Appendix A

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

Improving Emergency Care

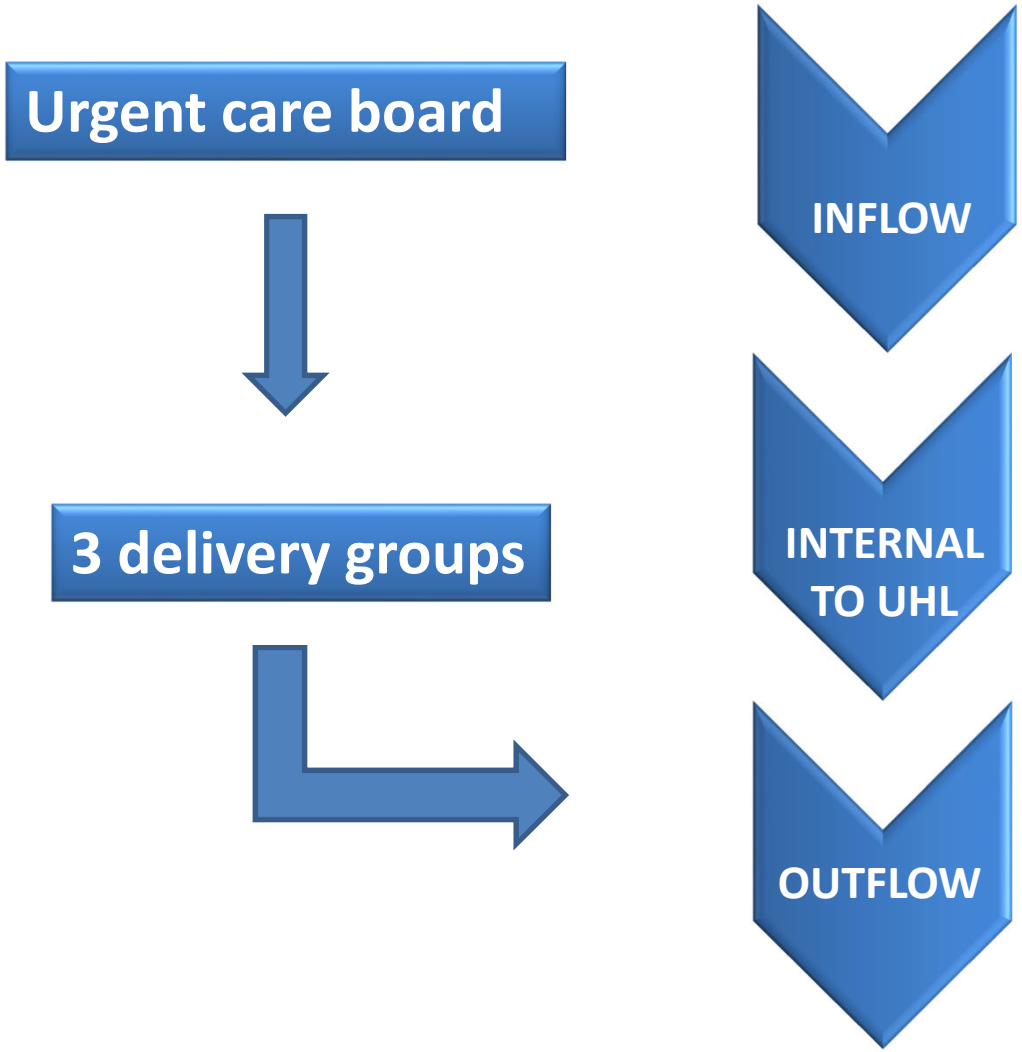
What is the problem?

- Patients are waiting too long in A&E to be seen / treated.
- The trust are failing the A&E target of 95% of patients seen within 4 hours
- Admission of patients from A&E is slow meaning some patients wait long periods of time on trolleys whilst waiting for ward beds
- Hospital discharges occur too late in the day- only 18% of patients are discharged before 3pm

Why is there a problem?

- Lots of diagnostics undertaken – external and internal
- 3% increase in activity
- Primary care referrals are channelled through A&E
- Under utilisation of UCC and confusion over role
- Internal flow issues - bed availability, ED process, capacity within A&E , flow onto wards
- Delays in the discharge process – planning, TTOs, transport, access to non-acute care packages
- Staffing levels, clinical leadership and matching workforce to peak demands

What are we doing about it?



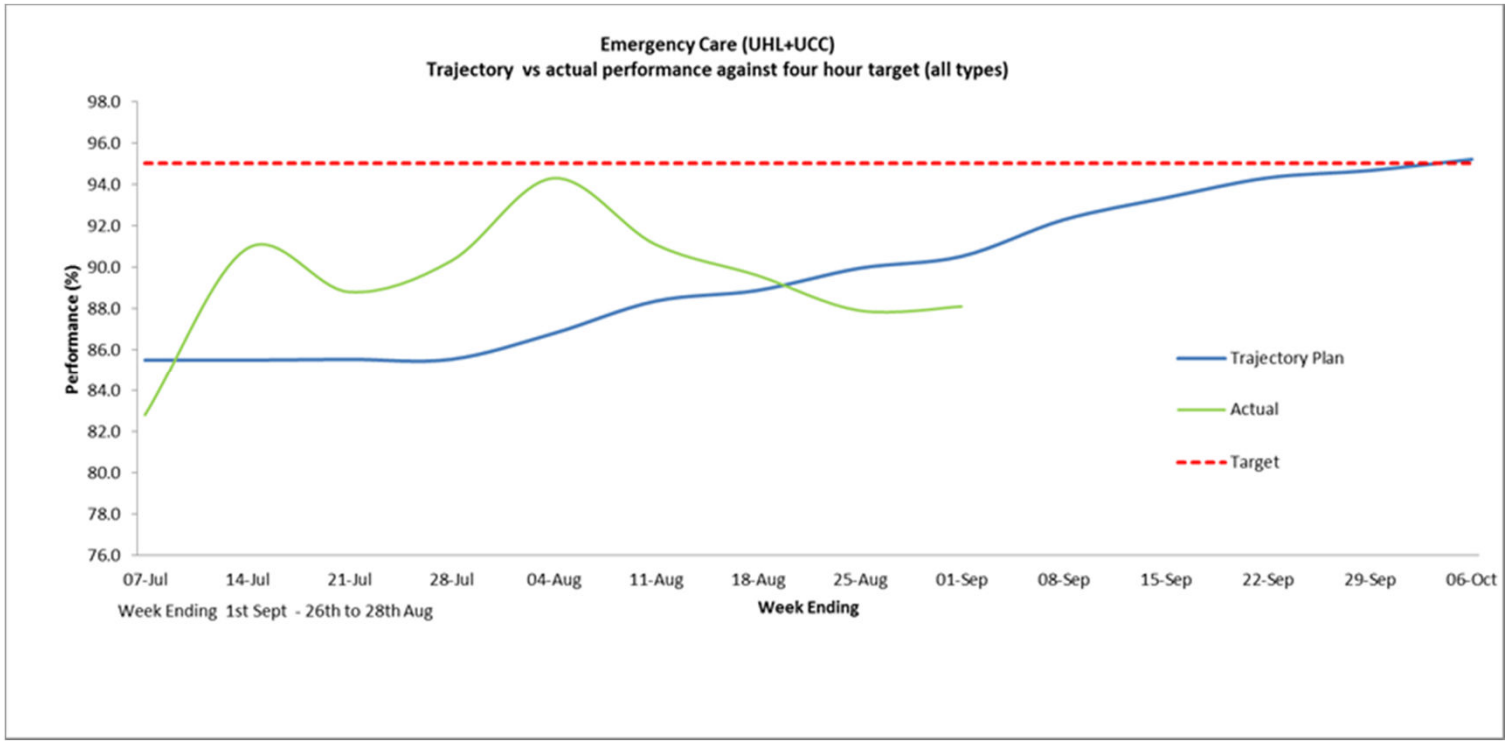
- Single front door
- Ambulatory care
- GP referrals
- Admission avoidance

- Staffing and clinical leadership
- ED process
- Downstream capacity and flow
- Improving the ambulance interface

- Assessment process
- Single point of access
- Discharge co-ordination
- Discharge to access and access to pathways
- UHL discharge process

Key Performance Indicators

Performance against trajectory

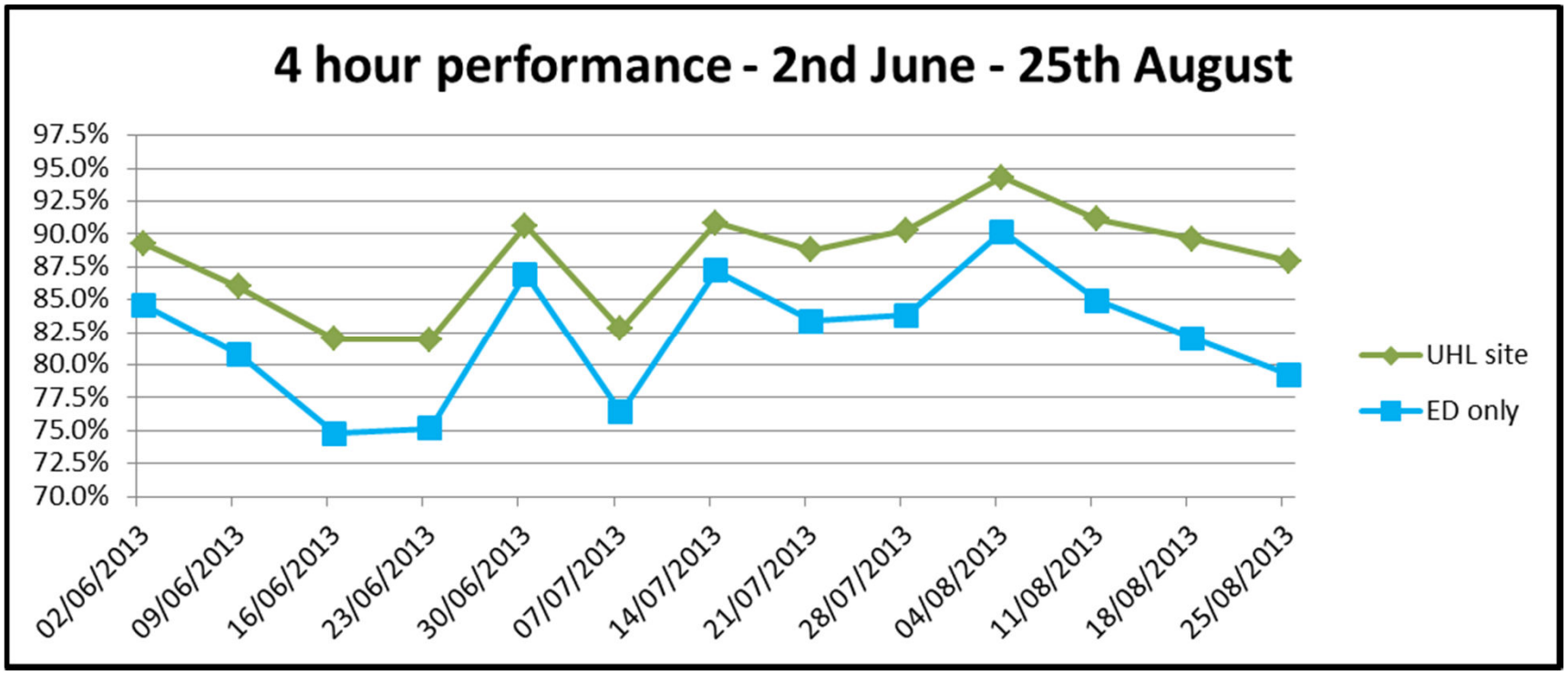


The National target for A&E is for 95% of patients to be treated within 4 hours.

The Trust have not achieved this since the start of the year. A planned recovery trajectory is set out in the graph above.

Key Performance Indicators

The chart below shows performance for ED and performance for the UHL site which also includes the performance for the Urgent Care Centre



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Emergency Planning, Response and Resilience (EPRR)

Responsibilities

- Former PCT responsibilities now split three ways
  - Health protection (DsPH) to local authorities
  - Management of surge to CCGs (as commissioners)
  - Responding to emergencies to NHS England Area Team

- Local Health Resilience Partnership provides the co-ordination between all three; co-chaired by DPH and NHS England Director with lead CCG Managing Director representative

Responsibilities (continued)

- Increase in activity in the urgent care system is managed by the CCGs (with Leicester City CCG as lead), co-ordinating activity across health and social care
- In a major emergency NHS England have responsibility for command, control and co-ordination of NHS funded services in support of the collective response
- In infectious disease outbreaks Public Health England will lead on behalf of DsPH, handing over to NHS England when NHS assets are required

Winter planning

Escalation and winter planning group:

- Escalation triggers and actions (organisation)
- Escalation triggers and actions (health and social care economy)
- Winter plans by organisation
- Communication (internal and external)
- Reporting and monitoring

Launch & Roll Out of NHS 111 Service Across LLR

- The NHS 111 service will roll out across LLR commencing in September and is due to be completed by the end of October 2013. The plan is flexible to allow sufficient monitoring of performance and clinical quality of the service before each tranche is launched.
- During the roll out of the NHS 111 service the risk of the service being "swamped" by calls will be mitigated by keeping the existing GP OOH service in place and available to take calls.
- The operational and clinical performance of the service will be monitored daily by the clinical leads, project team, service provider and NHS England using a set of metrics developed nationally and locally.

Launch & Roll Out of NHS 111 Service Across LLR

- Part of the monitoring of the service will be its impact upon other health services; ED, UCC, EMAS, GP's, etc.
- The quality of the service delivered will be monitored weekly during roll out by a clinical group made up of local GPs, UHL, EMAS and other urgent care clinicians who will carry out an end to end review of a sample of calls made to the service.
- Before each phase of the roll out, a checkpoint review will take place to ensure that the provider's performance, operationally and clinically is at the required standard and that the necessary measures are in place for the next phase of the roll out.

CALL 111
When it's less urgent than 999

Launch & Roll Out of NHS 111 Service Across LLR

- The resilience of the service has been tested using a “table top” exercise facilitated by NHS England which found that the providers resilience plans mitigates the main risks to business continuity. This was endorsed by the LMC representative who was part of the team carrying out the exercise.
- Directory of Services (DoS)
  - The DoS is a local database of services. The accuracy of it is paramount to the delivery of a safe, effective and efficient service. This has been rigorously tested and its accuracy will be monitored continuously during roll out.
- Staffing
  - Nationally reported problems with the NHS 111 service were largely due to insufficient staff being available to handle calls. The provider staff levels and rotas have been regularly reviewed in the preparation to launch and will continue to be monitored as the service rolls out.

NHS
East Leicestershire and Rutland
Clinical Commissioning Group

Improving Minor Injury and Illness Services

Why we need to change and how we will listen to the public

Tim Sacks, Chief Operating Officer

September 2013

Listening. Responding. **Delivering.**

Why we need to change and improve

- Our current services differ in what they offer from place to place and our patients have told us that they find the opening times confusing
- our patients have also told us services should be provided locally, such as in GP surgeries or community hospitals, and good transport links and parking are really important
- a national review to improve urgent care services sets out what good care means. Our services must:
  - *be efficient, consistently high in quality and safe, seven days a week*
  - *be simple – and must help patients and clinicians make good choices*
  - *provide the right care in the right place, by those with the right skills, first time*
- our current services do not comply with the national aims and are confusing for our patients so we need to make improvements.

The current services

Location	Opening times
Rutland Memorial Hospital Minor Injuries and Minor Illness, Oakham	Minor Illness (nurse led), Monday to Friday 8.30am to 6pm Minor Injuries, 9am to 5pm No services at weekend or bank holidays
Market Harborough District Hospital - Minor Injuries and Minor Illness	7 days a week, 9am to 9pm
Melton Mowbray Hospital – Minor Injuries and Minor Illness	Weekends and bank holidays, 9.30am to 1.30pm
Latham House, Melton Mowbray – Minor Injuries Service	Monday to Friday, 8.30am to 6.30pm
GPs across ELR offering Minor Injuries Service	Monday to Friday, 8.30am to 6.30pm
The following service is temporarily suspended due to staffing problems:-	
Feilding Palmer Hospital, Lutterworth - Minor Injuries and Minor Illness	7 days a week, 9am to 9pm

Public consultation

ELR CCG will be asking for public views over an eight week period on options for the future of minor injury and illness services. Consultation methods include public meetings and an online survey (also available in hard copy). The consultation will be promoted via the media and social media and details sent to all ELR CCG stakeholders.

Public events

We will be holding four public meetings. They will take place in Lutterworth, Melton Mowbray, Oakham and Market Harborough.

How public views will be used

Public views will be analysed and used to form a recommendation on the future of the services. This will go before the ELR CCG Governing Body during the coming winter for approval. If approved, any necessary procurement of services will begin and, if needed, changes in existing provider contracts will be negotiated. The new arrangements for minor injuries and illness will begin in 2015.

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Caring at its best

Creating a new A&E

for Leicester, Leicestershire and Rutland

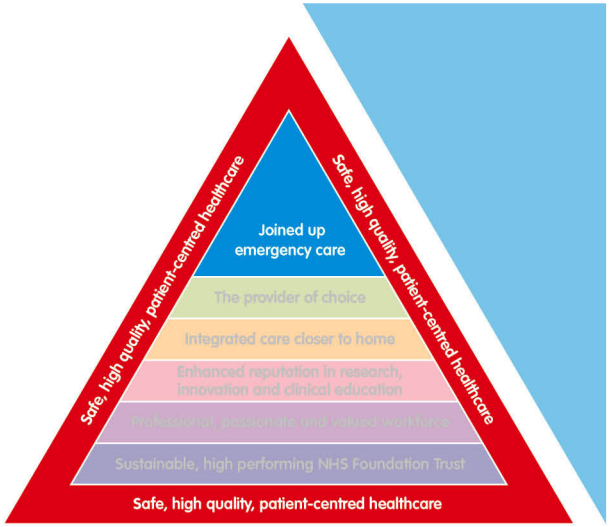
Our strategic direction

Caring at its best

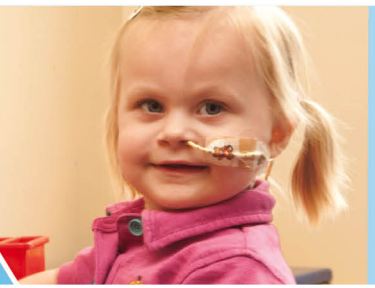
- Quality and safety first
- Timely, effective emergency care
- Patients **choose** us for planned care
- More opportunities for local people to be cared for in their community

- Research and teaching an integral part of our services
- Delivered by a professional and valued workforce to create a strong NHS Foundation Trust

Develop joined up emergency care that consistently meets patient expectations



- The new emergency care model
- Better services for frail older people
- Making as much care as possible 'planned'
- More critical and intensive care beds



Context: Emergency Care

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- One of the largest Emergency Departments in the country
- Serving a population of 1.2 million
- Department was built to accommodate **100,000 per year; we see 155,000**
- This figure is predicted to grow to 181,000 by 2017
- We are seeing more older frail patients (85 years +) / children / "majors"

Our Plan…

- **We will invest £40m to build a new A&E**
- "Single Front Door" – patients streamed to most appropriate area for their needs
- This work cannot start until we relocate some of our outpatient clinics (1 – 4)

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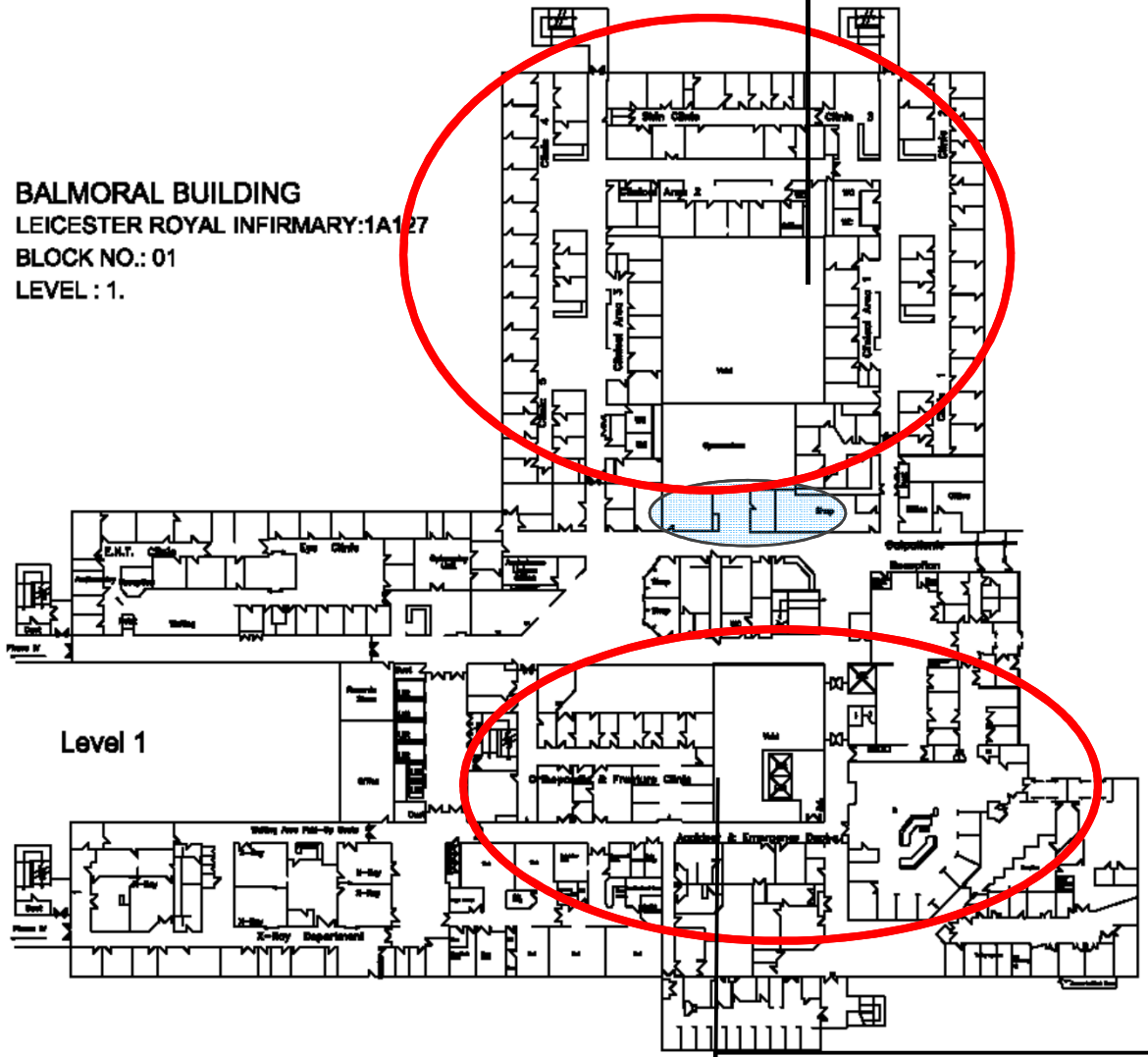
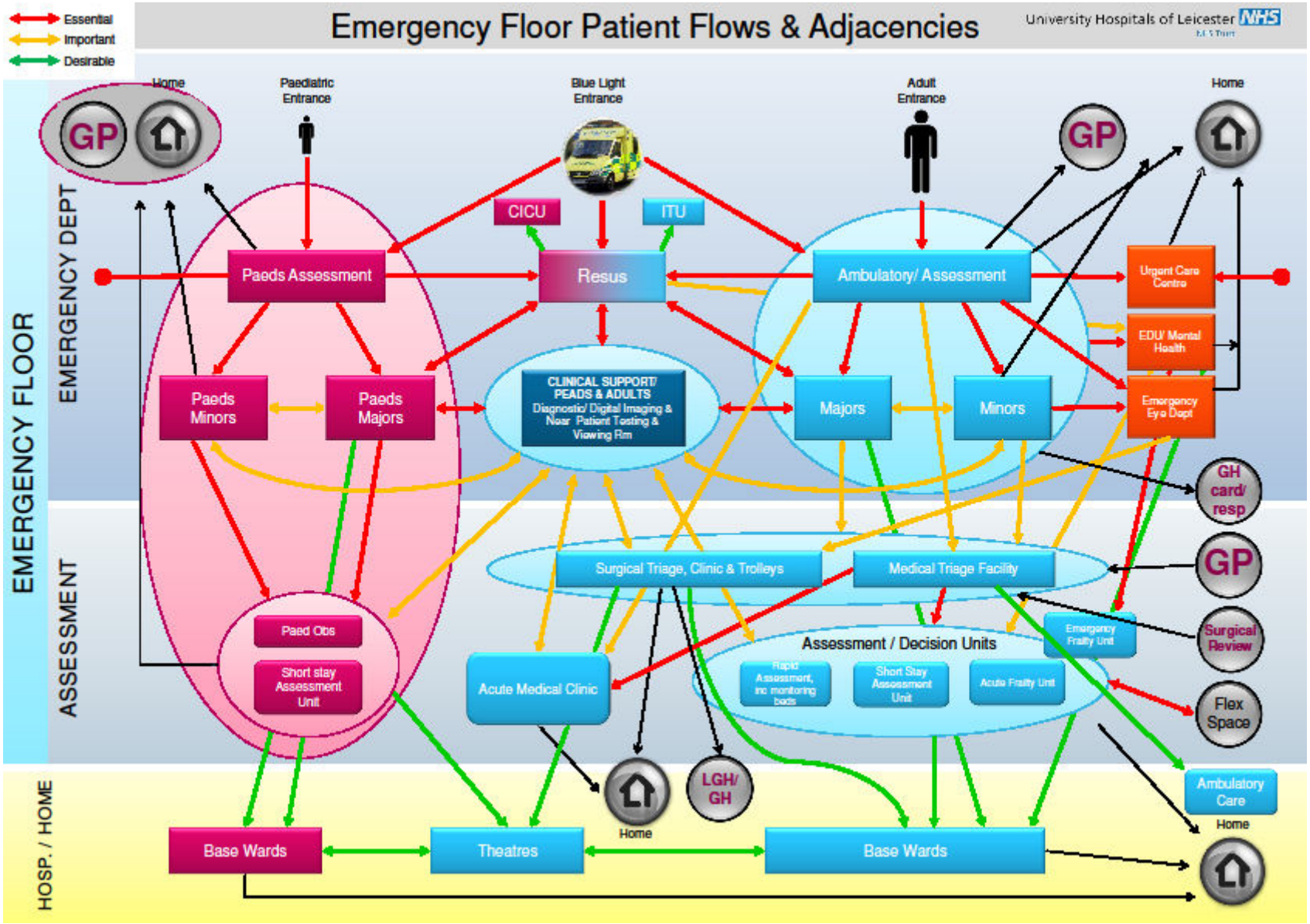
Outpatients 1 – 4 (Proposed site of new A&E)



Balmoral Entrance

Current Emergency Department (ED)


Essential
Important
Desirable
Emergency Floor Patient Flows & Adjacencies
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EMERGENCY FLOOR
EMERGENCY DEPT
ASSESSMENT
HOSP. / HOME
Home
GP
Paediatric Entrance
Blue Light Entrance
Adult Entrance
Home
GP
CICU
ITU
Paeds Assessment
Resus
Ambulatory/ Assessment
Urgent Care Centre
EDU/ Mental Health
Emergency Eye Dept
Paeds Minors
Paeds Majors
CLINICAL SUPPORT/ PEADS & ADULTS
Diagnostic/ Digital Imaging & Near Patient Testing & Viewing Rm
Majors
Minors
GH card/ resp
GP
Surgical Triage, Clinic & Trolleys
Medical Triage Facility
Surgical Review
Paed Obs
Short stay Assessment Unit
Assessment / Decision Units
Emergency Frailty Unit
Rapid Assessment, inc monitoring beds
Short Stay Assessment Unit
Acute Frailty Unit
Acute Medical Clinic
Flex Space
Home
LGH/ GH
Ambulatory Care
Home
Base Wards
Theatres
Base Wards

A safer, better patient experience

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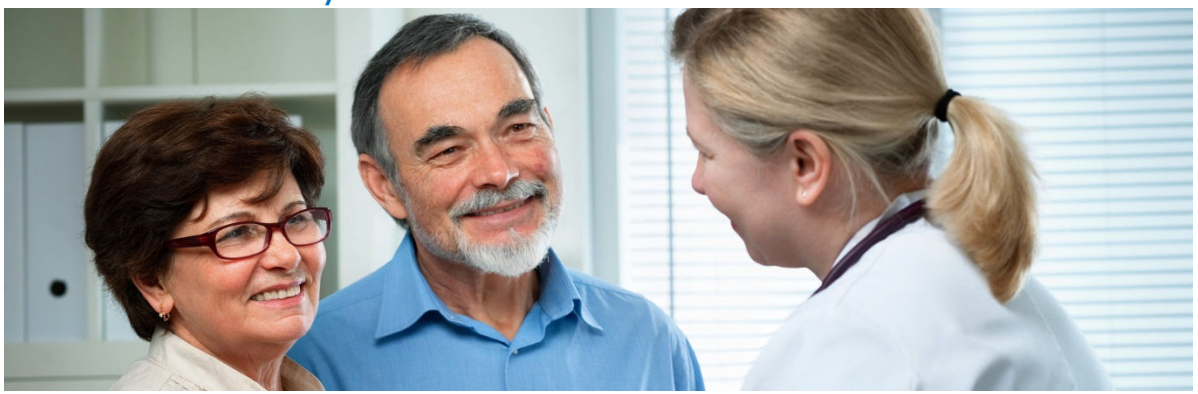
A new, fit for purpose and fit for 21st Century A&E delivers:

- State of the art facilities, with all key services on one level
- Nicer environment for patients, relative ad staff
- Better integration with the main hospital
- No overcrowding, reduced clinical risk and increased patient experience

BUT we can't get a quart into a pint pot!

Solution:
Move outpatient clinics 1-4 from Royal to Brandon Building at the General…
… this is our *preferred option* but we are confirming that this is the *best solution* in terms of value for money and clinical 'fit'



Easing the proposed move for patients and residents

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We have reviewed the potential impact on car parking for patients, visitors and staff. 65% of patients currently access Royal OP by car.

We will create new dedicated OP parking adjacent to the Brandon building. Data shows that there will be easily enough to cope with the extra 343 patients a day

We are also exploring public transport access to the General (i.e. linking the 'Hospital Hopper' to the city Bus Station at St Margaret's / better links with the Park and Ride service).

We have talked to the City Council to explore how best to protect residents parking spaces in the local area,

The City Council are prepared to work with us and local residents on this if there are parking issues.

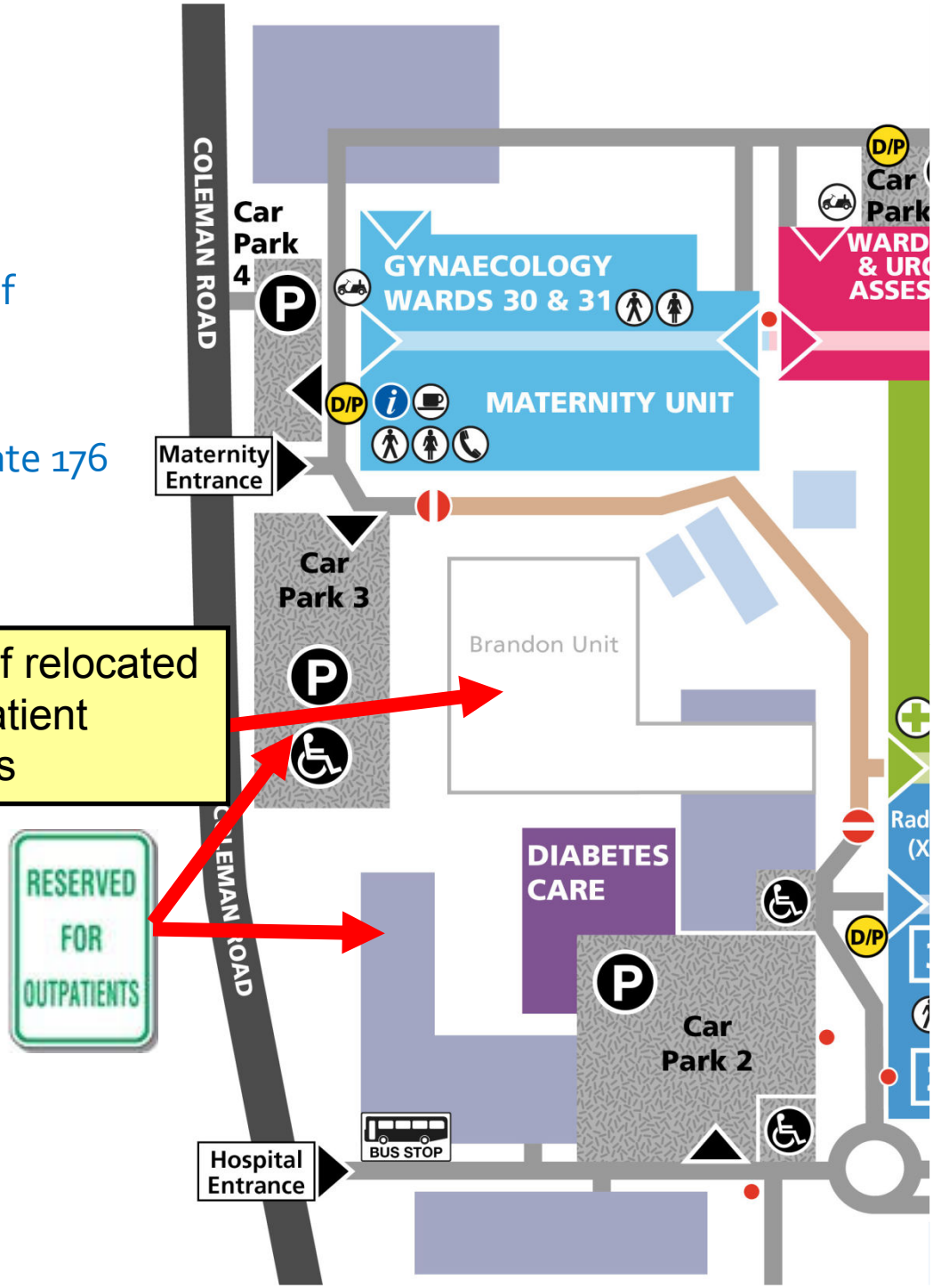
Parking in more detail

We have an average hourly attendance of between 35 – 48 patients

By reorganising our car parks we will create 176 car parking spaces; more than enough to accommodate patients attending clinics

These spaces will be reserved for outpatients

Approximately 60 staff will be relocated to the LGH as part of this move. There is sufficient space for them in our existing staff car parks



Being a good neighbour

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Not in the Trust's gift to make changes to local roads and highways but our conversations with the City Council have been positive.

We recognise that there are already issues around our Coleman Road entrances. Together with the Council we will be exploring the feasibility of;

- Additional pedestrian crossings
- Time limited parking
- Residents parking scheme
- Double yellow lines at danger points
- Safety cameras
- Vehicle activated speed signs
- Residential lay by's for carer access
- Varying speed limits in the area

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Summary

- Widely recognised that our current ED and our current performance is not what it ought to be nor what patients and the public deserve.
- The issues are more than just space but no getting away from the fact that it is *simply too small* and creates clinical risk
- Solution is to move OPDs and create space for A&E… preferred option is to redevelop the Brandon building into a new out patient centre
- This is urgent work, time is not on our side
- More work to do (but quickly) to determine if the preferred solution is the best solution in terms of value for money.
- We want to do what's best clinically, whilst doing our best to be a good neighbour.

Ultimately we would like your support for the preferred way forward

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Questions?

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