Paper ref:	PublicTB (05/24) 012

REPORT TITLE:	Emergency Access Standard Recovery Plan Including Winter Plan Update
SPONSORING EXECUTIVE:	Johanne Newens – Chief Operating Officer
REPORT AUTHOR:	Demetri Wade – Deputy Chief Operating Officer
MEETING:	Public Trust Board
DATE	8th May 2024

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

This report follows on from the bed fit assurance report that the Trust Board received last month during the exceptional meeting for MMUH readiness.

The Trust Board should discuss the improvement in Length of Stay (LoS) in March and rightsizing impact. The data from March, along with the future trajectory provides partial assurance on progress towards the "most likely" rightsizing outcome. The paper invites discussion on LoS and bed fit forecast.

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

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

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

MMUHOC

4. Recommendation(s)

The Public Trust Board is asked to:

a) **DISCUSS** the March position for rightsizing and LoS along with the future trajectory and associated actions.

b) **EXPECT** updates against the trajectories for both rightsizing and length of stay improvements that collectively provide assurance on our fit into MMUH.

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	X	*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]		
Is Quality Impact Assessment required if so, add date:		

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board on 8th May 2024

MMUH Bed Fit and Winter Plan for 2024/25

1. Introduction

1.1 Fitting into our bed base at MMUH still remains one of the most significant risks on our programme risk register now (risk 5157, risk score 20).

1.2 The paper outlines the March 2024 position and future forecast into MMUH.

1.3 The paper provides the forward trajectories for all of our rightsizing schemes, our Length of Stay (LoS) trajectories and bed fit for MMUH.

2. Analysis

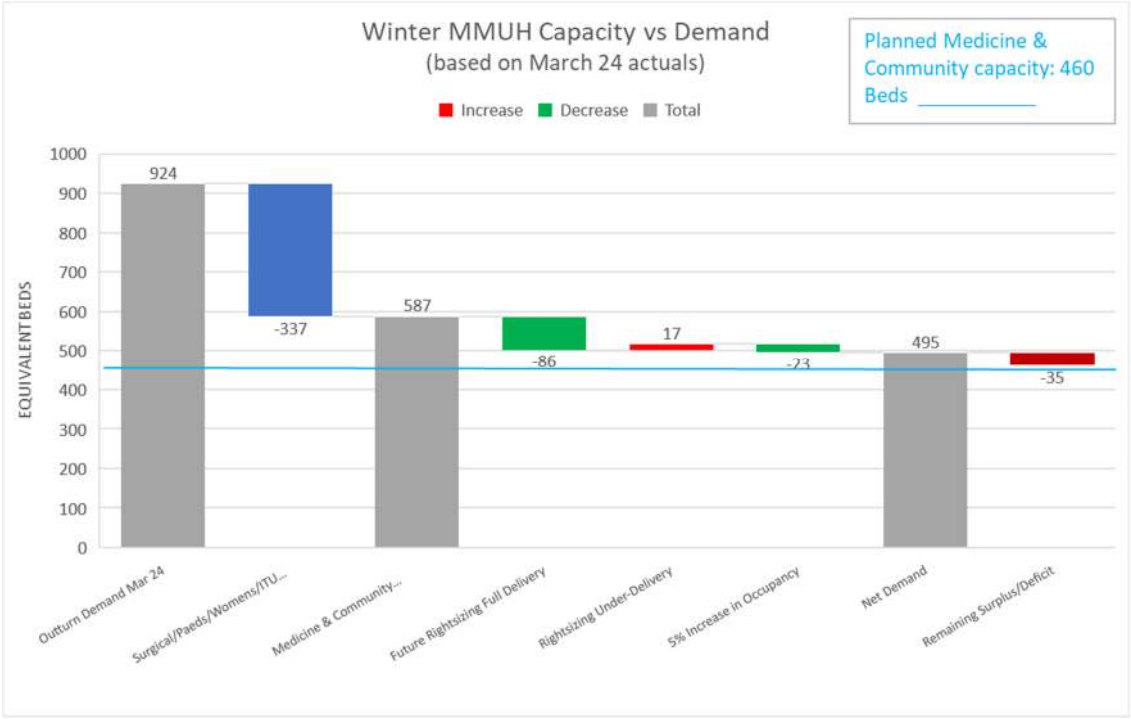
2.1 Chart 1 below shows the route from our current January 2024 medicine and community bed base to our bed base in MMUH. It is anticipated that for 4 months of the year (November 2024 – February 2025) we will need to increase our bed occupancy levels by 5% to ensure we can adequately fit into the new hospital.

2.2 The chart shows a further deterioration of 21 beds from our December 2024 position. This is mainly linked to a further increase in LoS seen in January 2024 (6.1 vs 5.6 days in December). This is nearly a day greater than the LoS seen iGDn January 2023 which was 5.3 days; **Annex 1 Length of Stay Actuals and Forecast Delivery Back to 2022 LoS** and highlights the importance of the LoS delivery work.

1.4 Annex 3 provides a summary of our top 6 Interventions for Medicine LoS Improvement and associated impact forecast to achieve the 5.2-day LoS target.

2.3 We have seen an improvement in March for the frailty rightsizing scheme with a return to our target trajectory following the implementation of extended hours of frailty SDEC operation in the week and Saturday opening (**Annex 2 Frailty scheme trajectory and delivery**).

Chart 1 showing route from current beds to the required MMUH bed position based on the March 2024 actuals.



2.4 This data is for March 2024 and demonstrate positive progress since the previous Trust Board representing a reduced deficit from -51 beds to -35.

2.5 March 2024 ended with our overall beds open in both medicine and community having reduced to 587 from the 603 in January, this would align back to our 'likely scenario' in the winter planning.

2.6 This improvement has been driven predominantly by the frailty and medical SDEC rightsizing schemes delivery increasing in March.

3. Future Trajectories

3.1 We have discussed with the Trust Board previously that 2 variables are driving our overall bed usage; length of stay and our right sizing scheme delivery.

3.2 **Annex 1 Medicine Emergency length of stay actuals and forecast delivery back to 2022 LOS** illustrates the length of stay increase that the organisation has seen from September 2023, when we were on plan to fit into our MMUH bed base. This increase in length of stay is the main driver for the continued utilisation of escalation beds in the organisation, and also why we are currently forecasting that additional winter beds are required for winter 2024 when we open MMUH.

3.3 There is a plan to deliver the improved LoS over the next 6 months with associated interventions and benefits which can be seen in **Annex 2 Top 6 Interventions for Medicine LoS Improvement and Anticipated Impact.** The trajectory in annex 1 and plans in annex 2 provide the context for how we can return our LoS back to our 2022/23 position. We can see that there was a reduction from February to March.

3.4 **Annex 3 Frailty Scheme Trajectory and Delivery** shows the frailty rightsizing trajectory and delivery. This is now back on track and the scheme implementation milestones have been

reached with the next development being consistent realisation of virtual ward utilisation up to 80%.

4. Winter Plan

4.1 The Trust Board previously received a report indicating that we would require 31 beds at Rowley Regis to deliver the 2024 winter plan when we move into MMUH.

4.2 Analysis has been completed with the clinical teams to identify 26 beds worth of opportunity over the winter months. These are patients that have No Criteria To Reside (NCTR) in an acute bed base and who therefore could be safely moved to Rowley.

4.3 If we are required to fill additional community beds there would need to be transfers of pathway 1 and 3 patients, but while this would provide acute site resilience it runs the risk of increasing the length of stay for patient journeys.

5. Risks

5.1 There remains a risk that we have circa 5 beds that require utilising in community to fully deliver the winter plan in winter 2024/25, which will need a specific cohort of patients to be identified. Work will be undertaken with clinical teams over the coming months to identify this cohort of patients.

5.2 There is also a risk that we are not able to reduce our LoS back to the required amount to align with our best or likely winter plan scenario. The improvement plans and governance previously reported to Trust Board will ensure monitoring of progress is managed on a weekly basis so that early intervention can be deployed as required.

6. Recommendations

The Private Trust Board is asked to:

a) **DISCUSS** the March position for rightsizing and LoS along with the future trajectory and associated actions.
b) **EXPECT** updates against the trajectories for both rightsizing and length of stay improvements that collectively provide assurance on our fit into MMUH.

Liam Kennedy: MMUH Delivery Director
Demetri Wade: Deputy Chief Operating Officer

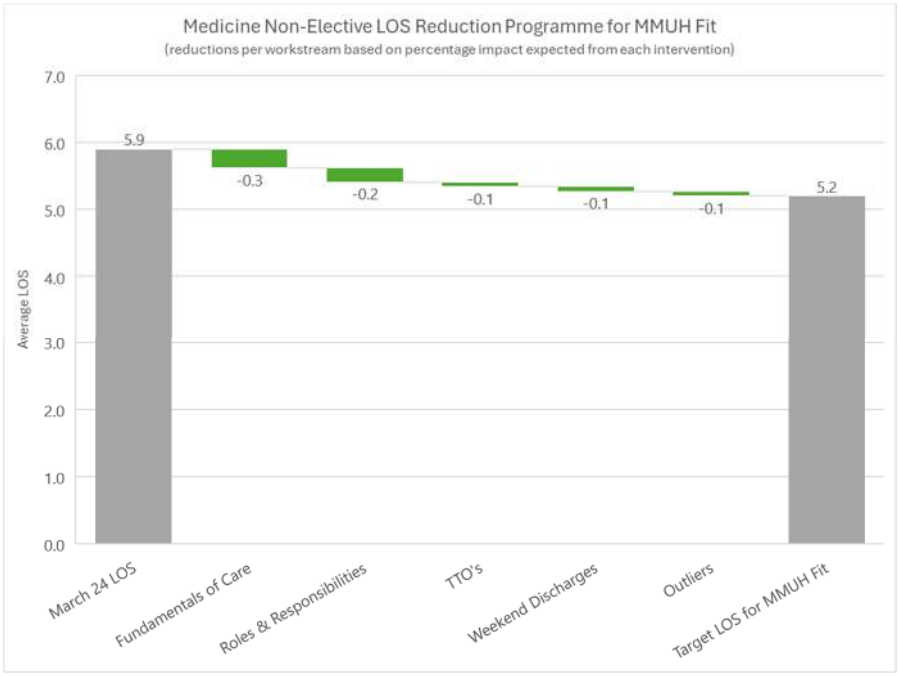
April 2024

Annex 1: Length of Stay Actuals and Forecast Delivery Back to 2022 LoS
Annex 2: Top 6 Interventions for Medicine LoS Improvement and Anticipated Impact
Annex 3: Frailty Scheme Trajectory and Delivery
Annex 4: Overall Bed Usage Versus Trajectory for MMUH

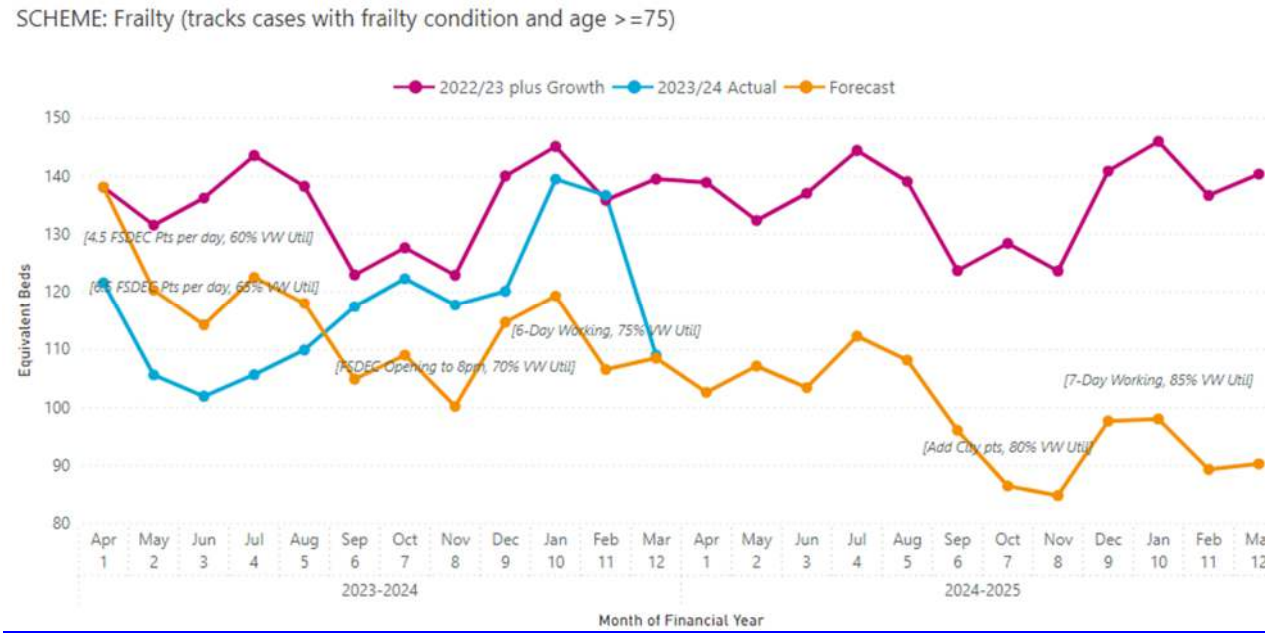
Annex 1: Length of Stay Actuals and Forecast Delivery Back to 2022 LoS

Annex 2: Top 6 Interventions for Medicine LoS Improvement and Anticipated Impact

Workstream	Area	Aims/Objectives	Improvement	Metric 1	Metric 2	Metric 3
1. Understanding and engaging with the problems.	MEC Group	Understand the problems. Engagement with MDT in identified solutions.	a. IP flow Dashboard created b. Implementation of governance processes and ward/speciality based monitoring and responses c. Targeted engagement with Clinical, nursing, allied professional, pharmacy and site team colleagues. d. Medical engagement to improve timeliness of	Compliance with discharge targets	Speciality LOS	Base ward LOS
2. Roles, responsibilities, standardisation and escalation points.	MEC Group	Reduce unnecessary variation. Elimination of duplication of effort.	a.Transfers from ED to AMUs and AMUs to bed base, bed base to discharge lounge b.Discharge coordinators – this should include a review of management structure and oversight, plus development of clearly defined roles, responsibilities, and standardised ways of working. c.Site/Matron/Ops teams roles and responsibilities to eliminate duplication of effort. d.Professional standards. e.Development of site/ward level escalation standards, so everyone understands trigger points	DTA to transfer	LOS on AMUs	Base ward LOS
3. TTOs & Pharmacy Management	MEC Group	Reducing delays caused by process issues around TTO management.	a.Pre-empting TTOs. b.Reducing batching of TTOs eg post ward rounds c.Quality of prescribing for TTOs. d.Identifying improvements to processes	%patients discharged before 12noon	LOS for pathway 0	Turnaround time for TTOs request to issue
4. Fundamentals of Care and ROTD	MEC Group	Standardised board rounds. Standardised rhythm of the day. Home first principles. Value adding to every patient, every day.	a.Supporting of roll out and embedding of principles. b.Adoption of principles for acute medicine areas not currently in the FoC programme. c.Introduction of action tracking in all areas. This is to include home first principles – to ensure every patient every day has value added actions identified and actions are completed. This should be driven by the NIC and supported by the MDT, ops team and discharge coordinators etc. d.Patient level escalation standards – agreeing timescales for patient level escalations, what	%patients discharged before 12noon	Number of daily discharges	Base ward LOS
5. Outliers.	MEC Group	Ensuring outliers receive safe care. Reduce the number of outliers.	a.Making outliers visible. b.Agreeing group level actions to respond to outliers. c.Agreeing group level actions to reduce outliers. d.Site team support to reduce outliers from out of group specialities.	Numbers of daily discharges	Speciality LOS	Reduction of medical spells with episodes on surgical wards
6. Weekend discharges.	MEC Group	Improving the management of discharges 7 days a week.	a. Explore weekend processes around weekend discharge team. b.Criteria based discharge. c.Explore how to eliminate the need to open additional capacity at the weekend.	Numbers of weekend discharges	Speciality LOS	Base ward LOS



Annex 3: Frailty Scheme Trajectory and Delivery



Annex 4: Overall Bed Usage Versus Trajectory for MMUH