Emergency Care Network: 11/12 Stocktake

1. Introduction

The LLR Emergency Care Network was established in February 2011 with the intention of providing a strategic Network focussed on improvements to the LLR urgent care system. This paper presents a 'stocktake' of these improvements, examining the schemes implemented and their impact across the system. The paper then presents a synopsis of the work programme for 12/13 and the governance arrangements to deliver the programme of work.

2. Overarching system performance

Measure	11/12 Target	11/12 Actual
INFLOW		
Patients sent to UCC from ED	12000	14828
LLR attendances to UHL ED (ED, eye casualty and CCU)	154024	153700
Conversion rate (excluding CAU and EDU)	26%	19.9%
EMAS GP urgent conveyance rate (8am-8pm)	80% within 2-4 hours	74.15%
THROUGHPUT - ED		
4 hour performance (campus report: ED+EC+CCU+UCC)	95%	93.89%
Time in Dept. (95th percentile)	240 mins	300
Time to assessment (95th percentile)	15 mins	47
Time to treatment (median)	60 mins	46
OUTFLOW		
Discharge before 1pm from wards to home or discharge lounge – UHL	20%	23%
Discharge before noon at CHS	40%	39%
EMAS rebed rate	< 5 per week	4 per week (average across year, 4 rebeds since Nov 2011 to March 2012)

Points to note:

- Despite surges in ED attendance, the year-end performance against planned activity for LLR commissioned patients stood at -0.2%. This reduction is further evidenced through statistical testing of variance between financial years which showed a decreasing trend over

the last 3 years. Analysis of daily attendance rates shows an increase in inflow at specific times of day and for specific parts of the year.

- The emergency admission trend shows a similar decrease; however, here statistical testing reveals that there is evidence of a significant decrease year on year over the last 3 years.
- In spite of an improvement in discharge rates across the system, discharge variability continues to be seen across both time of day and day of week.

3. Impact of key ECN-led schemes planned and delivered in 11/12

11/12 Scheme	Lead agency	Status update	Impact 11/12
INFLOW			
ED-UCC interface	PCT/LCCCG	Live. Further work being undertaken by City CCG to 'Left shift' activity to General Practice and back fill this activity with ambulatory care, further reducing ED activity	14828 patients diverted from ED to UCC
WiC Project group	West Leics CCG	Live. Service review has commenced	Redesigned service live in 2013-14
MIU Project group	East Leics CCG	Live. Service review has commenced	Redesigned service live in 2013-14
Frequent attenders	CCG	Live.	Patients with more than 3 attendances in 6 months reduced by 7% comparing 2011/12 to 2010/11
Frail older people	UHL	Live. EFU and FOPALS services both in place.	Data for 11/12 shows 620 admissions to base wards were prevented by the service with a relative 19% decrease in ED conversion rate for the 85+ age group.
Changes to management of bed bureau patients	UHL	Live. Further work planned in 12/13	19.9% of medical admissions and 12.1% of surgical admissions deflected
ED process changes	UHL	Live. 'Push' system implemented in Q3 2011.	67.4% of patients admitted within 30 minutes of decision being made compared to 64.7% in 2010. Since implementation of the scheme, this average rises to 71.45%.
Conveyance of GP urgents	EMAS	Complete. Extra resources live from November 2011 – March 2012.	**April 2011-Oct 2011:** 70.82% conveyance rate between 8-8pm **Nov 11 to Mar 2012:** 78.82% rate against a backdrop of increased demand for the service

			during the winter months.
Single point of access	CCG/LPT	Complete.	New single service live from April 2nd 2012
111	CCG	Live. Pilot due to be launched in Oct 2012	Redesigned service live in 2012/13
Mental health	CCG/LPT	Live. Full service live in ED from Jan 2012, providing ED liaison service from 9am to midnight 7days a week.	98% of patients are seen within 2 hours of presentation in ED
OUTFLOW			
Discharge before 1pm	UHL	Live. Revised discharge process designed and embedded in 20 wards across UHL. Planned roll out across UHL in 2012-13.	1.Discharges before 1pm from base wards to either discharge lounge or onward destination increased to c. 23% in 11/12 2. Board Round Process introduced across 22 wards at UHL- 90% attendance rates by all disciplines. 3. UHL therapy referral to transfer time reduced from 6.5 - 3.27 days (City) and 2.1 – 1.5 days (County)
Discharge before noon at CHS	LPT	Live. Revised discharge process designed and embedded.	Discharge before noon increased 26% 2010/11 to 39% in 2011/12 across community hospital sites.
Discharge to assess	CCG	Live.	**1.** DTOC rate across all providers has reduced from 5.9 – 5.3/100,000 in 2011/12 **2.** Non Weight Bearing patient implemented – 0ver 300 Acute bed days saved Oct '11 – Feb'12
Rebeds	CCG/EMAS	Complete. Extra resources live from November 2011 – March 2012.	**April 2011-Oct 2011:** 202 rebeds **Nov 11 to Mar 2012:** 4 rebeds
Reablement - city	Leicester City Council	Live: • Extended integrated team • Practical help at home • Additional reablement beds • Integrated RIT	Good uptake of all services, with data showing positive improvements across all schemes listed.
Reablement - County	Leics County Council	Live – the social care reablement and health care project commenced in Nov 2011	Nov – Jan 2012 shows that HART cases that ended in a readmission fell by 20.1% comparing year on year data

All projects continue to be monitored through the ECN governance structure in 12/13.

4. Revised ECN focus for 12/13

Despite a positive impact of the schemes outlined above on both attendance and admission rates throughout 2011/12, it is clear that focus needs to span both long term strategic requirements as well as on short-medium term operational projects.

ECN priorities for 12/13 are as follows:

a) Design and development of a safe, resilient and sustainable urgent care pathway, ensuring patients are streamed to the right place for treatment wherever they present in the urgent care system – including at the right time of day to prevent unnecessary admission as well as a reduction in the variability of discharges, both in terms of timing of discharge, day of week and the process used.
b) Better communications with patients and the public regarding use of urgent care, from self-care right across the spectrum of services available in the LLR urgent care system
c) Variability and time-related presentations at ED combined with sufficient planning for these times
d) Implementation of both CCG led and UHL led ambulatory care pathways to ensure patients are not treated in the acute site where possible; this will include disease specific pathways as well as pathways for mental health patients.
e) Further work with EMAS to increase appropriate conveyance to the right care setting across the system using the electronic Directory of Services
f) Ensuring sufficient capacity in the Patient Transport Service following transfer to the new provider
g) System wide escalation plans need refinement, to include opening of additional capacity as a planned option across providers.

The scope and governance of the ECN has been amended to reflect these priorities. The ECN will adopt a more strategic planning approach using data intelligence to design a safe, resilient and sustainable urgent care pathway. The delivery of short to medium term actions will be mobilised through the Senior Delivery Group, the operational arm of the ECN.

Further to this, a new system-wide operational network is being formed to facilitate the day-to-day management of flow across the system. Initially, this will involve a daily discharge focussed teleconference with the aim of expediting discharges out of the acute and community sites. Once this process is embedded, this will revert to a weekly face to face whole system operational meeting, focussed on flow across the system.

The UHL Board is requested to:

NOTE the contents of this report