University Hospitals of Leicester NHS
NHS Trust

To:	**Trust Board**
From:	**Catherine Griffiths – Joint Chief Executive, NHSLCR/LC**
Date:	**6 October 2011**
CQC regulation:	As applicable

Title:	**Progress on the LLR Emergency and Urgent Care Plan**

Author/Responsible Director:

Catherine Griffiths – Joint Chief Executive, NHSLCR/LC

Purpose of the Report:

To response to queries raised at the 1 September 2011 Trust Board development session.

The Report is provided to the Board for:

Decision		Discussion	
Assurance	X	**Endorsement**	

Summary / Key Points:

See report for details.

Recommendations:

The Trust Board is being asked to note the attached report.

Previously considered at another corporate UHL Committee ?

N/A

Strategic Risk Register Yes (UHL)	**Performance KPIs year to date Yes**

Resource Implications (eg Financial, HR)

See report.

Assurance Implications

See report.

Patient and Public Involvement (PPI) Implications

N/A

Equality Impact No
Information exempt from Disclosure No
Requirement for further review ? Already reviewed monthly at UHL Trust Board and also through the LLR ECN.

Report Title: Key Questions from the September UHL Board Development session

Date: October 6th 2011

Report Author: Catherine Griffiths, Chair, LLR Emergency Care Network
Rachna Vyas, Planning & Delivery Specialist, LLR PCT Cluster

1. Introduction

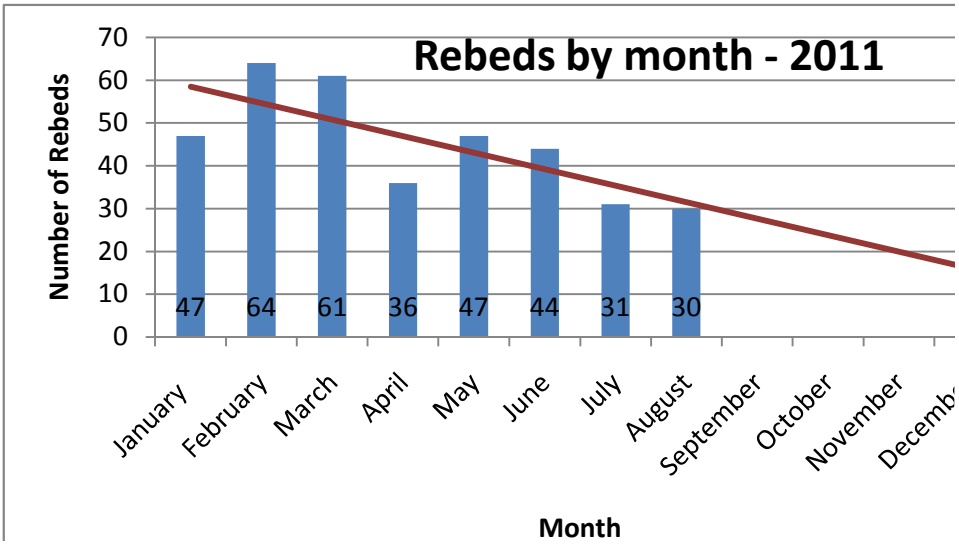
Following the Trust Board Development session in September 2011, the LLR Emergency Care Network was requested to provide clarity on a number of points referred to during the course of the discussion regarding the progress of the LLR Urgent Care Improvement Plan.

This paper intends to provide assurance to the Trust Board that the actions outlined in response to the said questions have been progressed further since the session.

2. Key questions posed:

a) Update regarding EMAS plans to mitigate re-beds and trajectory at which this would be zero

Target: < 5 rebeds per week by September 2011.
August total: 6.6 rebeds per week
Trajectory: As below



It is recognised that actions are required at both EMAS and UHL to achieve the trajectory described. To date, actions agreed to increase efficiency of the PTS include:

Agency	Action
EMAS	1. 10 – 10 Discharge Crew now planned on a daily basis to discharge patients. 2. Customer Service Manager spending time at LRI ED to speed up turn around of crews. 3. 10% of crews are not on the rota to enable the prioritisation of discharges

	4. A Customer Service Manager attends the Midday and 4pm bed meeting (sometimes telephone conference). 5. Renal drivers used for discharges in-between transporting Renal Patients. 6. Kate Jerram to work with a chosen ward to share best practice for booking transport and then rolled out to all wards (waiting for Andy Jones to confirm chosen ward). 7. Any staff brought in on overtime must start shift at midday and only be used for discharges. 8. Control staff (when available) contacting patient's day before to see if still travelling. 9. Monthly meeting with PTS SDM and CSM – Veronica Horton and Jon Missin to agree re-bed numbers. 10. All in correct bookings fed back to the booking office on the day. 11. Daily contact between Sue Smith/John Forster and UHL Duty Managers 12. Regular contact between Michael Byrne and Veronica Horton/Richard Jarvis to discuss potential issues. 13. Work with LLR PCT cluster/UHL at reducing aborts and on the day cancellations. 14. Agree capping levels for all patients for this years SLA. 15. Move to Auto Planning on the day. 16. During extreme pressures all Customer Service Manager's and Team Leader's are involved in moving patients. ED & A/E resources utilised where possible
UHL	1. Ensure that 20 – 25 patients are made ready before 1pm. 2. Address issues with 'To Take Out' medicines 3. Robustly enforce new eligibility criteria. 4. Work with LLR PCT Cluster/UHL at reducing aborts and on the day cancellations. 5. Agree capping levels for all patients for this years SLA

This workstream is ongoing and will continue to be monitored at the ECN.

b) Clarity regarding the wider LLR bed capacity for the winter

All organisations across LLR have been involved in the production of a joint winter plan, including escalation and de-escalation routes. The plan has specifically applied the learning from last year and is far more robust than previous years. Following assessment by the Interim Management and Support Team (IMAS) and the Strategic Health Authority, the LLR winter plan was circulated across the region as an example of good practice.

As part of this process, agencies have been assessing the requirements for additional capacity for Winter 2011/12. This includes potential solutions such as:

Agency	Solution
UHL	A short term model of local provision utilising unused UHL capacity until the new city Intermediate Care service becomes operational has the potential to save significant numbers of bed days. This would also have benefits for patients, their carers and both UHL and LPT.

	This would be achieved by extending the capacity of Ward 8 by 4 beds from November 2011, providing 635 bed days, at a cost of £92,005.84. This was agreed at the Sept ECN and plans are being finalised to take this forward.
Adult Social Care	Collaborative work with Leicester City Adult Social Care continues with a view to commissioning a number of a residential care home beds to support reablement until full proposals are implemented.
LPT CHS	Senior clinicians and managers would be available to assist with supporting discharge in UHL as per previous years to maintain patient flow across the health and social care community – however the impact on other operational duties and performance targets would need to be acknowledged and agreed at the ECN
EMAS PTS	Extra crews to aid discharge to increase the flow out of hospital would be considered by the ECN as per previous years. Financial cases have been prepared in case of urgent need.

In reality, throughout winter 10/11, every agency provided mutual support and it was found that the key to running a successful winter was clear escalation and communication processes within and across organisations. To support this the ECN will move to weekly meeting (should this be required) as it did last year.

c) Clarity regarding receipt of patients to community beds during the evening

LPT continue to accept patients transferring from UHL as flexibly as possible. The core reasons for implementing cut off times were to safeguard patient safety and experience because of the issues described below:

1. Patients arriving after hours when no medics are on site to review them, and intervene as necessary.
2. Patients arriving sicker that was indicated when they were handed over, and therefore require medical intervention.
3. Transfer of patients where prescription charts are not fully completed or a clear management plan documented.

However, cut off times are always relaxed when UHL are on a stage 3 as a measure of continued support during periods of surge.

LPT will continue to work with UHL to improve the quality of information that accompanies patients when being admitted to a community hospital to facilitate the potential of later cut off times.

Work also continues with EMAS to upload formal cut off times onto the EMAS systems to ensure patients due to go out to Community Hospitals are prioritised according to cut off time.

d) Confirmation regarding when the expanded Mental Health service to ED will commence

LPT have outlined plans to enhance the current 'Liaison Psychiatry Service' in the Emergency Department from 9-5pm 5 days a week to 9am-midnight, 7 days a week. This is due to begin incrementally from mid-October; staff already in post will cover for the first few weeks while staff recruitment is completed.

e) Confirmation regarding use of reablement monies for 2011/12 and impact on winter plans

Reablement plans have now been submitted from each Local Authority across LLR. There is an inevitable difference between proposals from Leicester City, Leicestershire County and Rutland County as a result of the different start point for existing services. There are clear areas of similarity, though, with the following being the core themes.

1. Additional investment in order to expand existing services.
2. Extension of services to additional hours / weekends (24/7).
3. Improved co-ordination of health and social care.
4. Voluntary sector – help at home.

Leicestershire County

Summary of proposals is as follows:

1. Co-ordinated ICT (Intermediate care team) / reablement service (HART) (extended to 24/7) with additional investments in:
    a. Physiotherapy
    b. Occupational therapy
    c. Nursing
    d. Home care assistants
2. Commissioning of help at home service.
3. Development of SPA.
4. Project Management for planning and delivery.

Leicester City

Summary of proposals is as follows:

1. Co-ordinated RIT (Rapid Intervention team) / reablement service (extended to 24/7) with additional investment in:
    a. Physiotherapy
    b. Occupational therapy
    c. Nursing
    d. Social care assistants
2. Commissioning of help at home service.
3. Additional 10 IC beds for social care / health use.
4. Co-location / development of SPA.
5. Enhanced hospital team – dedicated social care assistant to support Emergency Frailty Unit.
6. Project Management for planning and delivery.

Rutland County

Summary of proposals is as follows:

1. Co-ordinated ICT (Intermediate care team) / reablement service (REACH) with additional investments in:
    a. 1x therapy post

These proposals were discussed at the September ECN – further clarity was asked for regarding the alignment of the 'Single Point of Access' (SPA) projects to the LPT transformation bid to formulate one health SPA across LLR, (see section f). Further, the ECN requested specific, quantified performance measures for each scheme.

The proposals have subsequently been presented to and agreed through each Clinical Commissioning Group and plans for implementation have been requested as soon as possible. It is, however, recognised that some of these schemes will not be live for Winter 2011/12. In recognition of this, the contract meeting on 27th September will assess the readmissions issue and the case for reimbursing UHL where appropriate.

f) Clarity regarding alignment of various SPA work-streams

There are currently a multitude of 'Single Points of Access' being formulated across sectors and agencies in LLR. The NHS 111 project is also gathering pace with a firm commitment across the East Midlands region to become one of the first regions to implement the system.

To prevent duplication and to ensure seamless transfer of information across agencies, one overarching plan covering the various stages of each project will be produced to brief the various agencies of the agreed way forward. The overarching project will sit within the portfolio of the LLR Emergency Care Network.

Current progress:

1. LPT are developing one SPA covering health as per the transformation bid.
2. This will then involve the Integrated Preventative Services from Leicestershire County Social Care and UHL bed bureau where possible.
3. Links to Leicester City Adult Social Care SPA are being assessed and will be progressed in partnership with Leicester City Council.
4. The 111 workstream will align to this as far as possible.

LPT have already been asked to develop further detail with bed bureau and both social care teams and plans are underway to do so. A workshop to produce the overarching plan will be held in early October.

3. Progress of other workstreams

Work continues across the other workstreams not discussed in this paper, covering, amongst others:

a) primary care demand management schemes,
b) improving the interface with care, nursing and residential homes across LLR,
c) implementing the Frail Older People pathway
d) achieving a collaborative model of working across the Emergency Department and the Urgent Care Centre

These continue to be managed through the Emergency Care Network. Engagement with the Clinical Commissioning Groups is also being strengthened.

4. RECOMMENDATIONS

The UHL Board is requested to:

NOTE the content of this report