergency admissions (red line)are showing an increasing trend over the last 5 weeks by approximately 75 – 100 cases per week – this equates to 9% increase in emergency admissions.

Why is A&E performance not being achieved:

- Lack of timely flow through UHL– beds not available at point of need
- Discharges too late in the day
- Weekend discharges not matching admission rates
- Lack of optimal substantive staffing levels (high use of locum and agency nurse and medical staffing) – reducing the ability to sustain or build continuity in the improved systems and processes
- Delays in transferring care when patients medically fit for transfer – Discharge to assess placements and process, pace on transfer to nursing and care homes, availability of complex care packages in some areas of the County
- Increased emergency admissions - although A&E attendance not increased significantly

What's In place



Primary Care Access and Demand Management

Care planning – LTC and nursing and care homes

Admission avoidance – GP in a car, LPT mental health triage care

Increased use of IT – Online patient access to appointments; repeat prescriptions; Use of Telecare to enable patients to self-care (eg COPD initiative)

Building capacity in primary care – exploring a scheme to increase clinical staff capacity through a CCG approved ‘staff bank’

Increasing opening hours for the walk-in centre as a pilot until 31 March 2014

Out of Hours access to GPs for patients at the end of their life – pilot to 31 March 2014

Exploring triage systems in primary care, and developing a shared learning resource through protected learning time

Responding to our Patients
Key EMAS changes so far -

- **Improved leadership in front line operations and for external engagement.**
- **Improved operational resourcing through predicted demand management.**
- **Improved dispatcher ratios in EOC; revised dispatch framework; regional surge cell; developing our service model.**
- **Enhanced Clinical Assessment Team, with a consultant paramedic link; dedicated Assessors for Red 2; focus on Green 'safety netting'**
- **CAD upgrades to correct inaccuracies in recordin**g.

- **… and a better understanding of our issues**

Working with UHL

- EMAS cooperative working with UHL & CCG senior managers to reduce ambulance turnaround times.
- Ambulance turnaround action plan developed & implemented.
- EMAS HALO – Hospital Ambulance Liaison Officer funded by LC CCG.
- Regular follow up meetings held to further improve.

- Ambulance turnaround time targets: -
  - From arrival at ED to handover to LRI = 15mins
  - Following handover to “green & available” = 15mins
  - Total target time for pre & post handover is 30mins

Working with UHL

- Ambulance turnaround performance at UHL now averages: -
- From arrival at ED to handover to LRI = 18mins
- Following handover to “green & available” = 11 to 12mins
- Total time for pre & post handover averages 30mins

- When patient flow through LRI ED is slower these times are exceeded.
- HALO assists LRI staff to ensure any delay is minimised.
- EMAS staff support LRI by caring for patients in corridors / additional areas before handover can be achieved – this is to release ambulances for response.

Impact to EMAS of handover delays

- Monday 17th February – pre handover increased from 18mins to 39mins 20secs
- This affected 174 patient journeys.
- Up to 17 ambulances queuing at any one time.
- Ambulances available = 41 to 19-00hrs and 30 post 19-00hrs.
- Additional lost time = 61.77hrs of front line operational response.
- This equates to 35 emergency responses.

- Handover @ 30 to 59mins = 41 patients
- Handover@ 1 – 2hrs = 16 patients
- Handover greater than 2hrs = 16 patients

- EMAS provided “Gold on Call” manager + 3 clinical managers on site until 02-30hrs Tuesday morning.

Impact to EMAS of handover delays

- Monday 24th February pre handover delays increased from 18mins to 39mins 5secs
- This affected 166 patient journeys.
- Up to 17 ambulances queuing at any one time.
- Additional lost time = 58.32hrs of front line operational response.
- This equates to 33 emergency responses.

- Handover @ 30 to 59mins = 32 patients
- Handover @ 1 – 2hrs = 21 patients
- Handover greater than 2hrs = 10 patients

- EMAS provided “Silver on Call “ manager + 3 clinical managers and 4 clinical staff until 02-30hrs, then 1 clinical manager until 04-30hrs
- Red 2 performance declined from 83% @ 19-00hrs to 72% midnight.

UHL Actions & Change: Context

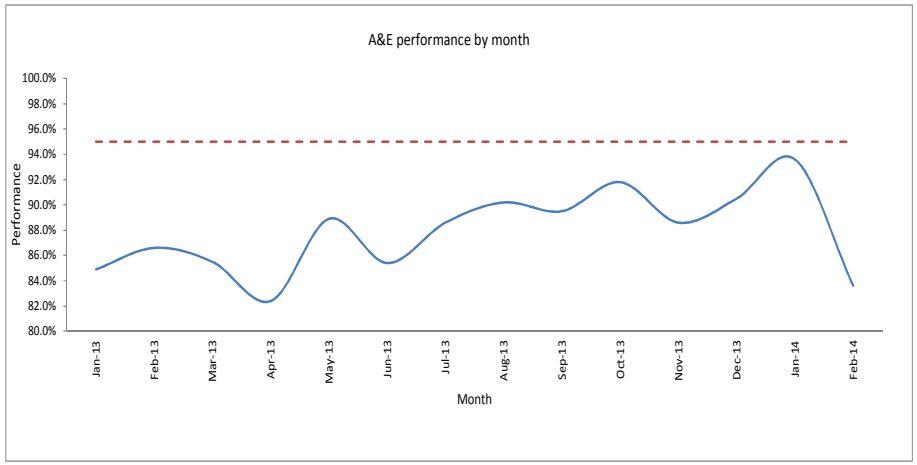
- UHL has circa 70 few beds based on occupancy, LOS and activity. This was shared with TDA on 11/10/13 and discussed at UCWG on 31/10/13.
- Every possible action has been taken to open additional beds in UHL and LOS compares well.

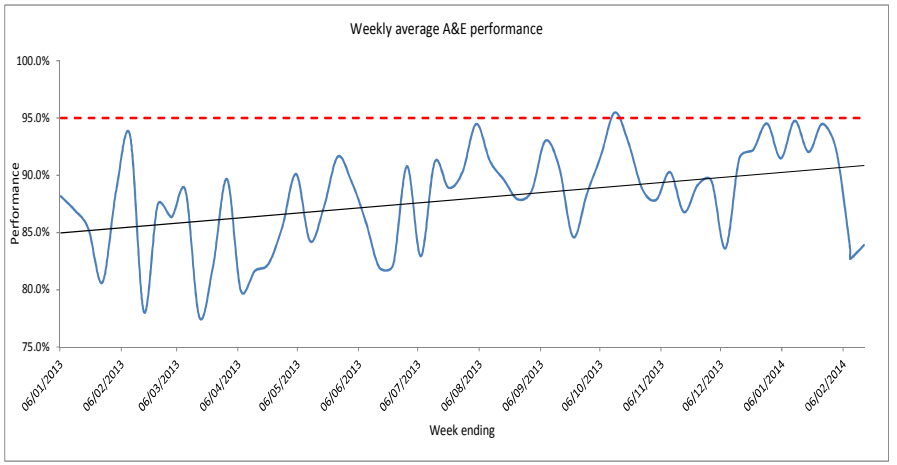
Non Elective medicine	2012/13	2013/14
UHL	5.7	5.2
HES PEER Average	6.8	5.6
BCBV Average	6.7	6.7
Nottingham	5.5	5.5
Sheffield	7.1	7.7
Newcastle	8.6	7.1
Leeds	7.1	7.7
Birmingham	6.3	7.4
Coventry	7.1	5.8

- A&E dept was built for 100,000 and is seeing circa 180,000 per year.
- Plans for a new emergency floor are being developed

Process improvement

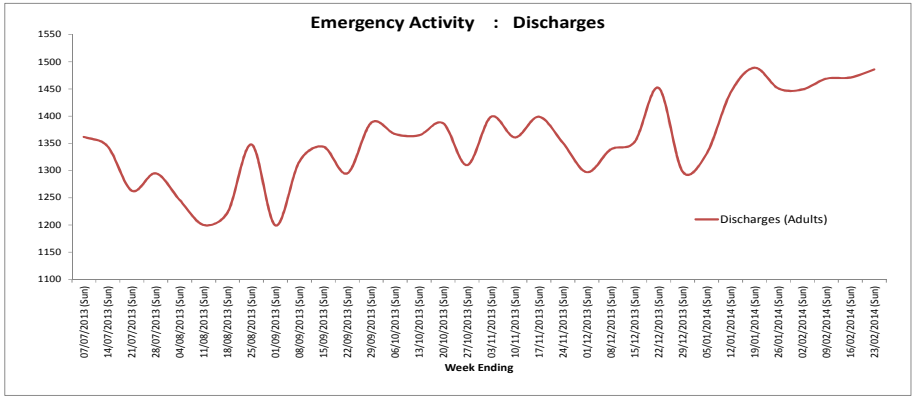
- Detailed work in July – August 2013 identified breach issues.
- Key improvements include: staffing increase, changes to A&E process, flow through UHL, site meetings and command and control style of working
- Performance reached 93.6% in January 2014 – best in 15 months
- Continuous performance improvement in 2013 -14

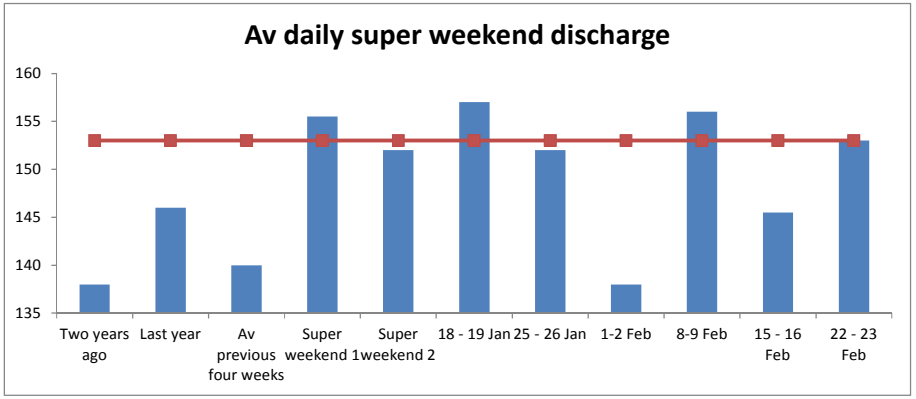




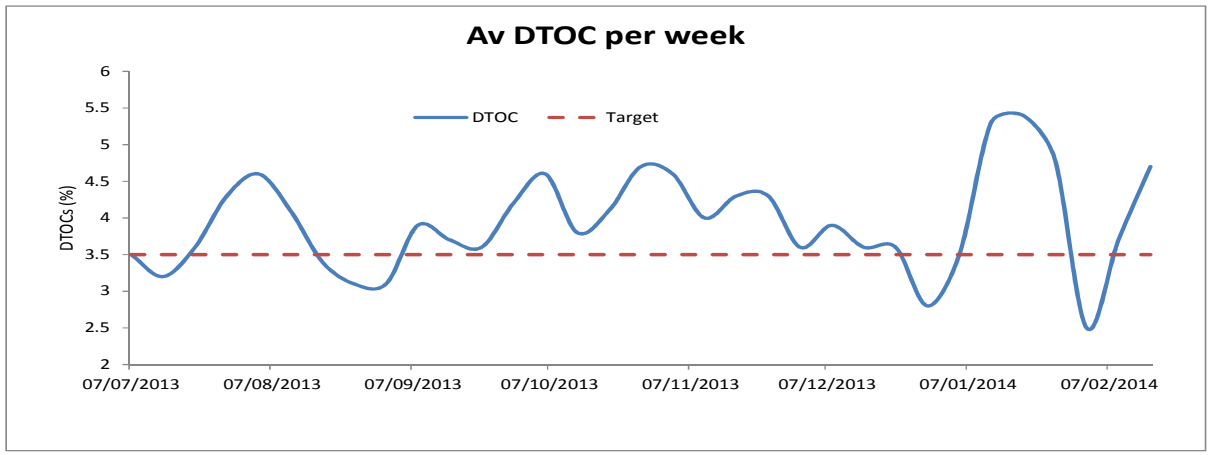
Discharge improvement

- Discharge process improved with twice daily discharge phone calls and step up in weekend discharges



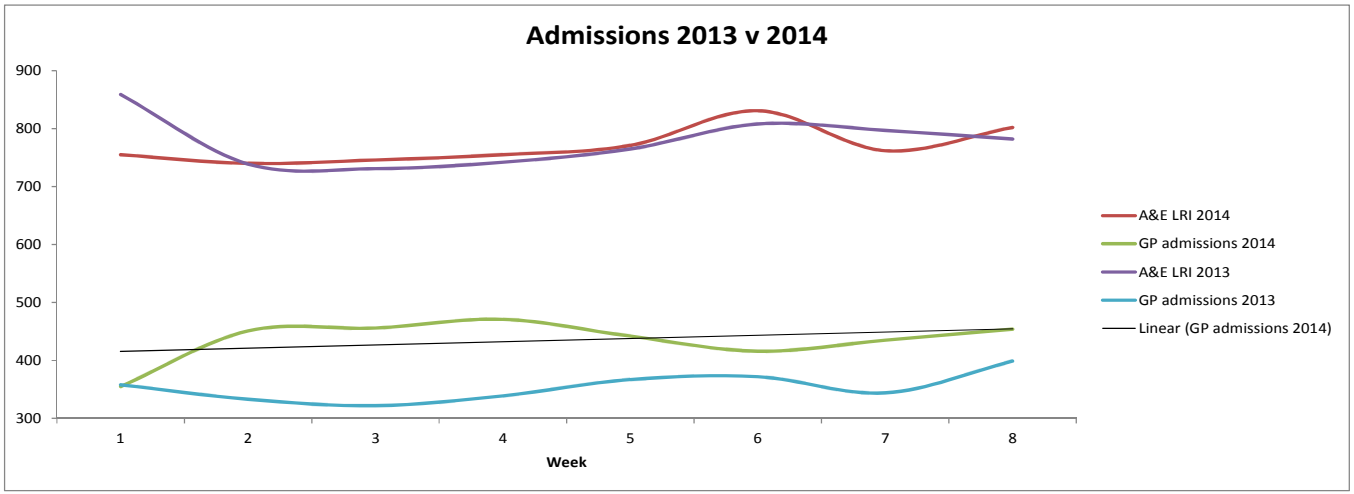


- Delayed transfers of care are consistently higher than 3.5%



Admissions and February performance

- Performance deteriorated in February as admissions increased. UHL process has remained exactly the same
- 9.5% more admissions in February compared to January
- 61 fewer A&E admissions in Feb 2014 compared to Feb 2013 but a 646 increase in GP admissions
- GP admissions up 62% w/e 23 Feb 2014 compared to first week in April 2013. A&E admissions up by less than 1%
- As confirmed in October, when demand goes up, we cannot cope because we do not have any more beds to open and flow dries up



Integrated Discharge

Supporting actions:

- Admission avoidance – role of primary care co-ordinators within the emergency portals
- Non-weight bearing pathway
- Patient progress and discharge monitoring via ward census and twice daily conference calls
- Discharges earlier in the day
- Increasing weekend discharges
- Reducing delays in transfers of care
- Working with partners to reduce bed days delayed due to Delays in transfers of care

Community Beds/Support

LPT support in UHL

Urgent Care Centre: Mental Health Triage Nurse Pilot

ED and assessment units: Primary Care Coordinators

Base wards: Integrated Discharge Team

Frail Older Persons' Assessment and Liaison Service

LPT bed coordinator

LPT support outside of UHL

264 in-patient rehabilitation beds (City 47)

120 Intensive Community Support ‘beds’ (City 24)

Integrated medical management model (Advanced Nurse

Practitioners/Consultant Geriatricians)

Integrated Crisis Response Service/Rapid Intervention Team

Community nursing neighbourhood teams centred around GP practice populations (City 10 teams)

LPT next steps with partner agencies: Better Care Fund

Integrating our community health ‘single point of access’ and our local authority ‘single point of contact’

Increasing and enhancing the community offer of unscheduled care services

Additional Intensive Community Support capacity

Adult Social Care
Role and Contribution to the Acute Care Pathway

Ruth Lake

Divisional Director, Adult Social Care and Safeguarding

ASC Statutory Role

- To assess people who appear to be in need of care
- To determine eligibility for LA funded or arranged services
- In Leicester the eligibility threshold is set at substantial and critical
- To provide advice and information to people who do not have eligible needs

Community Care (Delayed Discharges) Act 2003

- Duties on ASC and UHL to communicate about discharge
- Process of s.2 & 5 notifications
- s2 = likely need for community care services; s5 = planned discharge date
- Failure to transfer 24 hrs after s5 date = delayed transfer attributable
- Monitored via SITREP and links to national perfomance reporting

Partnership Contribution

- Significant strategic input and recognition of challenges
- Significant operational input to the systems in place to flag discharges and ensure action
- Few statutory delays
- Increasing options to secure discharge before any statutory timescale

Proactive Case Identification

- 10am telecon produces daily patient census list – expanding ward base. Real time prior to any s2
- Also highlights internal process delays
- Used by Head of Service to check and provide comments to 3pm call
- 12.30 call chaired by UHL to look at delays. Value and use under consideration by ECD&I Group
- Formal list of delayed transfers produced end of day to hos
- ASC record of all s2&5 and provide an immediate response to originating ward where patient not currently known to ASC
- Work to close down 2s and withdraw invalid 5's to avoid wasted time
- 3 workers linked to specific groups of wards; attend board rounds and to help navigate system Impact reported weekly to ECD&I

Services to support discharge

- Generally responsive domiciliary care market
- Re-procurement 2013 – increased capacity by 20,000 hours; addressed difficult to secure packages through fee incentive
- Provision of ‘holding team’ service to bridge gaps in available start dates
- ICRS to support pre-admission areas at UHL – direct access
- Reablement services available direct for non-complex weekend / evening discharges – without prior assessment
- Residential beds for IC, assessment and interim placements
- Work with providers re their timeliness

Weekend Working (Social Work)

- Well established holiday period working (key W/E or B/H)
- Super weekend working – mixed picture
- Continuing Saturday teams to deal with known s2/5 and any other flagged patients e.g. via census, telecon. Open to new s2/5 from UHL
- Evidence of lack of whole system approach – e.g. one agency stepped up but then discharge fails / delayed due to another part of the system

Further developments

- Exploring potential to block purchase interim capacity in independent sector
- Exploring potential to block purchase domiciliary care hours for hospital and reablement service discharges
- BCF to move to regularise 7 day / extended hours working
- Increase of ICRS capacity
- Changing role of H&SCC to Care Navigators with in patient & discharge focus

System observations

- Accurate, up to date information is vital
- Lack of above results in wasted time and partnership pressure
- Further coordination of the various ‘lists’ would be positive
- Whole system step up needed or individual efforts lack impact / value

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Appendix B

healthwatch Leicester

LEICESTER CITY HEALTH & WELLBEING BOARD
EXTRAORDINARY MEETING TO CONSIDER URGENT CARE – 6TH March 2014
SUBMISSION FROM HEALTHWATCH LEICESTER CITY

The performance of A&E at Leicester Royal Infirmary has been of real concern for many months and the particular circumstances arising on a number of occasions last autumn, and most recently on 17th February, causing great distress and anxiety to patients and their carers many of whom were frail and elderly, were completely unacceptable.

- Whilst the Emergency Department at Leicester Royal Infirmary is situated within the City and whilst this is a meeting of the City Health & Wellbeing Board, UHL serves a population of around 1million people and the resolution of the issues we face are not those of only the hospital **BUT** of the whole Leicester, Leicestershire & Rutland health **AND** social care community.
- The pressures upon the Emergency Department are not new; there have been several crisis moments over the last 15 years as Healthwatch, LINks and prior PPI bodies can attest.
- UHL's A&E department is by no means the only one facing huge pressures.
- The present A&E Department was never built to envisage the current numbers coming through the doors – originally envisaged 100,000, currently nearly 200,000.
- There has been a year on year cumulative increase in the number of people attending A&E since 2000, with a significant increase in numbers over the last three weeks to levels not previously recorded.
- The evidence would suggest that UHL are clearly dealing with more acute cases coming through A&E but on the same bed base which has remained constant for many years.
- In July 2013 an Urgent Care Working Group [UCWG] was established to get a grip upon Urgent Care because UHL was failing consistently to meet the 95% target for people to been seen, dealt with, admitted or allowed home within 4 hours.
- The UCWG has met weekly, with Dr M Pepperman representing Healthwatch Leicester & Leicestershire, taking a full part.
- Strenuous efforts have been made to fully understand the challenges facing the Emergency Department with a huge commitment from everyone involved.
- **Considerable strides have been made – the introduction of the front of house triage system for ambulatory patients has been very successful in diverting perhaps a third of patients away from A&E to more appropriate community provision e.g. GPs, Pharmacists.**
- A most thorough research of all the component factors has been undertaken and before Christmas the three CCGs in LLR led a piece of work within ED and the hospital, with Healthwatch input, to identify a range of solutions.

- The City CCG has stimulated a range of initiatives to keep people who do not need to be there, out of hospital; however, the data presented to the UHL Board on 27th February 2014 indicates that this has not yet resulted in any reduction in GP referrals; in fact they continue to rise. If this is indeed the case, could we know why?
- Similarly, has there been any reduction in the number of people being referred inappropriately to hospital by the Out of Hours Service?
- We recognise that a number of additional community and intermediate care beds have been provided or reinstated but are not sure these are sufficient to take into account the projected growth in the elderly population in LLR.
- The number of patients needing to be accepted by the Leicestershire Partnership NHS Trust is growing and some of these patients are having to be treated out of County.
- We are very aware of the on going pressures on social care as a result of the huge cuts in local government expenditure.
- UHL has recognised many of its own system failings and carried out extensive work to remedy these; key senior staff have been recruited – there are now 16 out of 24 A&E Consultants in post.
- **Performance has improved considerably BUT not consistently.**
- Two "super weekends", involving the collaborative work of all partners, were successfully held in January.
- **Notwithstanding the above, there have been a number of occasions when pressures upon A&E have become intolerable for patients; on 17th February ambulances were backing up at the hospital with patients facing long waits and delays BEFORE even getting into A&E. For elderly, frail and possibly confused patients in particular and those in pain and distress this is clearly an unsatisfactory and unacceptable situation.**
- Healthwatch finds it surprising that given these situations, just how few people complain, and how understanding many are, of the pressures being faced by staff within the ED. HW is really concerned about the unremitting nature of the demands placed upon front line staff and their managers within the department and their possible demoralisation.
- Perhaps the most challenging issues to be resolved are those related to the INFLOW of patients to the ED and the **DISCHARGE/TRANSFER of patients from the UHL; patients and the public and Healthwatch on their behalf** need to know **what else** the LLR health and social care community, **working together**, can do.
- Whilst Healthwatch may understand and do its best to explain, many members of the public find it hard to understand why, if the system is struggling to find suitable alternative places for patients so they can be discharged from hospital, a Ward at Loughborough Hospital can be closed, opened again and now about to be closed again, all within the space of nine months.

This submission has been informed by enquiries made to the Healthwatch Information line, comments made to Healthwatch at the various engagement events held in the last six months, information from the Healthwatch Participating Observers on the Urgent Care Working Group, the CCG and UHL and matters raised with the Interim Chair when he has made presentations at the Community Meetings throughout the City.

Philip Parkinson, Interim Chair, Healthwatch Leicester and Healthwatch representative on the Health & Wellbeing Board.

2nd March 2014

Role of NHS England within the context of Urgent Care in Leicester

Dr David Sharp - Director

NHS England (Leicestershire & Lincolnshire Area)

6 March 2014

THE NHS CONSTITUTION
the NHS belongs to us all

Appendix C

1. Primary Care – Contract Holder

Primary care is key to treating patients in the right care setting more efficiently and effectively and with better outcomes.

The Leicester Context:

•13% of patients are treated by single-handed GPs in Leicester compared to approximately 9% nationally. This causes problems for continuity of care, access and recruitment/retention of GP's. Leicester City CCG and NHS England are working closely together, particularly during the current planning round, to identify opportunities to co-commission services which improve quality of primary care and develop new service models.

For example :

•The new GP contract secures specific arrangements for all patients aged 75 and over to have an accountable GP, this is a responsibility for NHS England to deliver. CCG's have a financial commitment to make £5/head available to these GP's to commission services which maintain the frail elderly in the community and safely avoid acute hospital admission

2. Assuring Plans and NHS System Management

- NHS England has to assure the quality of CCG commissioned services, such as A&E to ensure they deliver the NHS constitution, to facilitate 'system management' by working across organisations to resolve system problems and provide impetus to improve quality.

- NHS England also fulfils a strategic planning role in relation to the development and assurance of strategic plans, alongside the implementation of national policy.