Paper ref:	TB (01/23) 008

PATIENTS PEOPLE POPULATION

AMBITION RESPECT COMPASSION

NHS Sandwell and West Birmingham NHS Trust

REPORT TITLE:	Board Level Metrics for Population		
SPONSORING EXECUTIVE:	Daren Fradgley, Chief Integration Officer		
REPORT AUTHOR:	Daren Fradgley, Chief Integration Officer Rachel Barlow, Chief Development Officer		
MEETING:	Public Trust Board	**DATE:**	11th January 2023

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

Each member of the Executive Team has personally provided their own commentary to the area for which they are the lead within the Population Strategic Objective.

This adds a further strengthening to the ownership and accountability where improvements are required in the main IQPR Report.

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		To cultivate and sustain happy, productive and engaged staff		To work seamlessly with our partners to improve lives	X

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

The metrics and associated data have been considered in the Integration Committee

4. Recommendation(s)

The Public Trust Board is asked to:

a. **RECEIVE** and note the report for assurance

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

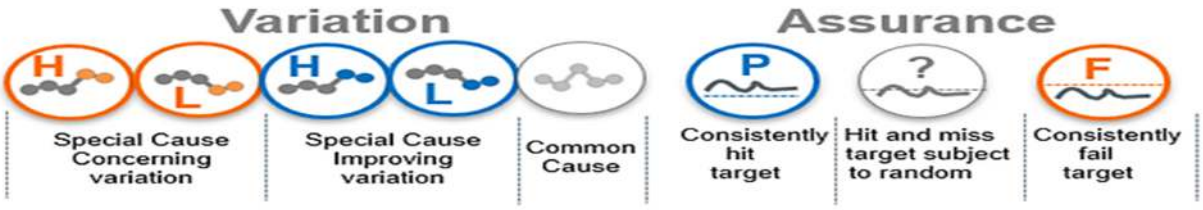
Board Assurance Framework Risk 01		*Deliver safe, high-quality care.*
Board Assurance Framework Risk 02		*Make best strategic use of its resources*
Board Assurance Framework Risk 03		*Deliver the MMUH benefits case*
Board Assurance Framework Risk 04		*Recruit, retain, train, and develop an engaged and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

Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed		
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed		

SANDWELL AND WEST BIRMINGHAM NHS TRUST

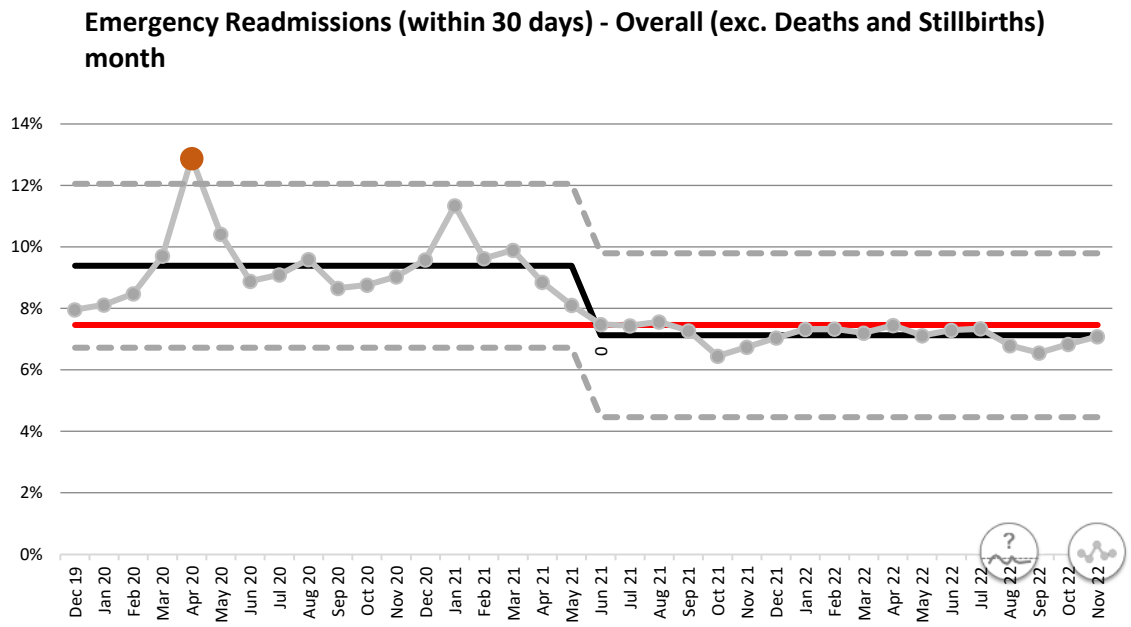
Report to the Public Trust Board on 11th January 2023

Board Level Metrics for Population



1.1

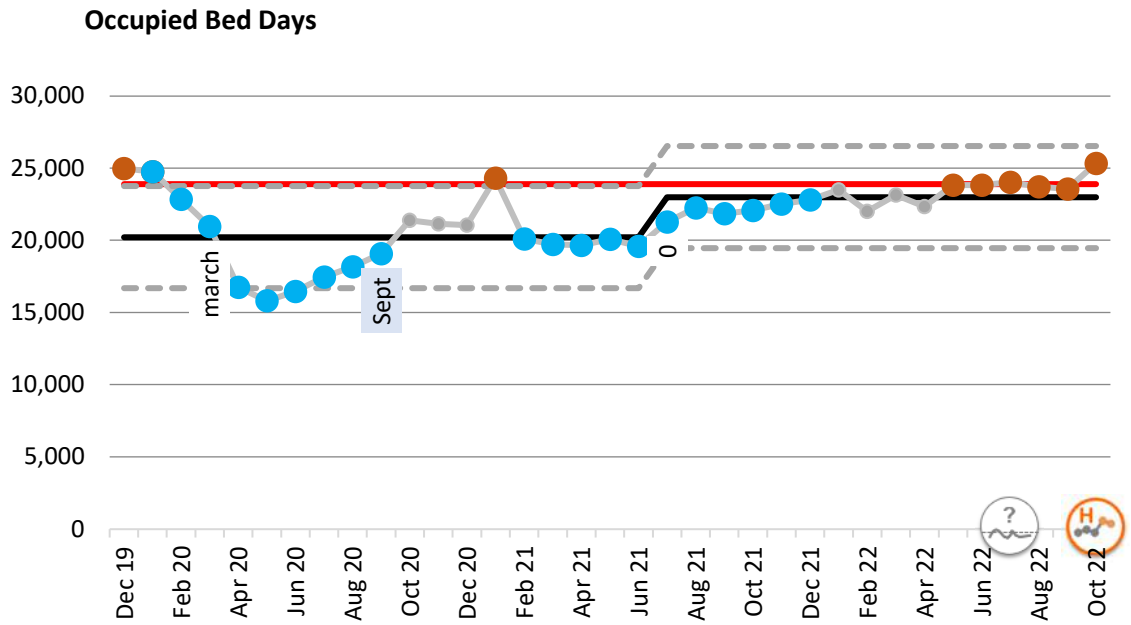
1.1.1 Emergency Readmissions (within 30 days) – INTEGRATION COMMITTEE



Analyst Commentary	Commentary on current performance and actions in place	What will we do next and when?
A step change in the mean and control limits have been added from May '21, due the persistent period of lower readmissions thereafter. This means that we have a new average level of performance, from 9.3% to 7.5%. Although the process is 'in control' as indicated by common cause variation, we are reporting at 7% which is just below our mean and 6% our Target	There are 2 main areas of focus to support performance in this area; chronic disease management through Town teams and increased capacity through Pathway 1 (Home Based Intermediate Care) to increase therapy frequency. The readmission rates for people discharged on Pathway 1 are reducing in line with the overall improvement against national target of 'time to therapy' and	We will undertake a review of specific conditions where readmission rates are higher than national and regional benchmarking. In areas where we are showing as an outlier, we will analyse the discharge pathways to look for any potential improvement strategies. In addition, the town teams are developing the local population 'at risk' registers to include people who are frequently admitted. They will enable additional

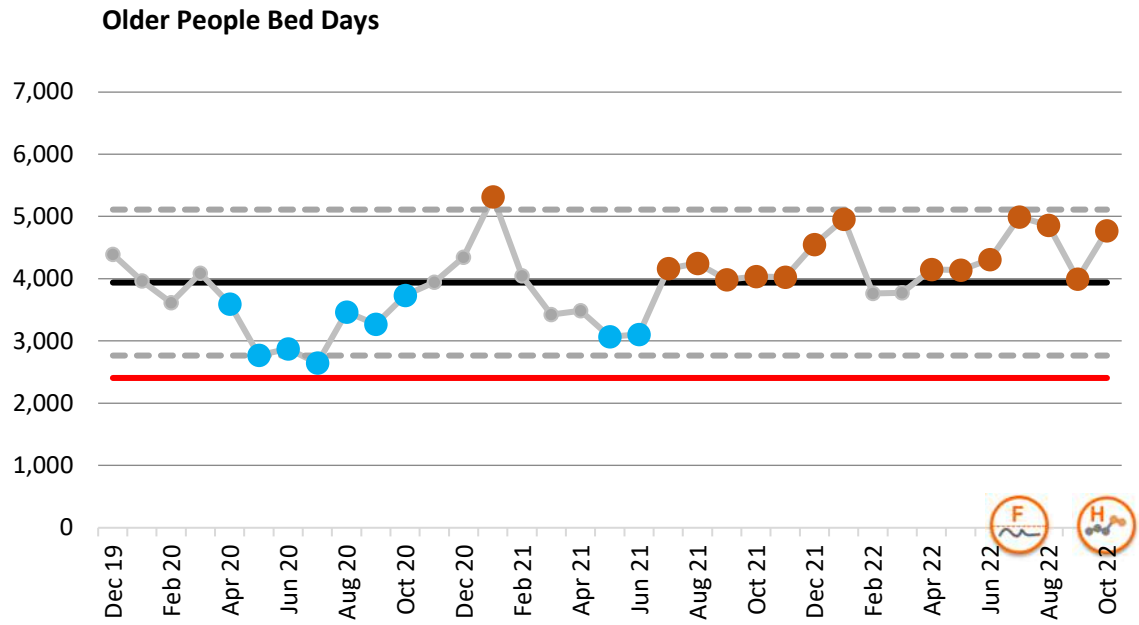
Target Source: Model Hospital	frequency of therapy intervention. The team continue to contact all people discharged from hospital within 48 hours to explore additional support that may be required through community and voluntary services	proactive interventions such as post discharge calls

1.1.2 Occupied Bed Days – INTEGRATION COMMITTEE



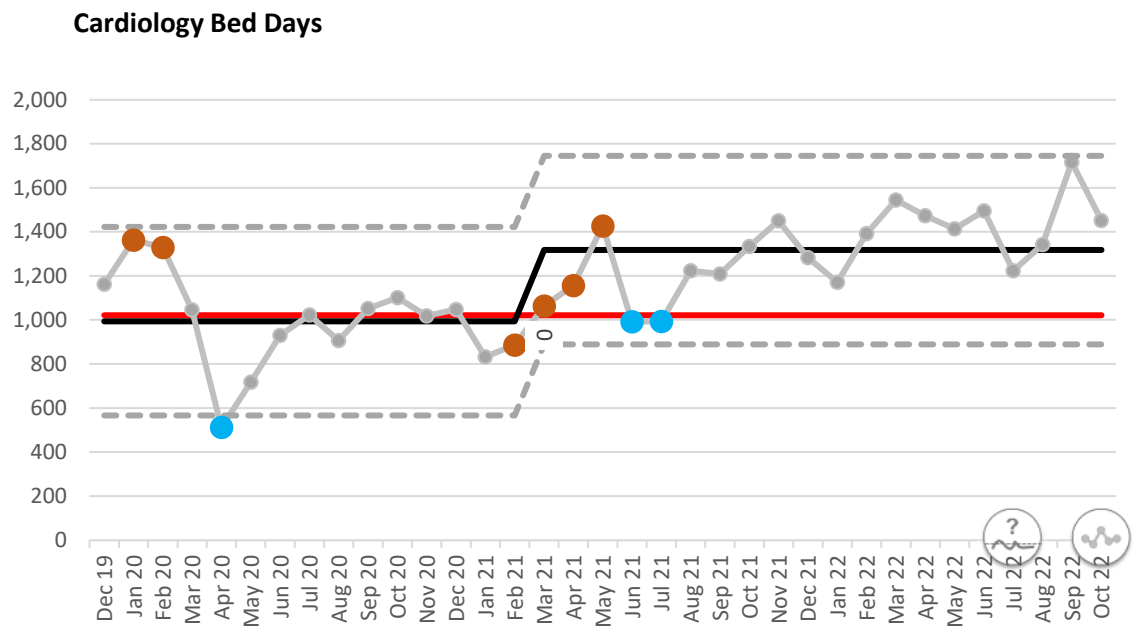
Analyst Commentary	Commentary on current performance and actions in place	What will we do next and when?
A step change in the mean and control limits have been added from July '21, due the persistent period of higher occupied bed days. This means that we have a new average level of performance, from 20,700~ bed days to 23,892~. This indicator shows special cause concerning variation. We have observed the slight increase in the number from previous month. This shows a GAP of between 25 and 28 beds dependant on aggregated occupancy rates, this hides variability within each bed type. Target Source: Beds build in Midland Metropolitan University Hospital based on occupancy rates	The virtual wards for frailty, respiratory, palliative care, hospital at home (Epicentre) and paediatrics are now operational albeit recruitment difficulties have led to less capacity that forecasted. On average the combined wards are now seeing 30 patients at home who would other be in an acute bed, reducing length of stay. Discharging people with 'no criteria to reside' remains a key focus and although there are improving total numbers, we are seeing a deteriorating total length of stay position on the remaining complex patients. This is mainly driven by social care capacity across pathway 1 and 2, the market capacity that we added is holding up well. In addition, there are a small number of people with extremely complex needs requiring national placements who have long stays.	Harvest View opened in December providing increased capacity for people requiring pathway 2 support (bed based intermediate care). Total capacity will increase over the next 8 weeks up to the total of 80 beds. In addition, Sandwell Place are temporarily commissioning additional spot purchase Extra Assessment Beds (EAB) as required. Virtual wards will continue to increase total capacity and alongside this we are working with acute clinicians to increase utilisation of available beds. We have received significant system investment to support discharge over winter (and beyond). This will enable us to invest in additional services to support length of stay reduction. We are focussing specifically on the voluntary sector.

1.1.3 Older People Bed Days – INTEGRATION COMMITTEE



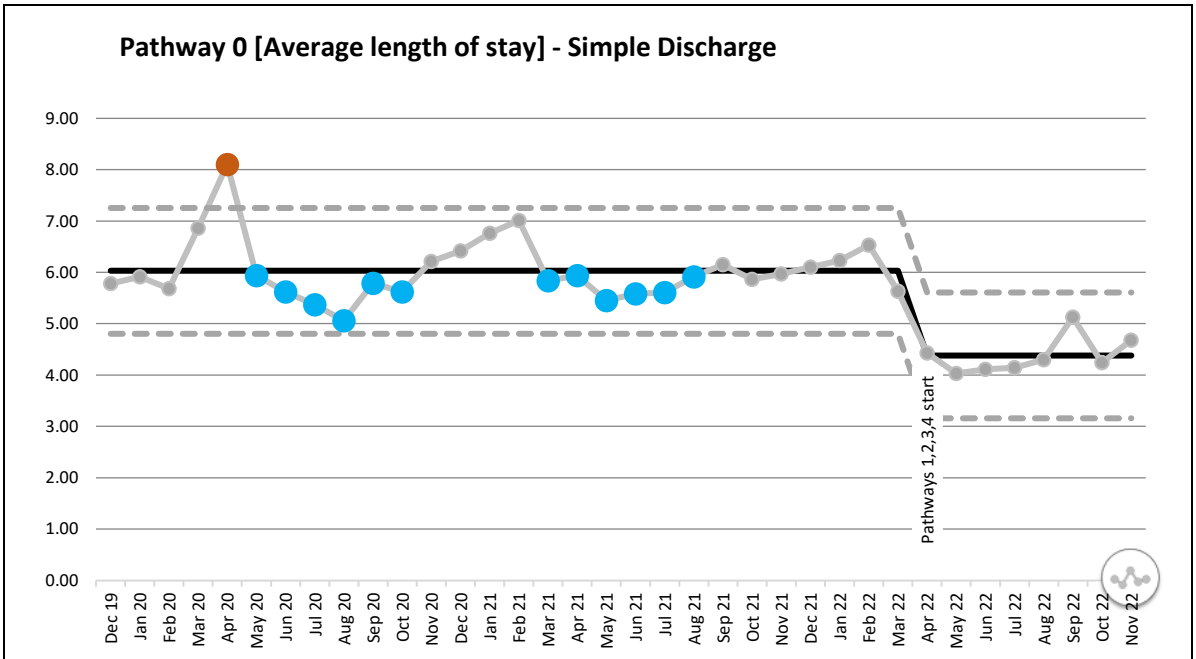
Analyst Commentary	Commentary on current performance and actions in place	What will we do next and when?
This shows special cause concern, with a GAP of around 74 beds dependant on occupancy rates. Target Source: 96 Beds build in Midland Metropolitan University Hospital based on occupancy rates	Older adult bed days continue to be higher than target. Actions to support reduction include the frailty virtual ward which is now being utilised and reducing length of stay. The Frailty Intervention Teams (FIT) are supporting ED attendances to reduce admissions and Frailty SDEC is now operational to ensure rapid assessment and discharge	We are targeting older adult bed days through the following interventions: **Attendance reduction** – In December we commenced WMAS triage calls to pull people from the ambulance waiting list into community services. We have developed a community falls service to respond to people who have fallen at home and would otherwise attend ED. This will expand from January. We are expanding Urgent Community Response to cover 8am to 10pm (currently 8am – 8pm) We are further extending the role of the care homes team supporting by remote monitoring **Admission reduction –** We are recruiting to the Integrated front Door service to work with FIT and support people attending ED into community pathways. **Length of stay reduction –** The expansion of Harvest View will reduce length of stay for people requiring intermediate care

1.1.4 Cardiology Bed Days – INTEGRATION COMMITTEE



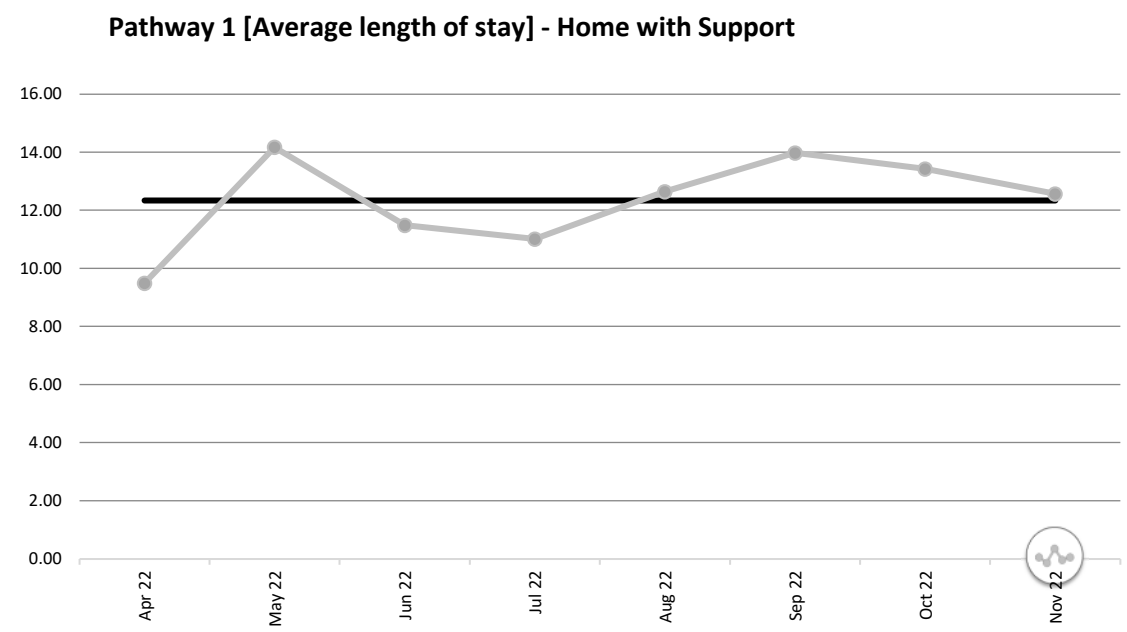
Analyst Commentary	Commentary on current performance and actions in place	What will we do next and when?
A step change in the mean and control limits have been added from March '21, due the persistent period of higher occupied bed days. This means that we have a new average level of performance, from 1,000~ bed days to 1,317~ bed days. Although the process is 'in control' as indicated by common cause variation, this establishes that a poorer position is the 'new norm'. This shows a gap of 25 beds. We report a month behind as activity is allocated using discharge HRGs. Target Source: 32 Beds build in Midland Metropolitan University Hospital based on occupancy rates.	The Hospital at home virtual ward is providing a service to support people with heart failure who would otherwise be in an acute hospital bed by delivering Intravenous (IV) diuretics in the community. We are also providing IV antibiotics to people with endocarditis to facilitate early discharge.	We will increase the support for people with heart failure in the community by launching the heart failure virtual ward. This will enable more complex people to be discharged from hospital or avoid admission.

1.1.5 Discharge to Access Pathway 0 (Average length of stay) – Simple Discharge – INTEGRATION COMMITTEE



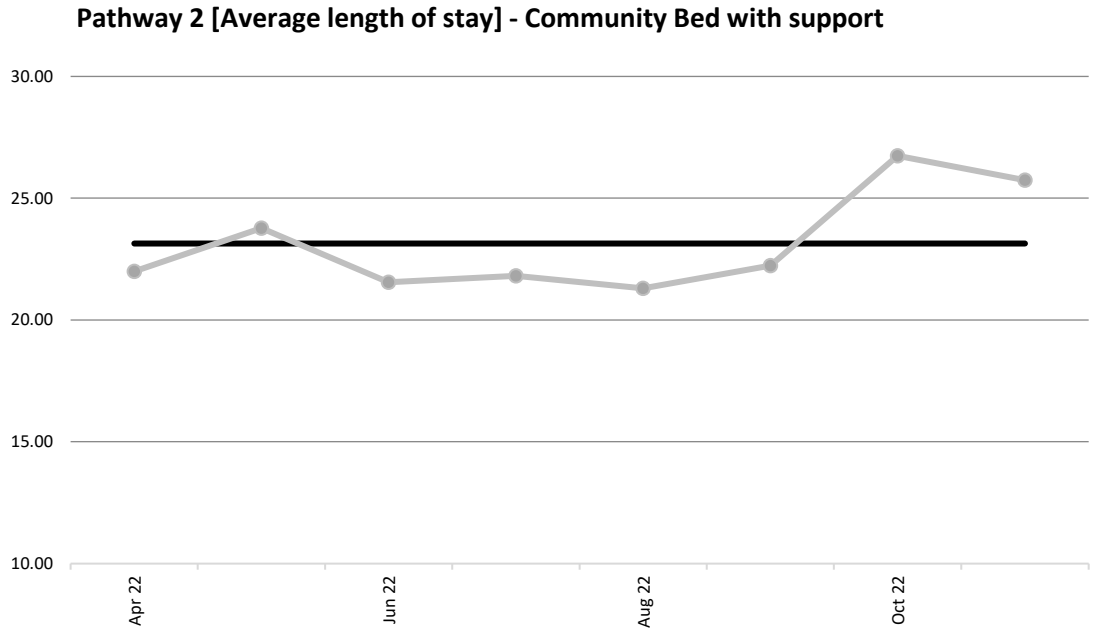
Analyst Commentary	Commentary on current performance and actions in place	What will we do next and when?
A step change has been added to adjust the mean from April '22 which factors in pathways 1,2,3,4 being taken out of the reporting figures. This brings down the average level of performance. The graph is showing common cause variation. Target Source: No Target	Education and engagement with ward staff to identify discharges earlier in the day to avoid delays is underway.	We have commissioned the British Red Cross to support people being discharged on pathway 0 by providing transport and a 'settling in' service to ensure people can go home without delay. This is part of the additional winter discharge money recently made available.

1.1.6 Pathways 1 – INTEGRATION COMMITTEE



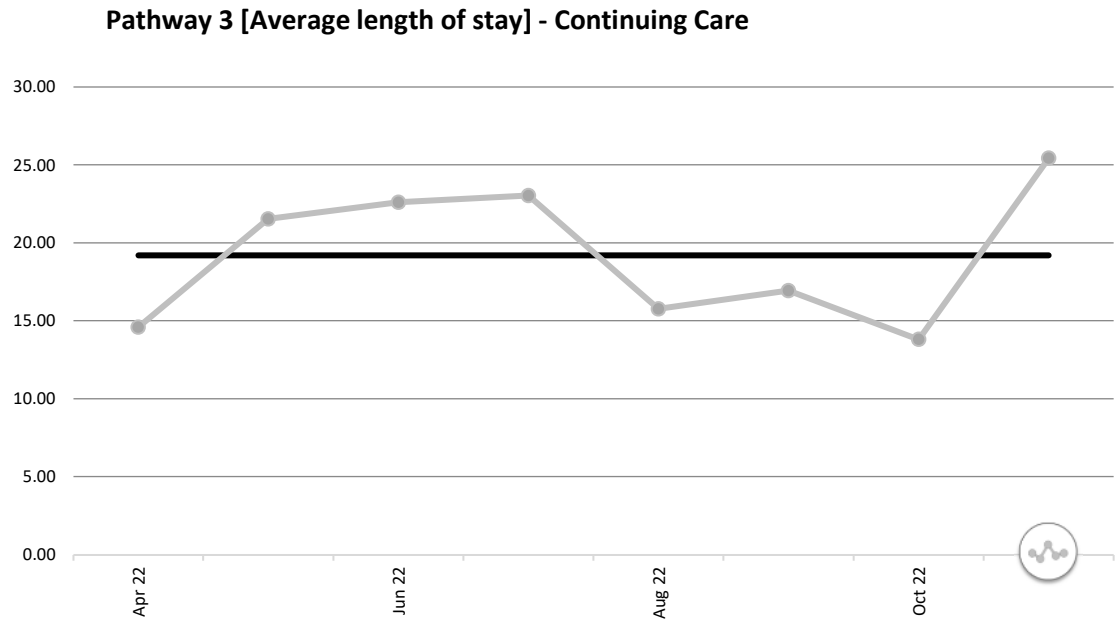
Analyst Commentary	Commentary on current performance and actions in place	What will we do next and when?
We do not have enough data points for any specific analysis to be concluded. The graph is currently showing common cause variation. Target Source: No Target	Pathway 1 has increasing demand with on average 180 people on this pathway in the community. We continue to recruit to both therapy, nursing, and social care posts to reduce delays. The integrated Discharge Hub (IDH) are proactively managing discharges through this pathway. Regardless of which the Average LOS is falling in this area albeit the complex cases are challenging at this time of year.	Further recruitment to increase capacity. We are utilising the discharge funds to commission voluntary services to support this pathway We are also utilising community beds (including Rowley and Harvest View) for people if there is a significant delay in domiciliary support. We have extended the availability of community equipment and assessment services to 7 days to prevent weekend delays.

1.1.7 Pathways 2 – INTEGRATION COMMITTEE



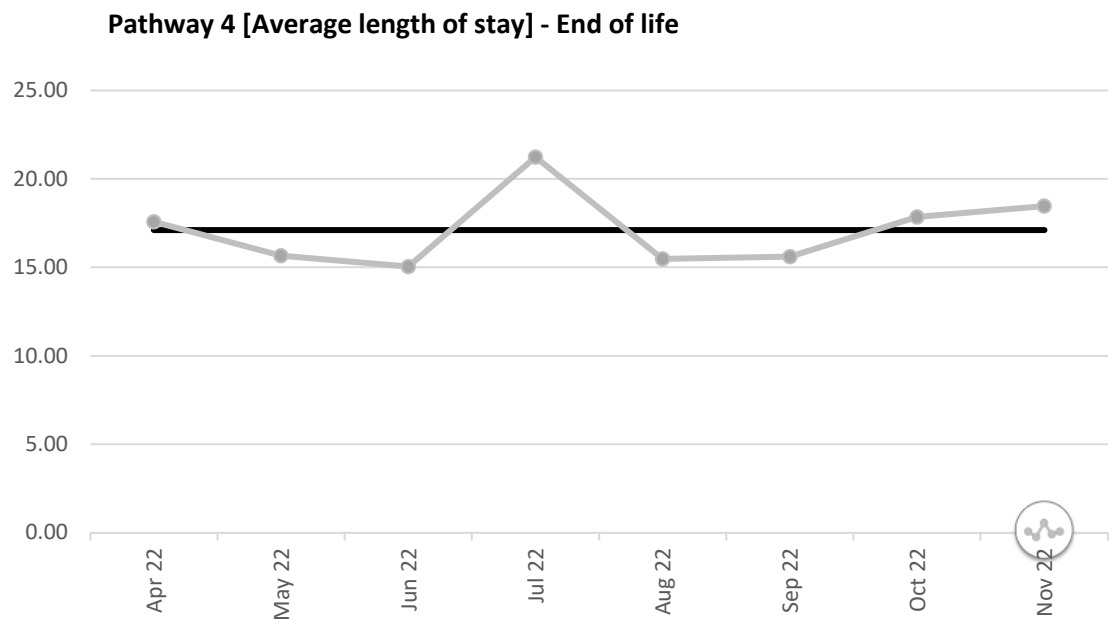
Analyst Commentary	Commentary on current performance and actions in place	What will we do next and when?
We do not have enough data points for any specific analysis to be concluded. Target Source: No Target	We have now received additional funding for brokerage to prevent delays waiting for care homes. The integrated Discharge Hub (IDH) are proactively managing discharges through this pathway	Harvest View opened in December with 32 beds available. This will increase to 80 beds over the next 6 weeks. In addition, we are funding spot purchase Extra Assessment Beds (EAB) to maintain capacity during the transition of Harvest View. We have utilised the winter surge funding to maintain bed numbers at Rowley Hospital and will open an additional 24 beds to support delays if required

1.1.8 Pathways 3 – INTEGRATION COMMITTEE



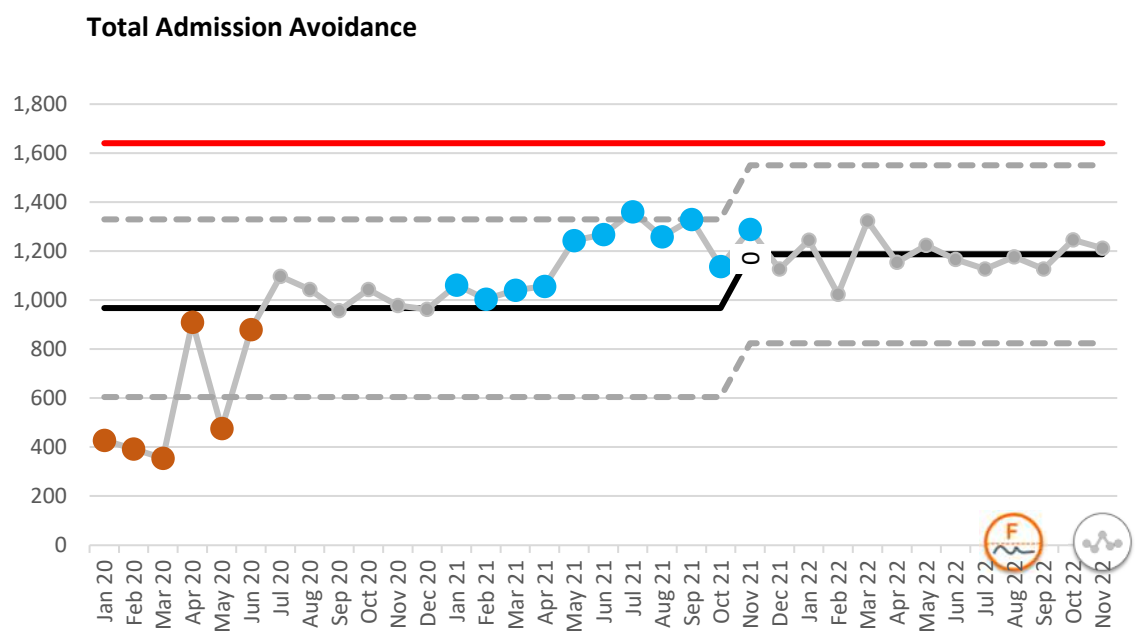
Analyst Commentary	Commentary on current performance and actions in place	What will we do next and when?
We do not have enough data points for any specific analysis to be concluded. The graph is currently showing common cause variation. We are reporting an 84.1% increase on the previous months average LOS, now at 25.43. Target Source: No Target	Length of stay for pathway 3 has increased. However, this is largely driven by low numbers with significantly long length of stay waiting national placements for complex LD support. At the time of writing, this related to 3 patients.	We are working with the care home sector to ensure adequate capacity and access to beds out of hours

1.1.9 Pathways 4 – INTEGRATION COMMITTEE



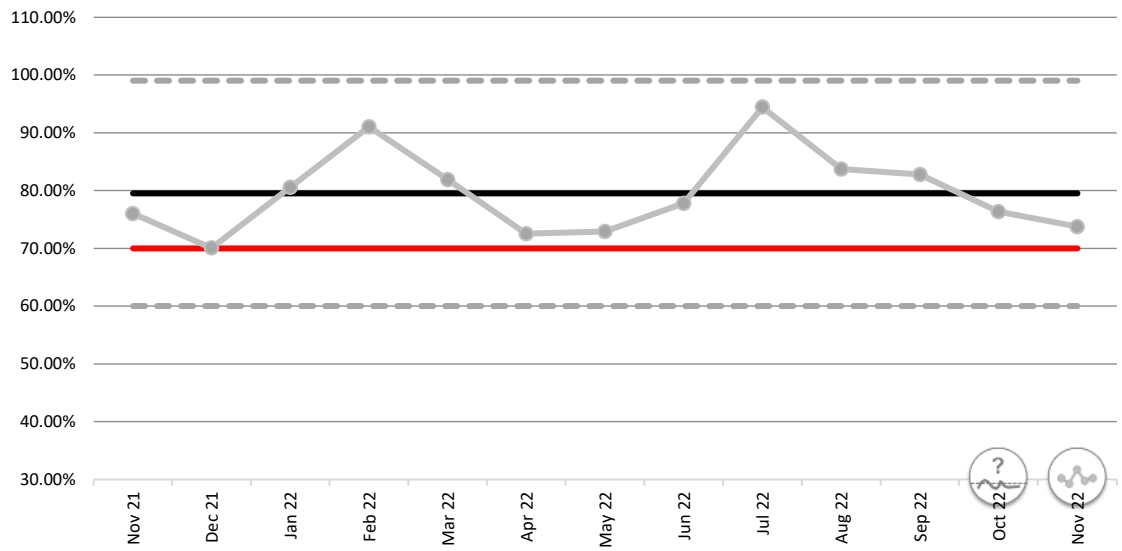
Analyst Commentary	Commentary on current performance and actions in place	What will we do next and when?
We do not have enough data points for any specific analysis to be concluded. The graph is currently showing common cause variation. The average LOS increased by 3.4% on the previous month, now reporting at 18.46. Target Source: No Target	We have extended the Discharge Enablement Team capacity to provide short term care for people awaiting home care at the end of life. The palliative care team are supporting the IDH in early identification and planning for people on pathway 4. Capacity in this area is starting to come under some pressure and will be off set with additional support from virtual wards planned	We are working with the voluntary sector to provide additional home support

1.1.10 Total Admission Avoidance – INTEGRATION COMMITTEE



Analyst Commentary	Commentary on current performance and actions in place	What will we do next and when?
This indicator indicates common cause but failing to achieve the target. A step change in the mean and control limits have been added from November '21, due the persistent period increased admission avoidance. This means that we have a new average level of performance, from 960~ avoided admissions to 1,180~. Although the process is 'in control' as indicated by common cause variation, we are still failing the target (red line) of 1,640. This chart includes schemes: Frailty Intervention Team (FIT), Covid, Hospital at Home, Palliative Care, District Nursing, and Other Admission avoidance schemes. Target Source: No Target	Total admission avoidance has been largely static in numbers. Further recruitment to the Advance Clinical Practitioner team and the wider community response team is supporting increased capacity. The Care Navigation Centre has now combined with Single Point of Access this will further support the transfer from acute services to community pathways.	There are additional ACPs due to start over the next 2 months supporting additional capacity. We are developing an enhanced triage model with WMAS to further pull people waiting for an ambulance into community pathways. Given the importance in this area of growth, we are adding this to the breakthrough objectives list.

1.1.11 2 Hour Community Response – INTEGRATION COMMITTEE



Analyst Commentary	Commentary on current performance and actions in place	What will we do next and when?
This shows common cause variation. We are reporting at 73.8% which is a decrease of 3.4% on the previous month and is now just above the target level of 70%. Target Source: National	Although there is a slight reduction in performance, we continue to meet the national target of seeing at least 70% of people meeting criteria within 2 hours	The increased capacity in the team and the on-going work with care navigation is aimed at increasing numbers seen in addition to responsiveness. We are developing an enhanced triage model with WMAS to increase numbers