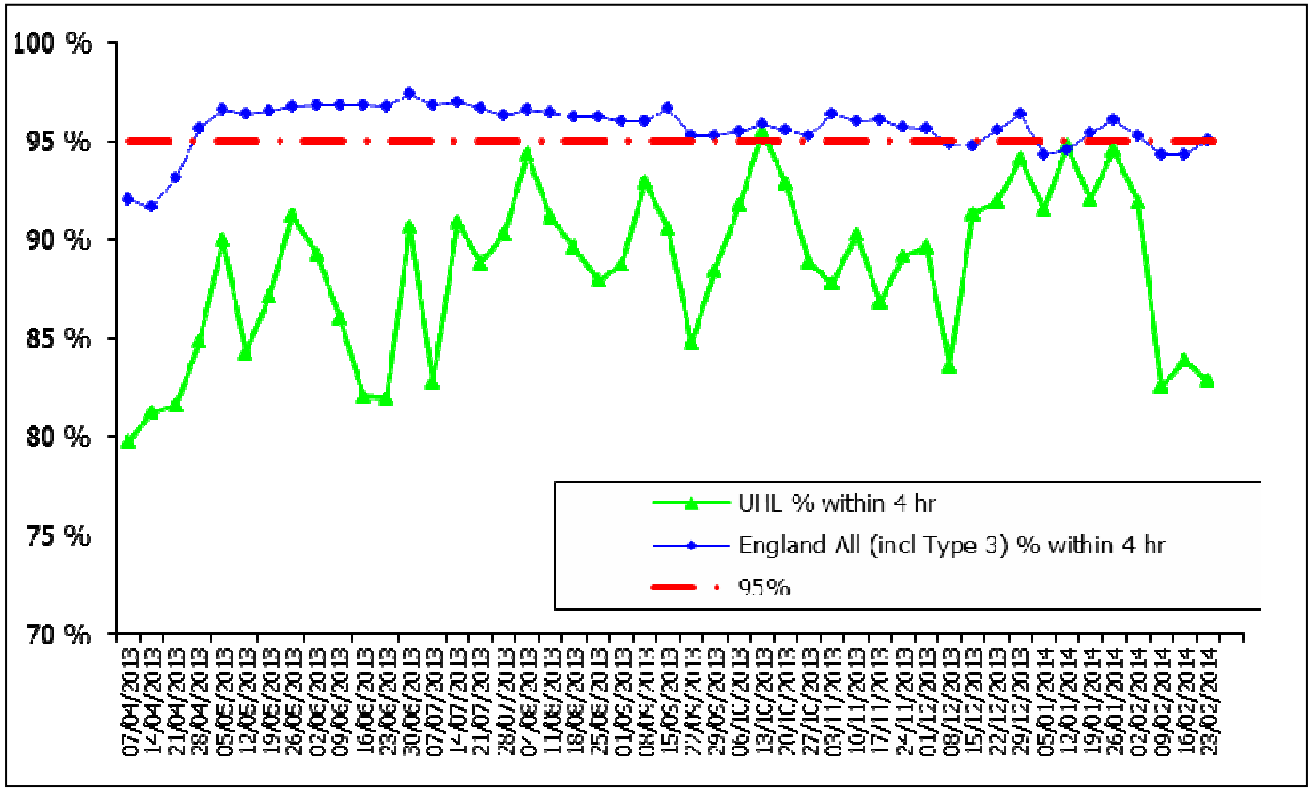
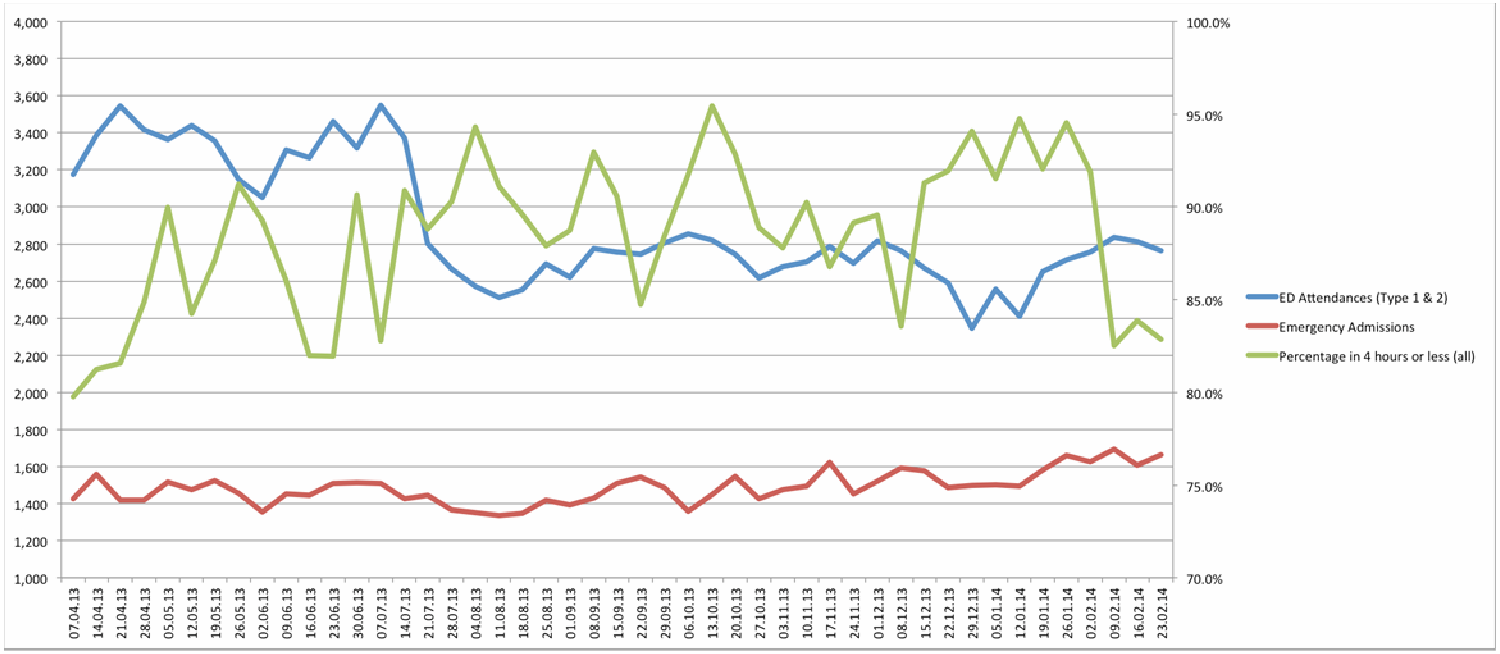
Overview of Performance and Governance



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.

Activity and Performance



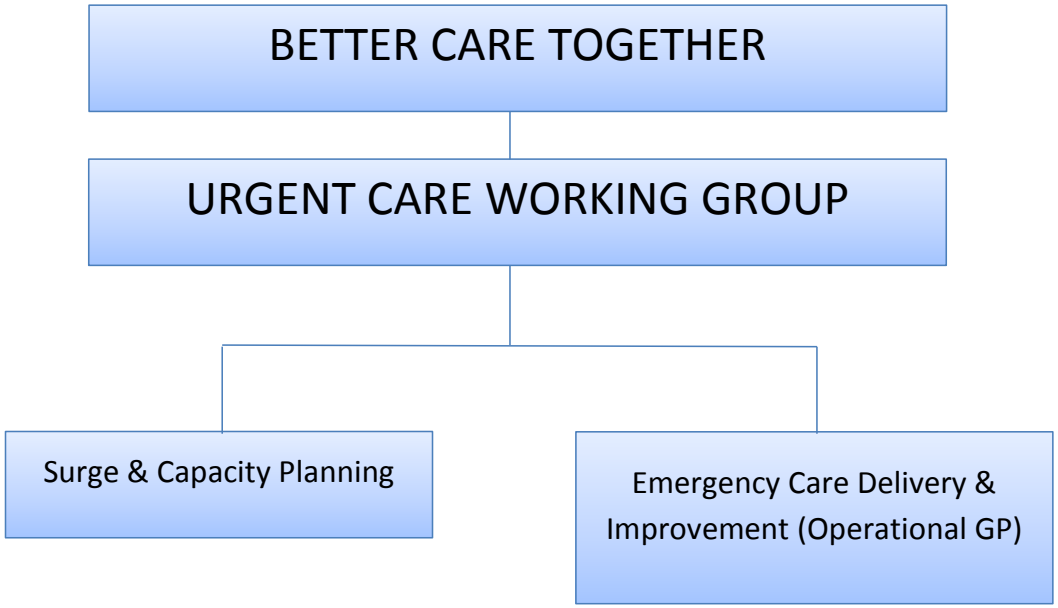
A&E attendance (blue line) dropped in July following the implementation of the single front door into the Urgent Care Centre for ambulatory patients. This reduced attendance by about 30%. Activity over the week has been reasonably consistent during over the last 6 months but the graph doesn't portray 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

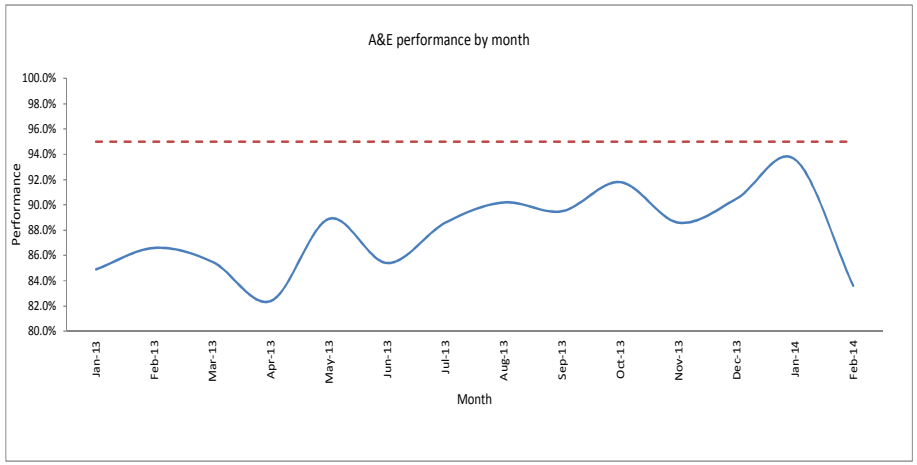
- UHL has circa 70 few beds based on occupancy, LOS and activity. This was shared with TDA on 11/10/13 and discussed at UCWG on 31/10/13.
- Every possible action has been taken to open additional beds in UHL and LOS compares well.

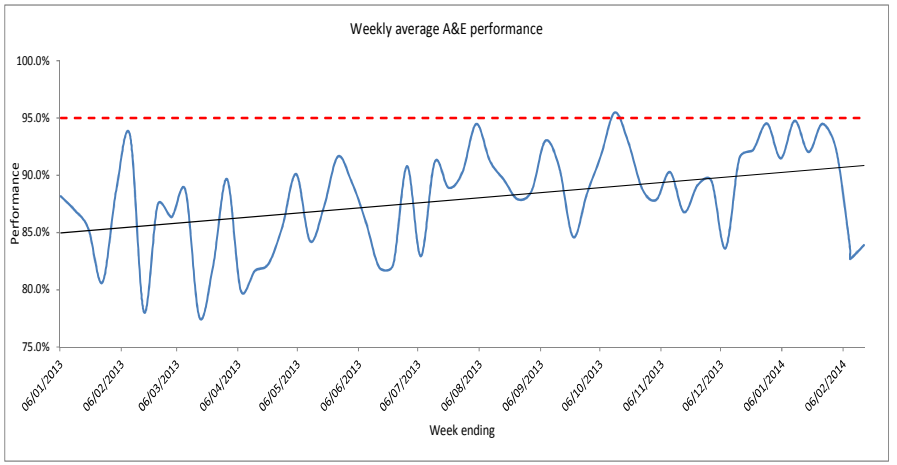
Non Elective medicine	2012/13	2013/14
UHL	5.7	5.2
HES PEER Average	6.8	5.6
BCBV Average	6.7	6.7
Nottingham	5.5	5.5
Sheffield	7.1	7.7
Newcastle	8.6	7.1
Leeds	7.1	7.7
Birmingham	6.3	7.4
Coventry	7.1	5.8

- 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

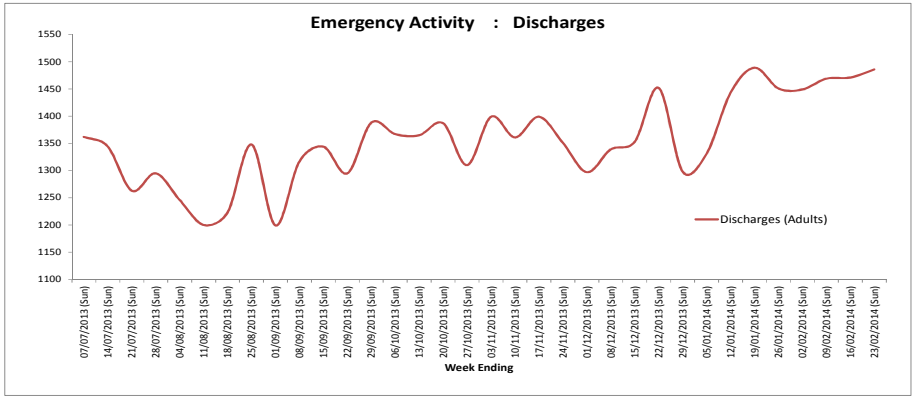
- Detailed work in July – August 2013 identified breach issues.
- Key improvements include: staffing increase, changes to A&E process, flow through UHL, site meetings and command and control style of working
- Performance reached 93.6% in January 2014 – best in 15 months
- Continuous performance improvement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

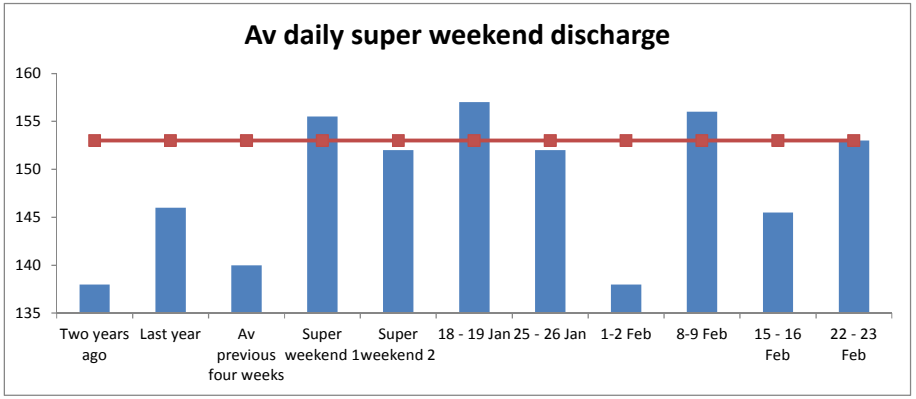




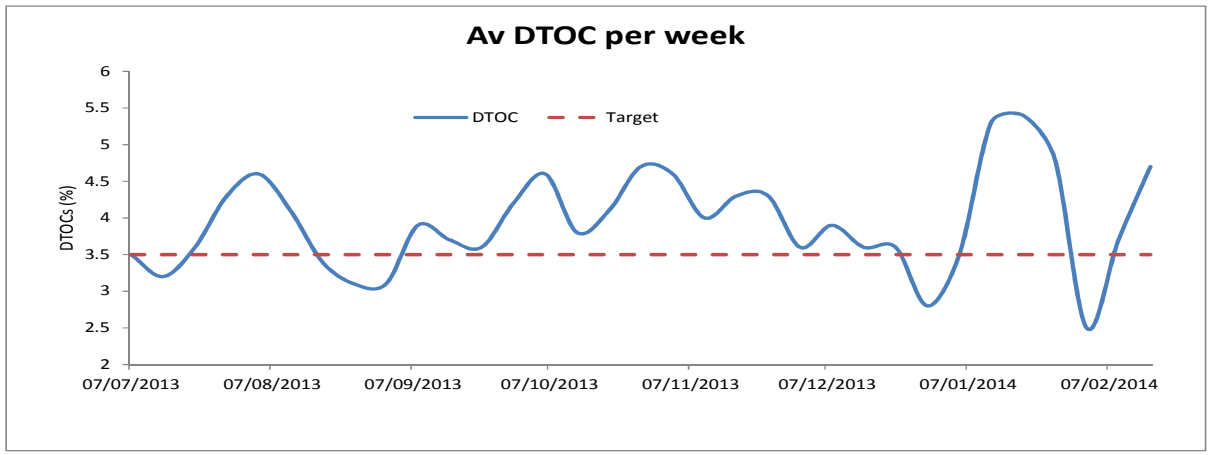
Discharge improvement

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



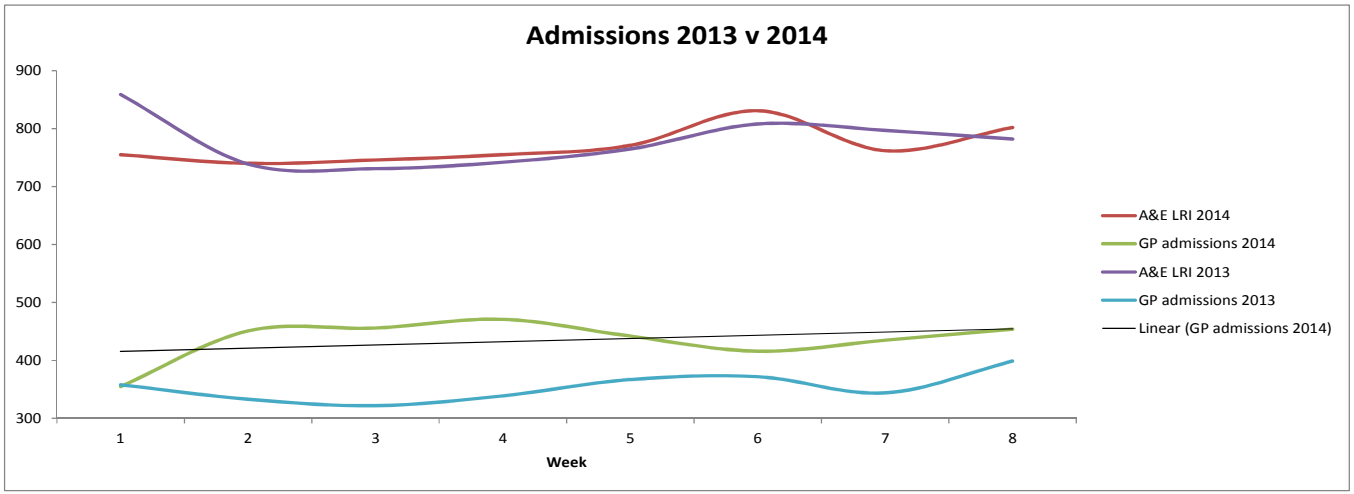


- Delayed transfers of care are consistently higher than 3.5%



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