Paper ref:	PublicTB (01/24) 014

PATIENTS PEOPLE POPULATION

AMBITION RESPECT COMPASSION

NHS Sandwell and West Birmingham NHS Trust

REPORT TITLE:	Emergency Access Standard Recovery Plan Including winter Plan Update		
SPONSORING EXECUTIVES:	Johanne Newens – Chief Operating Officer		
	Daren Fradgley – Managing Director/Deputy CEO		
REPORT AUTHORS:	Demetri Wade – Deputy Chief Operating Officer		
	Tammy Davies – Deputy Chief Integration Officer		
MEETING:	Public Trust Board	**DATE:**	10th January 2024

1. Suggested discussion points *[two or three issues you consider FIP should focus on in discussion]*

This paper provides an update on the implementation and impact of the Sandwell and West Birmingham Places and Acute Hospital Emergency Access standard (EAS) recovery and winter plan for 2023 to date. The paper includes an analysis of performance against Urgent and Emergency Care metrics, quality and safety considerations, an assessment of delivery against planned interventions, further mitigation deployed to support the plan, oversight and leadership of the plan.

2. Alignment to our Vision *[indicate with an 'X' which Strategic Objective[s] this paper supports]*

OUR PATIENTS		OUR PEOPLE		OUR POPULATION	
To be good or outstanding in everything that we do	X	To cultivate and sustain happy, productive and engaged staff	X	To work seamlessly with our partners to improve lives	X

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*

Plan delivery, mitigations, safety and quality considerations, and performance metrics in this paper have been considered at Performance Management Group, Trust Management Committee and Quality Committee.

4. Recommendation(s)

The Trust Board is asked to:

a.	**DISCUSS** and **ACCEPT** the winter plan/ EAS recovery plan update and further mitigation interventions for assurance.
b.	**DISCUSS** and **ACCEPT** the approach to tracking improvement (performance measures, qualitative measures)

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and, where shown, elaborate in the paper]*

Board Assurance Framework Risk 01	x	*Deliver safe, high-quality care.*
Board Assurance Framework Risk 02	x	*Make best strategic use of its resources*
Board Assurance Framework Risk 03		*Deliver the MMUH benefits case*
Board Assurance Framework Risk 04		*Recruit, retain, train, and develop an engaged and effective workforce*
Board Assurance Framework Risk 05	x	*Deliver on its ambitions as an integrated care organisation*
Corporate Risk Register [Safeguard Risk Nos]		

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board

Sandwell and West Birmingham Places and Acute Hospitals Winter Plan Update

1. Introduction and Context

1.1 To date, this winter has seen significant pressure on our urgent and emergency care (UEC) services as forecast in the Trust's winter plan presented to Board in November 2023. Further resilience was required beyond the scope of the plan to ensure safety was maintained. Therefore, the Trust has responded with further interventions following Board approval of the Emergency Access Standard (EAS) recovery plan, with associated financial run rate implications, while developing a longer-term sustainable UEC improvement plan.

1.2 Performance against EAS and ambulance offloads deteriorated in October but improved in November following the deployment of the EAS recovery plan. Through the winter and EAS recovery plans, our trajectory is to improve EAS performance from 66.6% in October to 70.9% in March. The UEC improvement plan in development will present to March Trust Board a trajectory from April 2024 to return EAS to the upper quartile nationally prior to the opening of the Midland Metropolitan University Hospital.

1.3 The overall impact of adverse performance results in the risk of / actual patient harm. The objective of the winter plan and EAS recovery plan is ultimately to minimise and where possible avoid any harm. We know that overcrowding in Emergency Departments (ED), long waits to be seen and to be admitted to the appropriate location is an indicator of increased mortality. Therefore, the recent episodes of pressure have required decisive and sustainable actions. Further focus on monitoring and learning from episodes of harm are being planned to support future plans. It is also important to note that we have undertaken quality evaluation and impact assessment of our wider UEC interventions which has been approved by the Quality Committee.

1.4 Workforce resilience is a significant challenge within the EDs, with vacancies in nursing, and Emergency Medicine consultants and registrars. This has provided further pressure to our winter response with limited capacity to review and treat patients within target at periods of peak demand. This is being mitigated by additional bank, agency, and locum cover through the Board approved EAS recovery funding, however a recruitment and retention plan is being developed with support from the People and Organisational Development team to address this sustainably.

1.5 Clinical Leadership within the Emergency Care Directorate is a risk to winter resilience and performance improvement. We have Clinical Director and Speciality Lead vacancies for both

Emergency and Acute Medicine. There are interim arrangements to partially mitigate these gaps and a recruitment process has begun. We have also increased our nursing leadership within our EDs. Historically, we have had 1 Matron covering both EDs. We have created a further 2 matron posts. One of these posts will lead our paediatric EDs and will join us in March and another post, currently out to recruitment will join our existing matron to lead the adult ED service. All 3 posts will enable us to deliver a 7 day matron service for our EDs.

1.6 Planned interventions for winter were focussed on our MMUH rightsizing schemes, and additional acute and community beds to support our admission capacity based on the winter activity profile and bed deficit projection. The schemes have continued to deliver collectively since April 2023, there was some deviation for Frailty and Medical Same Day Emergency Care in October, but this recovered in November. The additional medical and community beds have been utilised as proposed.

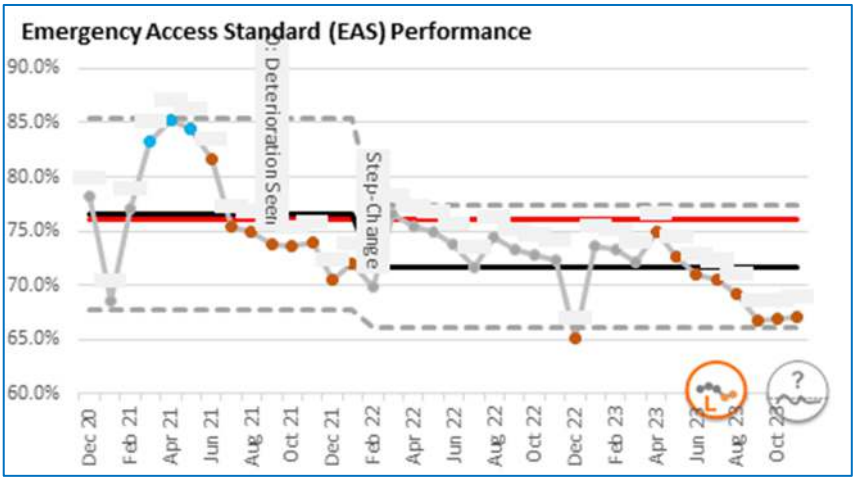
2. Measures of performance improvement

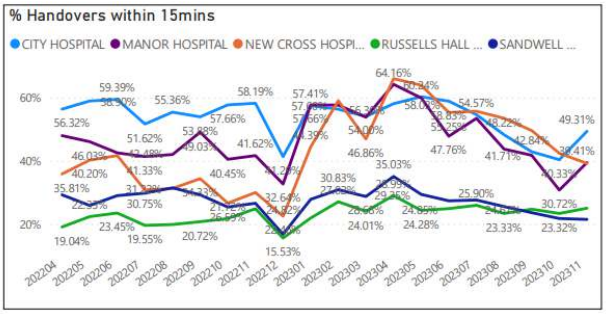
2.1 During November there was an improvement against UEC metrics with an increase in EAS performance, ambulance offload times reducing, as well as time patients spent in ED, and the number of 12 hour breaches decreasing. Rightsizing scheme delivery also improved against trajectory and ED attendances were marginally reduced.

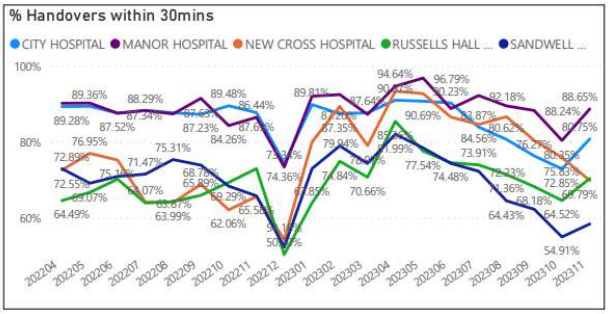
2.2 The following table illustrates the changes to UEC metrics from October to November and improvement trajectory to March 2024. The target is to improve by 4.3% over this period. This is considered realistic.

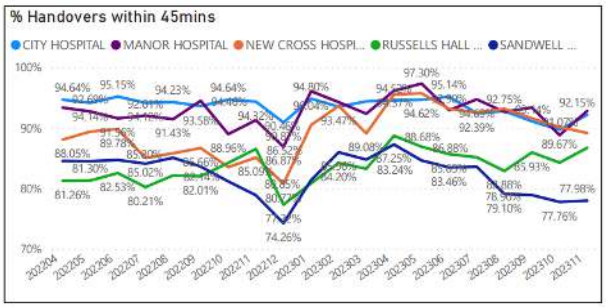
Metric	Site	Trajectory/Performance							
		Target	Baseline	Nov	Direction	Dec	Jan	Feb	March
EAS Performance	Trust	76%	66.6%	66.9%		67.9%	68.9%	69.9%	70.9%
				67.05%	Improve				
Type 1 EAS	Trust	76%	46.82%	48.3%		50.3%	51.3%	52.3%	53.3%
				48.48%	Improve				
Door to Doctor (60 Mins)	City	TBC	24.6%	24.6%		29.6%	34.6%	39.6%	44.6%
				30.35%	Improve				
	Sandwell	TBC	31.6%	31.6%		36.6%	41.6%	46.6%	51.6%
				33.73%	Improve				
EAS Non-Admitted	City	76%	57.34%	57.34%		59%	61%	63%	65%
				60.66%	Improve				
	Sandwell	76%	55.98%	55.98%		58%	60%	62%	64%
				57.58%	Improve				
Ambulance Handover within 30 Min	City	95%	78.22%	78.22%		80%	85%	90%	95%
					Pending				
	Sandwell	95%	62.61%	62.61%		67%	72%	77%	82%
					Pending				
Emergency Care Meantime (Mins)	Trust		376	352	Improve				

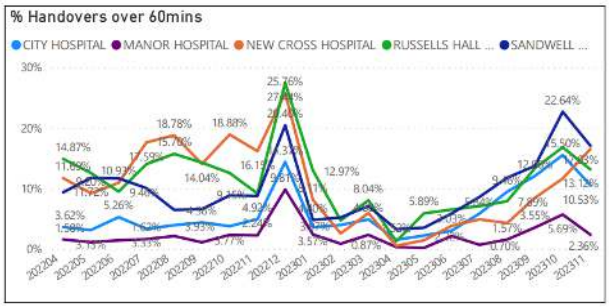
2.3 October had seen further deterioration against EAS and time taken for ambulance offloads, and increased time spent in ED and 12-hour breaches. This coincided with deviation from plan against the rightsizing schemes, with frailty particularly being impacted by the utilisation of the frailty same day emergency care (SDEC) space being used as extra bed capacity. There was also an increase in ED attendances, despite a reduction in ambulance activity, and admissions increased. Bed days also increased in October and again into November.







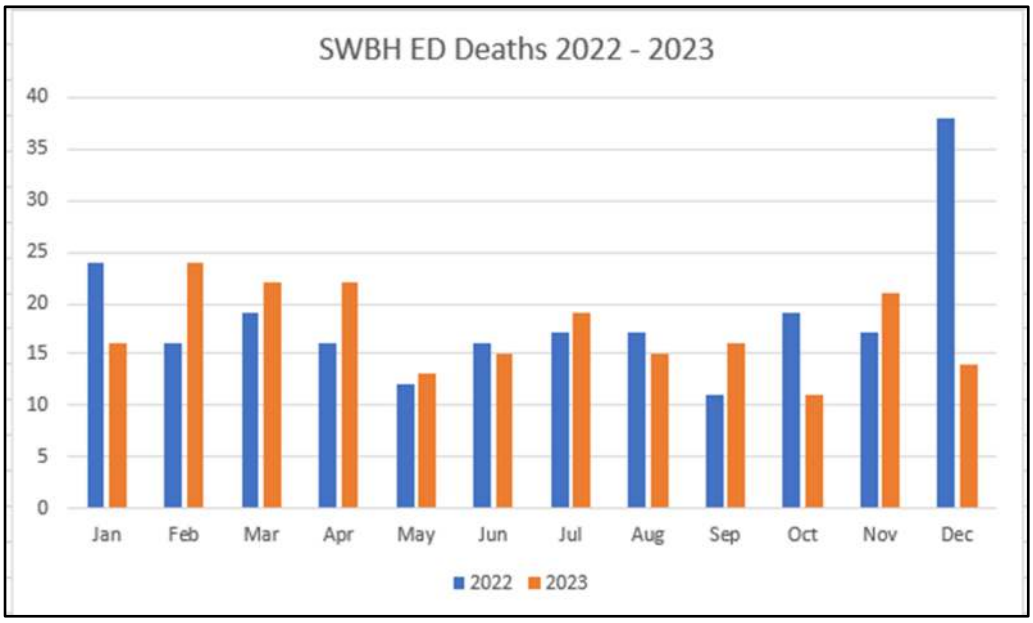




3. Proposed measures of patient safety and experience

3.1 It is imperative that we evaluate the impact of UEC improvement actions through winter on patient safety. Prolonged ED waits are associated with increased mortality and general poor outcomes and in addition delays offloading attending ambulances are an additional indicator of poor outcomes and harm that requires significant analysis to evaluate associated harm.

3.2 We are currently undertaking a harms review of the recent episodes of sustained pressure. As part of the review, to date we have compared the number of deaths in ED by month for the current and previous year. This is illustrated in the following chart with overall lower deaths in 2023 than 2022, although the December data is incomplete.



The graph above picks up deaths occurring in ED and as such is only one indicator, moving forward from January 2024:

- we will report anyone who has to wait in ambulance for over 2 hours as an incident.
- collate a list of patients for those that wait over 12 hours in ED to be admitted.

Analysing the above two points will give us a better understanding if longer delays have contributed to mortality or harm.

We will ask the mortality team to look at those cases for any alterations in mortality rates and for any cases that have concerns raised as part of the mortality review process of every death.

This same list will be used to identify any incidents of moderate harm or above and investigate any link to delay experienced in ED or because of ambulance delays.

3.3 As an on-going monitoring of safety and experience, we will report the above through Quality Committee the incidents and trends for people with prolonged ED waits. In addition, we will ensure that mortality reviews, reported through the learning from deaths groups, will look at ED waits and delays in all cases.

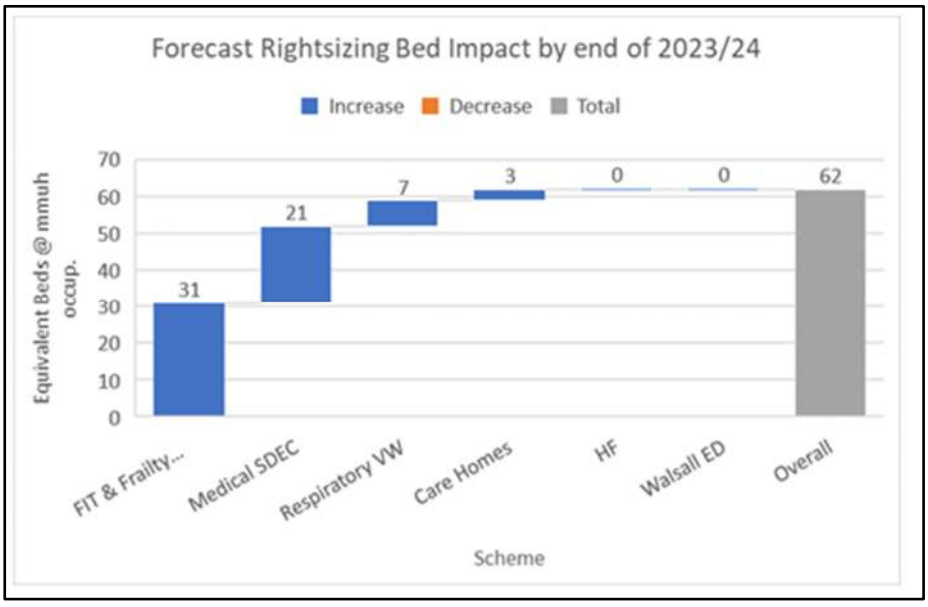
3.4 As an on-going evaluation, we will continue to monitor outcomes. For example, for people on Virtual Wards we are auditing the outcomes compared to people remaining in acute care. The outputs from audits will be used as a continuous quality review and reported via the Quality Committee.

3.5 The Friends and Family patient experience indicator has historically fluctuated in our EDs both inter terms of number of questionnaires completed and the content of these results. Coupled with complaints associated with our EDs both these indicators will be reported to Quality committee as part of the regular ED Quality and safety report.

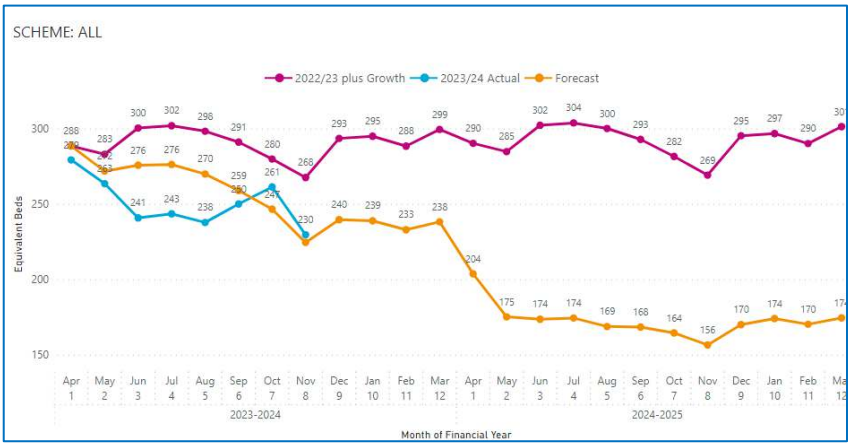
4. Rightsizing and Winter Scheme Delivery

4.1 There are 5 transformational schemes that support the overall MMUH bed right sizing and our winter resilience:

- Medical Same Day Emergency Care (SDEC) – Funded in current run rate
- Frailty Virtual Ward (VW) and Frailty Intervention Team (FIT) – System Development Funding and within current run rate
- Respiratory Virtual Ward (VW) – System Development Funding
- Heart Failure – System Development Funding and within current run rate
- Birmingham Care Homes – Birmingham Community Healthcare funding



These schemes provide benefit to the reduction of attendances, admissions, and length of stay. The graph below illustrates delivery against these schemes collectively and during the winter period so far. October shows deviation from forecast, which has improved during November.



4.2 Additional Beds

In addition to the rightsizing schemes the winter plans set out the requirements for additional medical and community beds to close the residual forecast bed deficit once rightsizing benefits were taken in to account. This profile is illustrated in the graph below.

The additional beds identified were to be deployed in the areas described in the following table and have been utilised during October and November.

Scheme Name	Bed Increase
Additional Capacity – Ward at Rowley	24 Elderly Care
Additional Capacity – D5/D7	5 Cardiology
Additional Capacity – D27	5 General Medicine
Additional Capacity – P5	8 Gastroenterology
Total	**42**

Full scheme analysis can be found in Annex 1.

4.3 **Further Mitigation**

With the deterioration of performance during October and associated risk to the delivery of same patient care in ED, additional medical beds were opened on D28 increasing the medicine beds by a further 16 above the planned 18 for winter.

In addition to bed expansion an EAS recovery plan was presented to Trust Board in November with further interventions proposed to specifically target:

- Improving time to be seen by a doctor within ED.
- Reducing the time it takes for patients who are waiting for a bed to be move into a bed.
- Reducing the total number of patients who access our EDs by utilising alternative pathways.
- Increasing the volume and opportunity in the avoidence schemes coordinated by Place and PCCT.
- Increased total Trust oversight of delays and patient waits. Bronze and Silver command, and Gold (Strategic) safety huddles.

This paper was supported and schemes were implemented in November 2023.

During November the Medicine and Emergency Care Clinical Group planned and held two "Winter Ambition" focus weeks (27/11 at City and 4/12 at Sandwell), in the model of national good practice "Perfect Week" intervention. This focussed on admitted pathway patient journey improvement with adoption of clearly defined and supported rhythm of day, reset of internal professional standards and support to identify opportunities for further intervention and development. This work included redefining targets for daily ward discharges and virtual ward utlisation, and reinforcing targets for pharmacy requests timeliness and transport booking.

5. Leadership and Oversight

5.1 As described in the winter plan, appropriate oversight of all winter interventions is vital to ensure we continue to drive forward performance and deliver the target trajectory for improvement.

5.2 Delivery of the winter plan is managed at Trust and Place level daily through capacity calls and safety huddles.

5.3 The Trust escalation process is utilised to mobilise Tactical and Strategic command as required in addition to daily Executive oversight.

5.4 The MMUH rightsizing and Urgent Care Scorecard dashboards are used alongside daily UEC data to inform decision making and progress against our plans.

5.5 Regular reports will be submitted to Quality Committee, Finance and Performance Committee and Trust Board to ensure that the plan continues to deliver against our strategic objectives.

6. Summary

6.1 This year's winter plan has been focussed on realising the potential of our rightsizing schemes, improving our community care offers and utilising additional bed capacity alongside practical efficiency improvements and support for staff.

6.2 An EAS recovery plan was presented to Board in November and supported. Performance has seen an improvement against UEC metrics and achievement of our target trajectories in November. The long term UEC improvement plan will be presented to March Board with a trajectory to reach the national upper quartile for EAS prior to moving in to MMUH.

6.3 The mortality review process is being evaluated with plans to include assessment of ED waiting times specifically. A process for reporting an evaluation of over ambulance with a more that 2-hour offload delays through the quality governance cycle is being developed.

6.4 The winter interventions have been delivered, however there has been a requirement for additional resource to be provided focussed on our EDs and bed availability for admissions. The combined winter plan, EAS recovery plan, the 2 winter ambition weeks and additional medical beds have started to translate into an improvement in UEC performance.

6.5 Leadership and oversight of the winter plan and EAS recovery plan is being led by the Executive team and Clinical Group teams. The daily capacity calls and safety huddles are being utilised to ensure delivery is on track and appropriate actions are taken. There are clear lines of reporting for monthly assurance of delivery and to determine interventions to be carried out at delivery and steering group and committee levels.

7. Recommendations

7.1 The Public Trust Board is asked to:

a. **DISCUSS** and **ACCEPT** the winter plan update and further mitigation interventions for assurance.
b. **DISCUSS** and **ACCEPT** the approach to tracking improvement (performance, qualitative measures)

Demetri Wade
Deputy Chief Operating Officer

Tammy Davies
Deputy Chief Integration Officer

December 2023

Annex 1 – Includes analysis of delivery to date for each of the rightsizing and winter interventions.

Annex 1

Same Day Emergency Care

The medical SDEC units have been demonstrating a positive impact on bed utilisation by avoiding admissions and reducing length of stay. The trajectory for delivery against potential opportunity was on target in October and was above forecast in November.

To improve this the service is focussing on developing processes to ensure all 55 condition-based pathways are accommodated and the consultant cover is extended.

Key Milestones	**Delivery Dates**
Launch SDEC scope at SDEC stakeholder event	16/12/23
Agree imaging service provision	31/12/23
Agree pathology service provision	31/12/23
Agree pharmacy service provision	31/12/23
Phase 2 pathways implemented	31/12/23
Phase 3 pathways implemented	31/03/24
7 day working in MSDEC	30/09/24

Frailty

The frailty scheme was impacted in October with bed pressures leading to frequent utilisation of the SDEC area on AMU for extra bed capacity. This translated into a shift away from trajectory. This was recovered in November however and the scheme is now ahead of target.

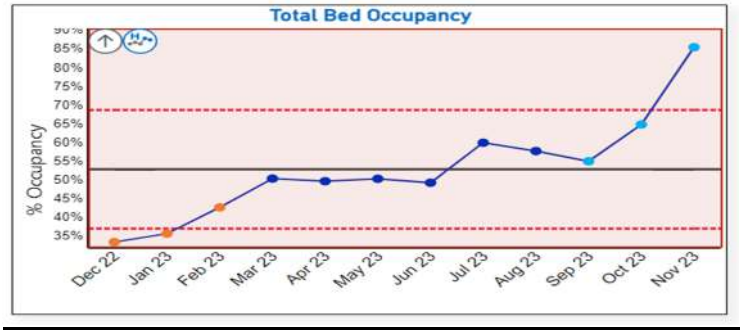
The frailty service has introduced the Frailty Assessment Unit (FAU) as planned at Sandwell site with two dedicated bays on AMU, this will contribute to realising further benefits from the scheme.

Key Milestones	**Delivery Dates**
6 day working	29/02/24
7 day working	30/09/24
FAU full model in place including Elderly Care in reach support	30/09/24

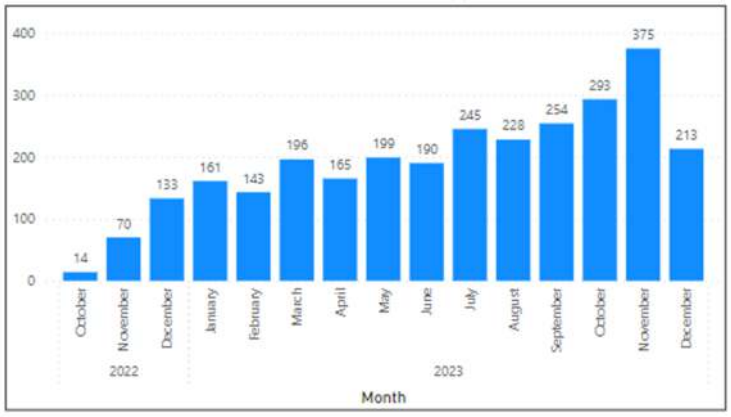
Virtual Wards

We have utilised our Virtual Wards to both reduce length of stay through step down and avoid admissions through step up. We currently have 75 Virtual Ward beds open across all specialities. The occupancy has been inconsistent both generally and between different specialities. The MMUH rightsizing schemes initially focussed on frailty and respiratory but we are now exploring the defined opportunity across all other wards. Clinical audit has indicated that on average each patient on a virtual ward saves 2-3 bed days. In order to see that impact on UEC performance and patient safety increase we need to ensure we have increasing numbers of patients on virtual wards with a target occupancy of 80%. The chart below shows the monthly occupancy across all virtual wards and the second chart shows the total number of patients. This indicates an improvement trajectory. However, it is imperative that we are maximising usage to full potential. We are operating a daily pull model across wards to promote the wards with clinical teams.

Monthly Virtual Ward Occupancy



Total Number of patients on Virtual Wards per month



Heart Failure

Pathway improvements and the implementation of the cardiology virtual ward has provided a reduction in admissions and re-admissions as a result of earlier intervention.

The scheme continues to develop and remains largely within trajectory with slight deviation in November.

Key Milestones	Delivery Dates
End to end pathways / SOPs signed off	15/12/23
Team orientation to revised SOPs	12/01/24
Delivery of aligned Birmingham Community HF IV service / HF Community service Care Pathways	29/07/24

No Criteria to Reside (NCTR)

Reducing the number of patients with No Criteria to Reside (NCTR) has been a key focus. Overall, we have seen positive results with lower numbers than neighbouring Trusts. However, the numbers have fluctuated at times with specific delays related to people with very complex needs such as Mental Health Learning Disabilities. Our Pathway 1 delays have improved considerably, supported by the Sandwell Pace led 48 hour Wrap which provides short term care at home for people to avoid delays whilst sourcing a long term package. We have also extended the caseload for the Home-Based Intermediate Care (HBIC) service. However, despite additional funding recruitment has limited our ability to provide therapy intervention in line with national KPIs. This has not delayed discharges but has resulted in higher than anticipated readmissions. Nevertheless, this has improved from 33% at the peak to 17% in October.

Pathway 2 delays have been an area of concern. We have worked with colleagues in Birmingham and Solihull (BSOL) ICB and Birmingham Community Healthcare NHS Foundation Trust (BCHCFT) to reduce the significant delays in this area. We have seen positive results over the last 6 weeks with a definite reduction in people on Pathway 2 in acute beds. The charts below show the reduction in acute hospital length of stay following being declared NCTR for Pathway 1 and 2. We include the mean average (nationally reported) and the median average which is less effected by the outlying patient with excessive length of stay.

Pathway 1

Days with NCtR before discharge			
Quarter	Months	Mean Average (days)	Median Average (days)
Q3 22/23	Oct 22 – Dec 22	4.14	1.80
Q4 22/23	Jan 23 – March 23	4.19	2.00
Q1 23/24	April 23 – June 23	3.00	1.60
Q2 23/24	July 23 – Sep 23	3.18	1.00

Pathway 2

Days with NCtR before discharge			
Quarter	Months	Mean Average (days)	Median Average (days)
Q3 22/23	Oct 22 – Dec 22	10	7
Q4 22/23	Jan 23 – March 23	9	6
Q1 23/24	April 23 – June 23	6	4
Q2 23/24	July 23 – Sep 23	7	5.8

We have opened an additional community ward at Rowley Regis hospital to support people with NCTR and delays to discharge. The ward can also be used for people with frailty that could be discharged to the Virtual Ward but where home circumstances don't allow. This criteria will be further evaluated and adapted over coming weeks

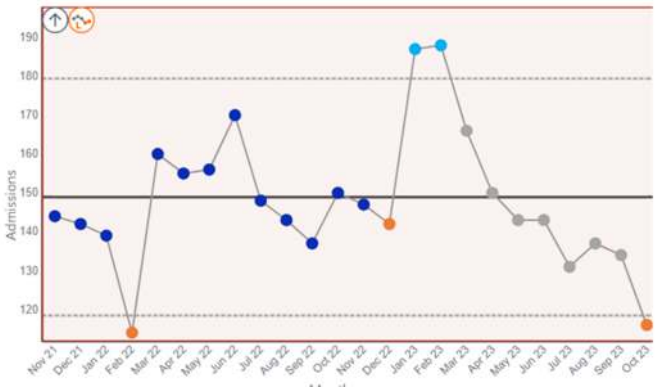
Attendance Avoidance

We have worked with colleagues in BCHCFT to drive improvement in attendance and admission avoidance. They are working with us to deliver an increase in Urgent Community Response (UCR) activity in West Birmingham. The chart below shows the weekly improvement against the agreed target.

Weekly UCR contacts for West Birmingham residents

In Sandwell, we have progress our UCR work through monthly increases in the falls response service. Which is achieving an average reduction of 11 acute bed savings per month. The chart below shows the number of admissions from falls which has reduced dramatically in line with the falls service development, particularly into winter.

Acute hospital admissions with falls



Paediatrics

The seasonal impact on acute paediatric services required specific actions. The following highlights progress against these.

- Increased ward capacity (12 beds – 4 on Lyndon Ground and 8 on Lyndon 1) has been implemented. Due to the current vacancies within paediatric nurse staffing establishment, in particular nurses with HDU skills, there have been occasions where full winter capacity has not been achieved.
- Increasing VW capacity utilising SDF income has been delivered. However, we are only funded for 8-10 beds, and exceed this on most days. There is an option being evaluated to increase the beds over the next 3-4 months by utilising bank shifts.
- A paediatric discharge lounge area is in place, supporting timely transfer from the wards to provide admission capacity.
- Keep it Moving initiative of discharge planning and rhythm of the day has been regularly communicated to nursing and medical staff to embed best practice.
- Community Nurse in-reach is being provided by the diabetes team for admission avoidance and review of patients on the wards. This helps to reduce length of stay by facilitating earlier discharge with a patient follow up in clinic.