NHS Improvement

Understanding resilient system A&E performance

Provider Projects team review of four systems in the South East region

November 2018

There is significant variation in A&E performance across trusts and over time.

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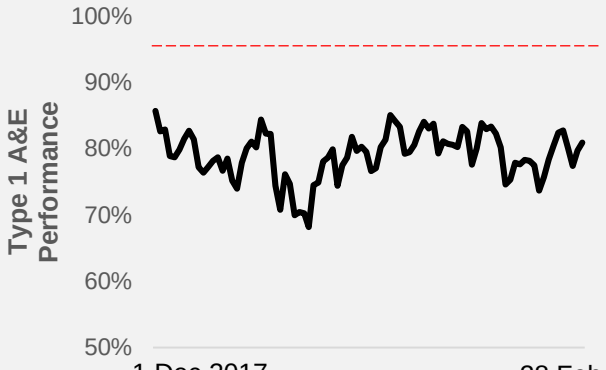
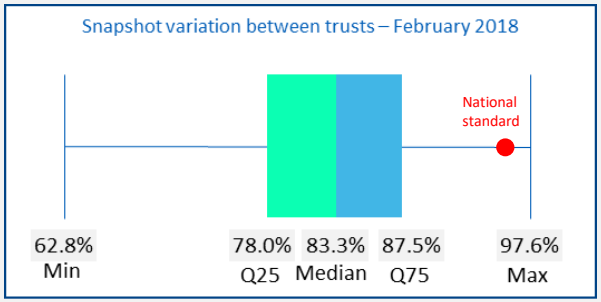
- **Last winter put significant pressure on providers.** This was due to both increased patient demand, and also the response of the whole local health and care system in supplying needed services.
- Within this trend, there is a **large variation** in performance between providers.

Average daily type 1 A&E performance in the South East region, last winter



Source: HES

Variation in monthly A&E performance across trusts in England, February 2018

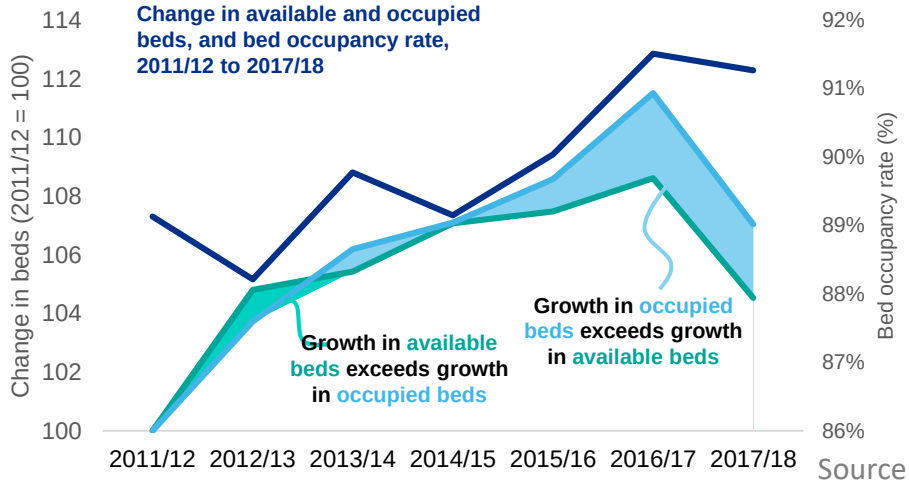


Previous analysis on each provider's A&E performance has shed some light on why performance can vary:

- Bed capacity, crucial to manage in the wards to ease congestion in crowded emergency departments.
- The number of long-stayers (21 days or more length of stay).
- Presence of senior clinical decision makers in A&E, essential for an organised and well-led workforce in the emergency department, and to lead multi-disciplinary teams in wards.
- Admissions surges that can exceed discharges, while there are constraints in primary, community and social care to manage patient demand and facilitate discharges.

The average proportion of beds that are occupied rose between 2011/12 and 2016/17, with the number of additional occupied beds outpacing the number of available beds

Change in available and occupied beds, and bed occupancy rate, 2011/12 to 2017/18



Source: HES

The winter context includes growth in emergency admissions, many of whom are complex.

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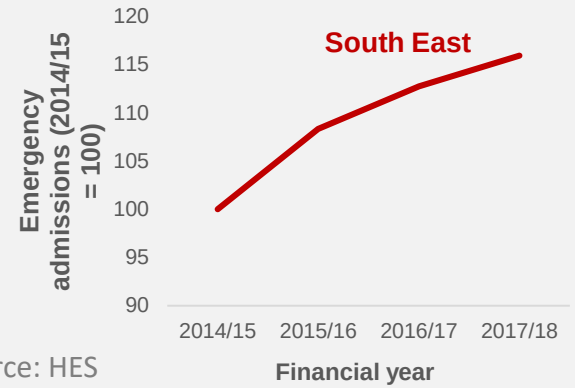
The context over previous winters has been sustained growth in emergency admissions.

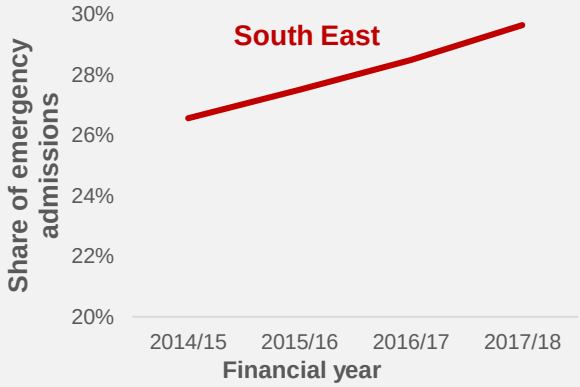
- Many of these admissions were for more complex, frail patients.
- High rates of flu added to difficulty. 3% of spells were for flu in 2017-18, compared to 1% or less in previous years.

Emergency admissions of all patients



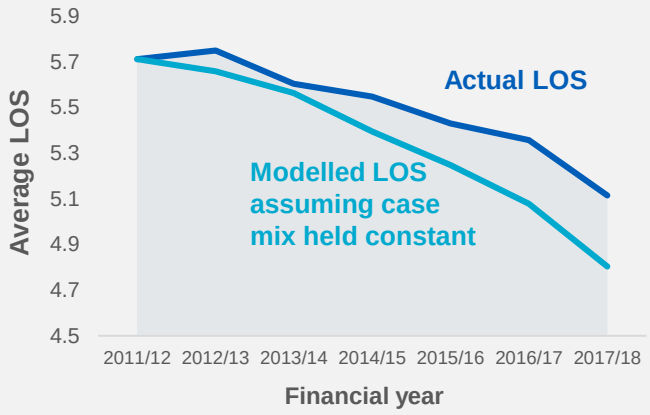
Source: HES

Emergency admissions of frail patients



Increasing patient complexity is making freeing up hospital beds more difficult. Average patient length of stay has fallen every year, though would have fallen more if patient complexity had not risen.

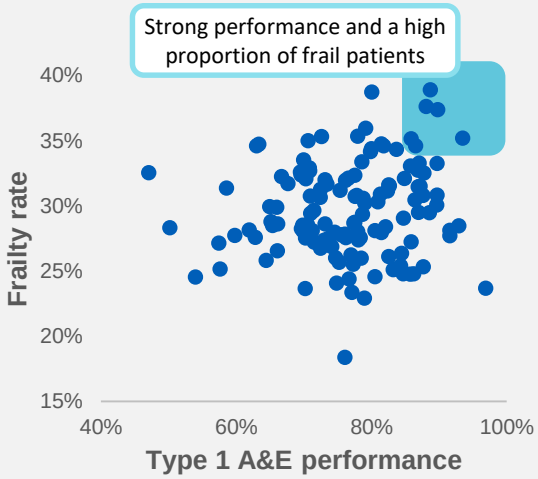
Average Length of Stay for admitted emergency patients



Source: NHSI analysis of HES

While, overall, providers are constrained by increases in frailty, some providers are performing at 90%+ A&E performance while still admitting a high number of frail patients.

A&E frailty and performance, 2017/18



Source: HES

Within the variation, some providers perform 'resiliently' in the face of higher pressure.

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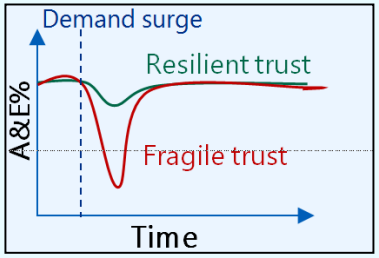
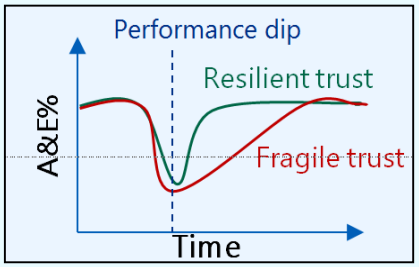
Measuring resilience helps us to see the differences in performance between providers over time.

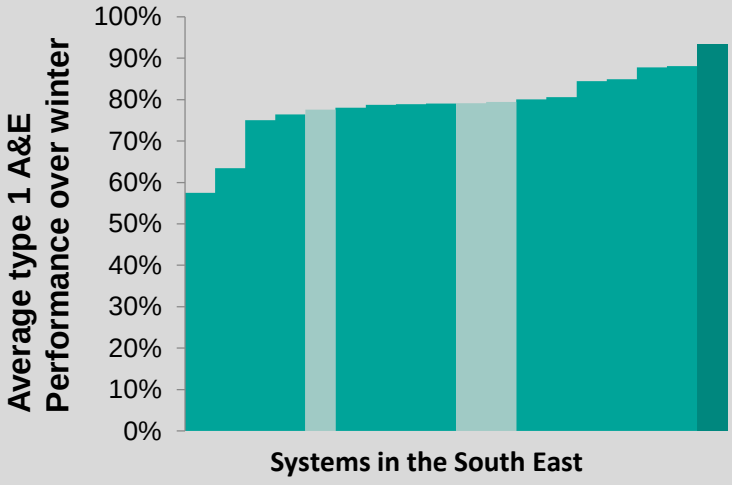


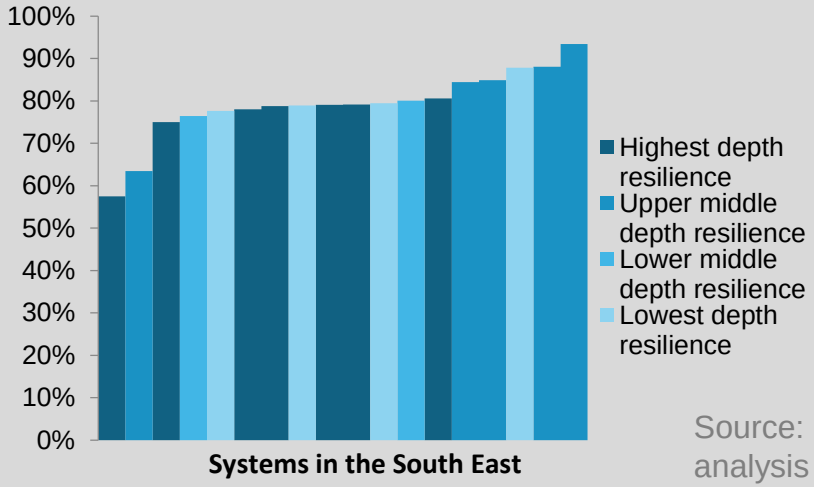
Depth resilience
How much A&E performance falls following a surge in admissions. The most resilient A&E departments experience half the dip in performance that the least resilient do. Data suggest unobservable factors such as culture contribute to this.



Bounce back resilience
How quickly, in days, A&E performance recovers after dropping. Data suggest systems with faster recoveries tend to have lower average bed capacity.

Across the South East, we see variety in which systems are most resilient. The most resilient trust for 'bounce back' also has the highest average performance. Systems with the most depth resilience are a mix of high and low performers, and some high performers have low depth resilience.





Source: NHSI analysis of HES

Through this work, we wanted to better understand what makes a system resilient, and how we can support systems to be more resilient. For instance by looking at:

- How staff effectively use processes to manage beds and escalate problems.
- Leadership and staff culture.
- How system partners work together and respond to crises.

For more information on how NHS Improvement uses resilience measures in its work to better understand drivers in A&E performance, see the technical annex to the NHS review of winter 2017/18.

We considered factors contributing to 'resilience' in systems

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Key questions in project scope

- **What factors contribute to a system's resilience?**
- **What does 'good' look like for these factors, and how can systems reach this?**
- **What actions can the South East region take to best help systems this winter?**

Factors likely to contribute to resilient performance

Internal factors	Operational management	• Bed management • Escalation • Discharge • Streaming • Communications • Staff planning • Ambulance handover • QI methods • Demand forecasting
	Using resources	• Financial position • Funding • Managing electives
External factors	System landscape	• Demographics • Partnership working • Capacity • Primary care • Community services • Social care • Leadership
	Winter pressure	• Demand growth • Acuity
	National and regional intervention	• Messaging • Input from regional and national teams

Planned deliverables

- **Sharing our findings and recommendations in detail**
- **Sharing summary insights with systems in the South East**
- **Linking up trusts with national teams where they have asks**

We focused on four systems to test our understanding of 'resilience'

What are the characteristics of a resilient system?

What does good look like and why does it work?

How can the region best help systems prepare for winter?

From December to February, our analysis found the following trusts to be the most resilient:

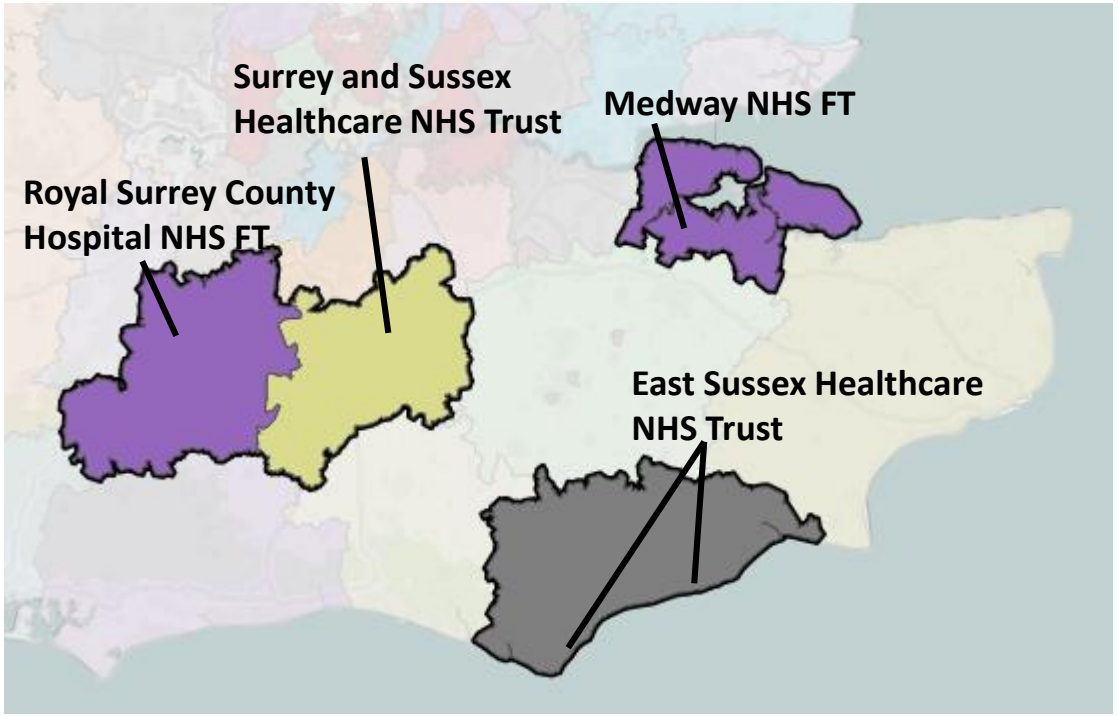
1. Royal Surrey County Hospital NHS FT

2. Surrey and Sussex Healthcare NHS Trust

3. East Sussex Healthcare NHS Trust

This project examined, using qualitative and quantitative methods, what factors contributed to the resilience of these organisations.

We also included ***Medway NHS Foundation Trust*** in our cohort.



System visits

We carried out visits to each of the resilient systems, which consisted of:

- **Interviewing** senior staff involved in running or overseeing the emergency patient pathway e.g. COO, Medical / Nursing Directors, A&E Delivery Board Chair, CCG lead, Local Authority lead
- **Interviewing** frontline staff based in the emergency department and along the urgent and emergency care pathway.

Analysis

- **Analysing** key metrics associated with winter pressure, such as admission rates, time of admission, bed occupancy, length of stay, and weekend admission/discharge (see annex for more detail)
- **Analysing** the landscape of the systems, including primary care capacity, financial and workforce indicators and quality indicators, such as CQC reports.

The resilience model developed by the economics team was used to generate hypotheses that we tested throughout the project

We have categorised key findings from our visits as follows

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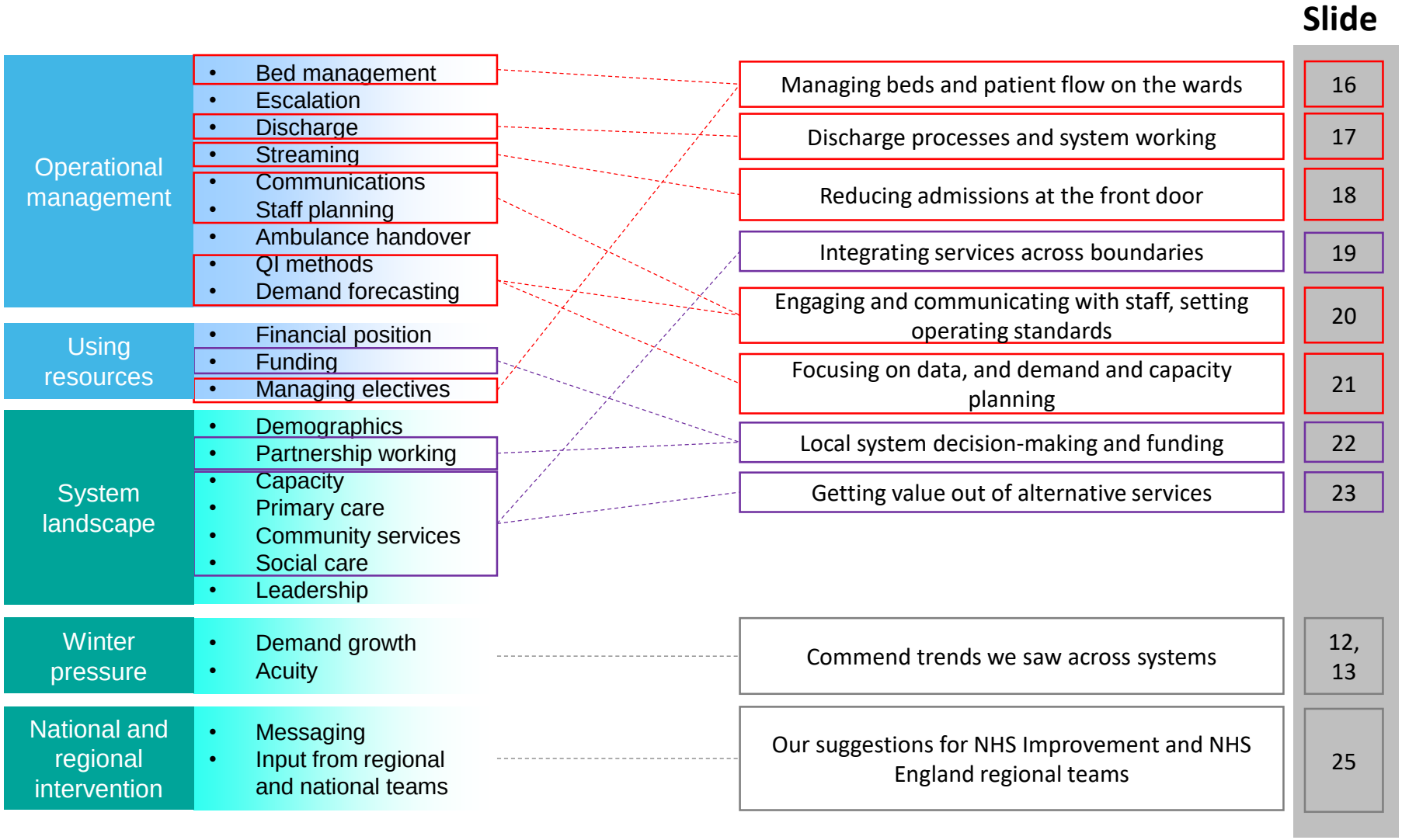
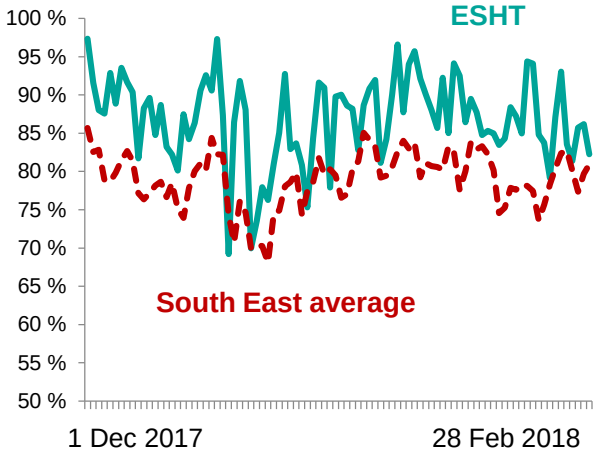


East Sussex

- Strong ability to manage performance dips following to surges in attendances.
- Average A&E performance of 87% between December and February. At the same time, the trust must meet complex patient needs including a sizeable cohort of elderly patients.

Type 1 A&E performance trend



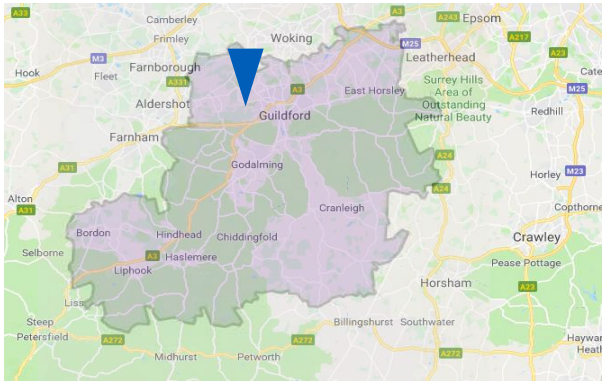
Source: ESHT A&E data

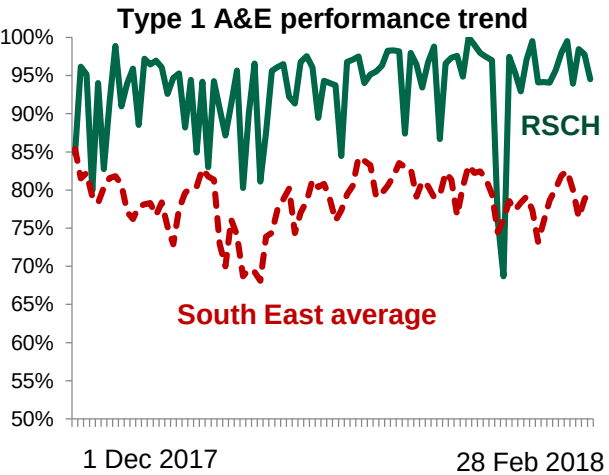
Factor	Measure	Response
Population	Rurality	Relatively rural population
	Deprivation	Medium to high (IMD 18.02 at E and 25.8 at C)
System	No. of GPs in CCG	E - 119; H – 114
	GPs per head in CCG	E - 5.54 (Amber); H - 5.16 (Amber/Red)
	GPs over 55 (%)	E - 15.7% (Amber); H - 23.2% (Red)
	GPs over 65 (%)	E - 2% (Amber/Red); H - 3% (Amber/Red)
	Time to next A&E	45 mins (Conquest and Eastbourne)
	Vanguards	No vanguard
Finances	CCG allocation 18-19	E – £1,380, H – £1,472
	Trust surplus 17-18	Deficit of £54M - 14% of provider turnover
	CCG surplus 17-18	E - surplus of £1.6M - 0.5%; H - 1.6M surplus - 0.5%
Staff and estates	Sickness absence	High sickness absence 4.5% - Amber/Red
	Staff leavers	Staff leavers 9.9% - Amber; nurses - 8.1% - Amber/Green; docs - 18.8% - Amber
	Estates function	7.7% non functioning
	Trust size	Footprint 84,467 sqm
Streaming	Rate of ambulatory care sensitive admissions	• For acute, Eastbourne - 1,243 and Hastings - 1,247 • For chronic Eastbourne - 657 and Hastings – 781
Quality of care	CQC rating	Requires improvement overall rating for Conquest and Eastbourne sites. Well-led rating is 'good'

Sources: CCG Outcome Indicator Set, NHSI finance for year end 2017-18, CQC

Royal Surrey

- Faster ability to 'bounce back' following dips in the 4-hour standard than other hospitals in the region.
- Reasonable ability to respond to surges in attendances.
- Average A&E performance of 93% between December and February.
- Challenges in March and beyond that provide 'lessons learned'.





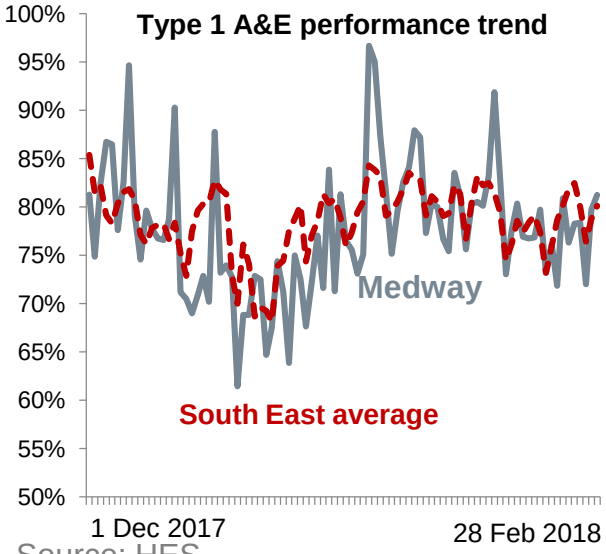
Source: HES

Factor	Measure	Response
Population	Rurality	Relatively rural population
	Deprivation	Low deprivation (IMD 8.25)
System	No. of GPs in CCG	141 GPs
	GPs per head in CCG	5.54 per 10k pop (amber), better than rest of STP
	GPs over 55 (%)	23.4% GPs over 55 (red)
	GPs over 65 (%)	0.4% GPs over 65 (amber)
	Time to next A&E	30 mins to next A&E dept (Frimley)
	Vanguards	Wave 1 ICS and devolved budget from 1 April 2018
	CCG allocation 18-19	Guildford and Waverley - £1,120
Finances	Trust surplus 17-18	Surplus of £31M - 8% of provider turnover
	CCG surplus 17-18	CCG has deficit of £8.4M - 3.2% of CCG outturn
Staff and estates	Sickness absence	Low sickness absence - 3.1%
	Staff leavers	Leavers medium/high - 13.1% (10.5% nurses and 11% docs)
	Estates function	0% estates non functioning
	Trust size	Footprint 35,000sqm
Streaming	Rate of ambulatory care sensitive admissions	Acute: 1,366 admissions per 100k patients. Chronic: 626 admissions per 100k patients. These figures includes zero length of stay admissions
Quality of care	CQC rating	Good overall rating, with outstanding for the 'responsive' domain. Good use of resources rating.

Sources: CCG Outcome Indicator Set, NHSI finance for year end 2017-18, CQC

Medway

- Average performance of 78% over winter.
- Struggles to 'bounce back' following dips in performance.
- Widespread geography with range of deprivation levels and demographic needs.
- Specific good practice around streaming and DTOC reduction.



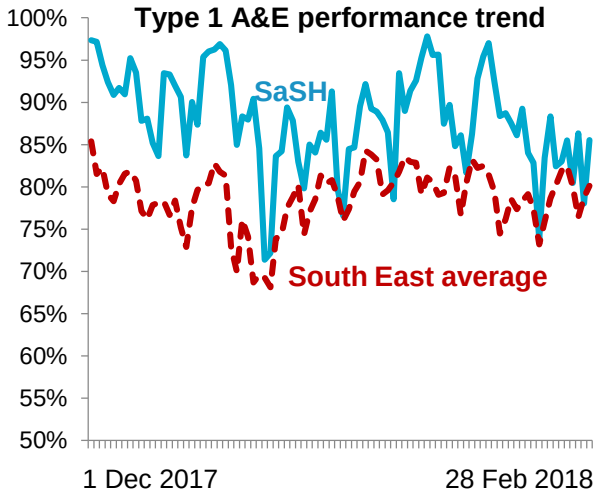
Source: HES

Factor	Measure	Response
Population	Rurality	Relatively urban population
	Deprivation	High deprivation (IMD 22.33)
System	No. of GPs in CCG	142
	GPs per head in CCG	4.33 (red)
	GPs over 55 (%)	24.5% (red)
	GPs over 65 (%)	8.5% (red)
	Time to next A&E	28 minutes to Maidstone Hospital
	Vanguards	Kent is an integrated care pioneer; Kent and Medway was also in phase 1 of the GP Access Fund
Finances	CCG allocation 18-19	£1,198
	Trust surplus 17-18	£62.1m deficit - 23% of provider turnover
	CCG surplus 17-18	£0.1m surplus – 0% of outturn
Staff and estates	Sickness absence	3.9% (amber)
	Staff leavers	Total 11% (amber), 11.8% for nurses (red/amber) and 13.8% for doctors (amber)
	Estates function	32.5% non-functioning
	Trust size	Footprint 41,581sqm
Streaming	Rate of ambulatory care sensitive admissions	Acute - 1,528 per 100k patients Chronic - 936 per 100k patients
Quality of care	CQC rating	Requires Improvement; good for 'effective' and 'caring' domains. Inspection in April 2018.

Sources: CCG Outcome Indicator Set, NHSI finance for year end 2017-18, CQC

Surrey and Sussex

- Resilient performance in the face of demand surges. Average A&E performance of 88% between December and February.
- A&E performance relies on multiple commissioners, community services providers and local authorities.



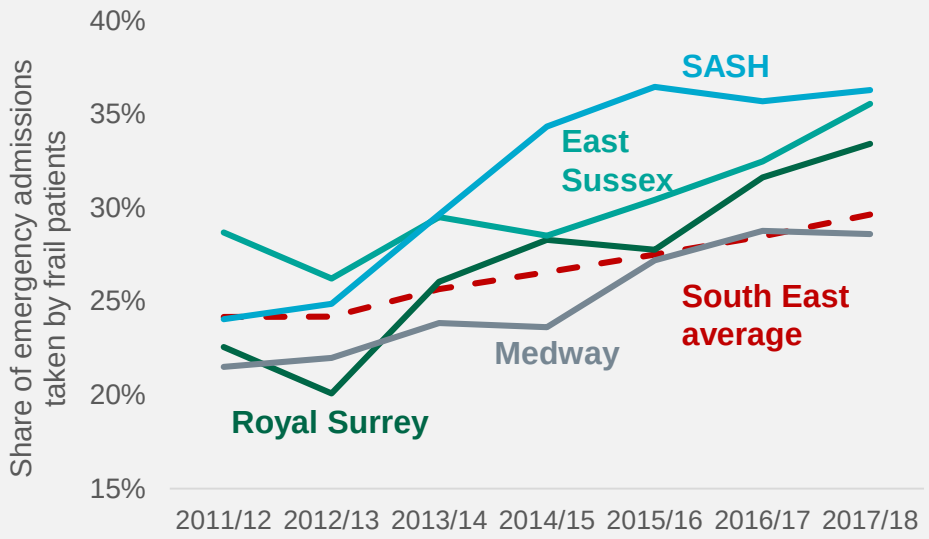
Source: HES

Factor	Measure	Response
Population	Rurality	Semi-rural population
	Deprivation	Low to medium deprivation (IMD 8.25)
System	No. of GPs in CCG	110 GPs
	GPs per head in CCG	5.07 per 10k pop (amber / red)
	GPs over 55 (%)	22.5% GPs over 55 (red)
	GPs over 65 (%)	0.6% GPs over 65 (amber)
	Time to next A&E	44 mins to next nearest A&E dept (Princess Royal)
	Vanguards	None
Finances	CCG allocation 18-19	East Surrey – £,1,239, Crawley - £1,249, Horsham and Mid Sussex – £1,127
	Trust surplus 17-18	Surplus of £13.6M - 4% of provider turnover
	CCG surplus 17-18	CCG has deficit of £16m – 7.1% of CCG outturn
Staff and estates	Sickness absence	3.7% rate (amber)
	Staff leavers	Leavers medium/high – 12.7% (11.6% nurses and 15.9% docs)
	Estates function	28% estates non functioning
	Trust size	Footprint 66,184sqm
Streaming	Rate of ambulatory care sensitive admissions	Second best in the country after its neighbour, Crawley. Acute: 253 per 100k patients. Chronic: 108 per 100k patients.
Quality of care	CQC rating	Good inspection ratings across all domains; the last inspection was in 2014

Sources: CCG Outcome Indicator Set, NHSI finance for year end 2017-18, CQC

We saw similar trends across each system

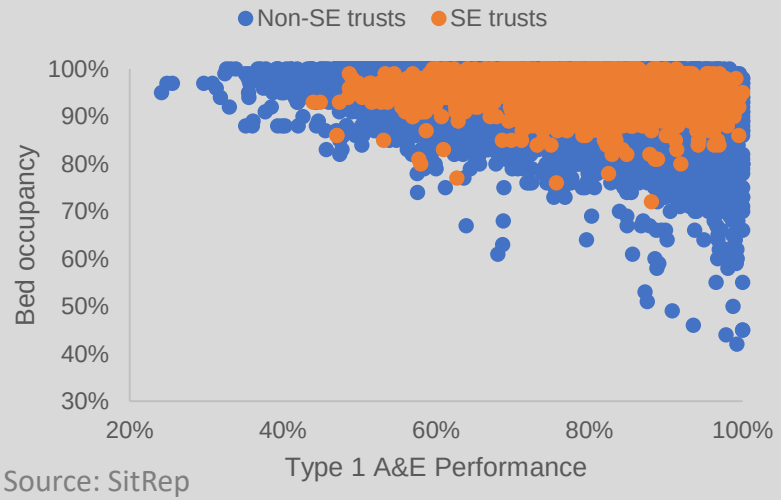
The systems we visited are all admitting an increasing number of frail patients.



Source: HES

All providers in the region struggled to lower their bed occupancy.

Scatter of daily measures of bed occupancy and type 1 A&E performance, each day in 2017/18

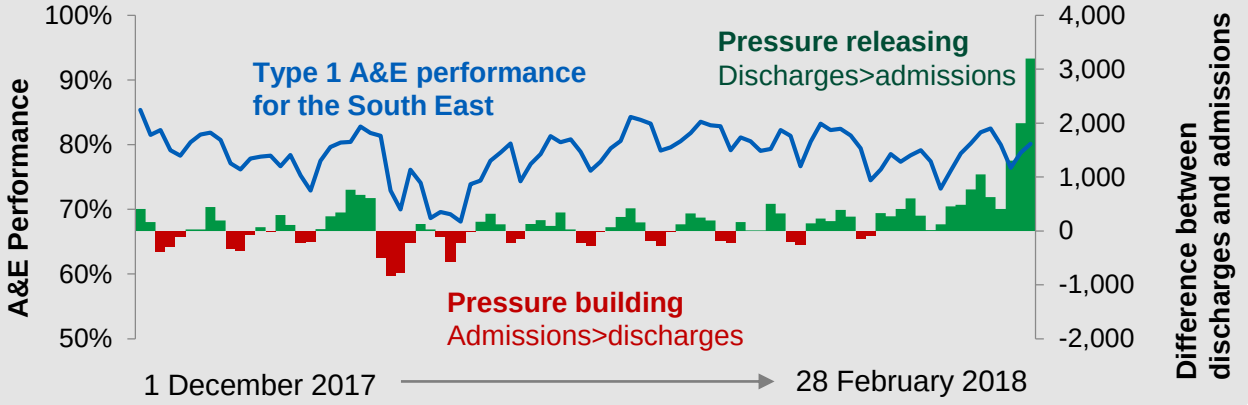


Source: SitRep

- Performance across the south east links closely with the build up and release of pressure, in terms of surges in demand over points in the week.
- All providers follow this pattern, though it becomes more difficult to explain their performance due to a range of one-off events contributing to demand and performance.

Source: HES, SitRep

A&E performance and admissions net discharges for the South East (last winter)

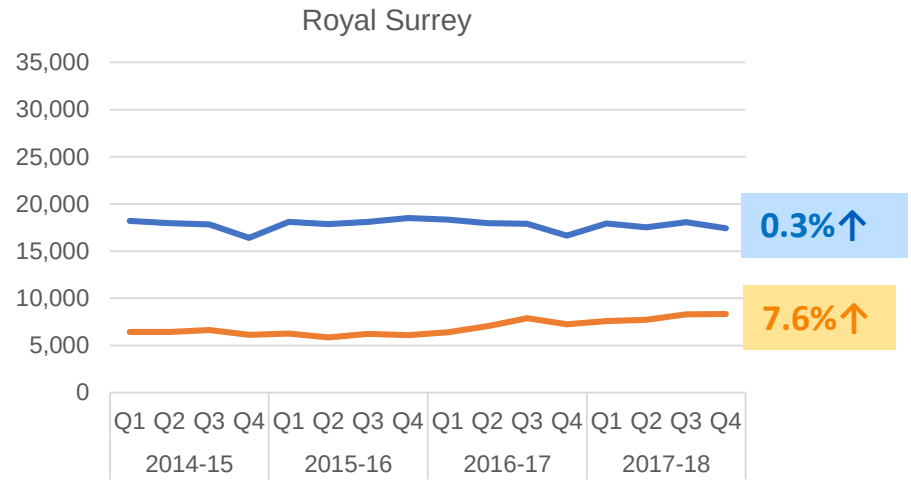


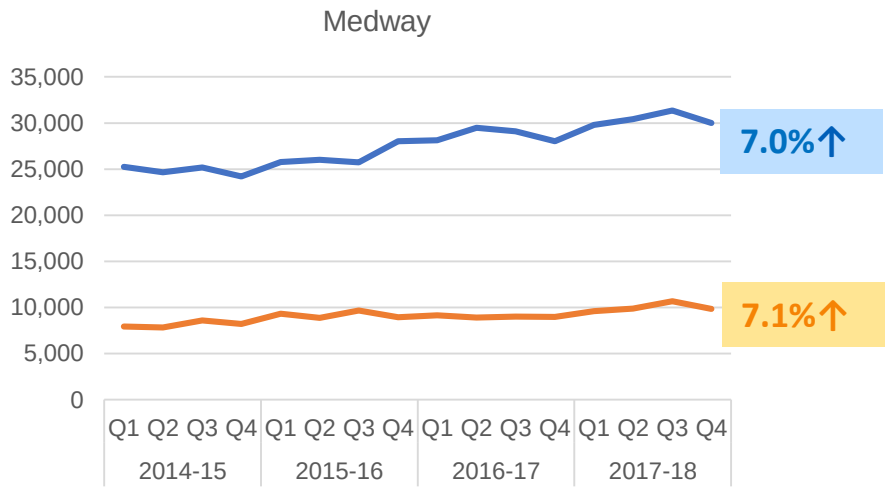
Growth in attendances and admissions varied across systems.

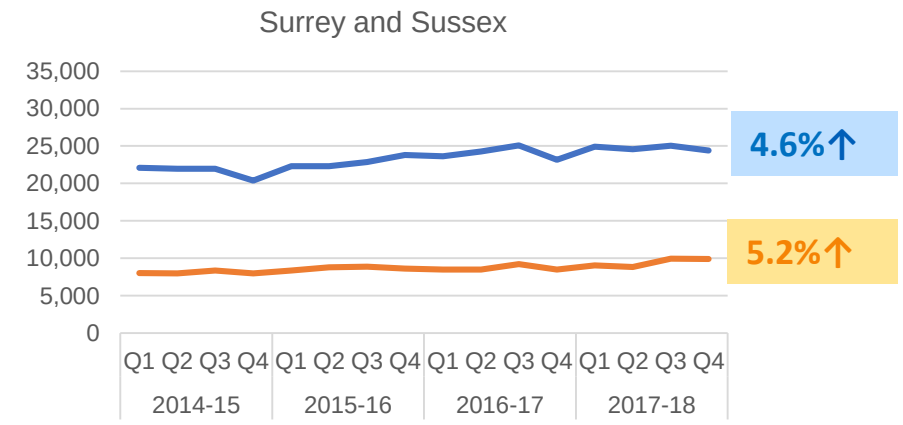
Looking at changes in the total number of **attendances** and **admissions** in HES, **all systems experienced growth**. Between 2014-15 and 2017-18, Royal Surrey experienced a much larger increase in admissions than attendances. Surrey and Sussex saw admissions grow by a small margin more than attendances. Medway saw an increase in attendances that slightly exceeded the increase in admissions.

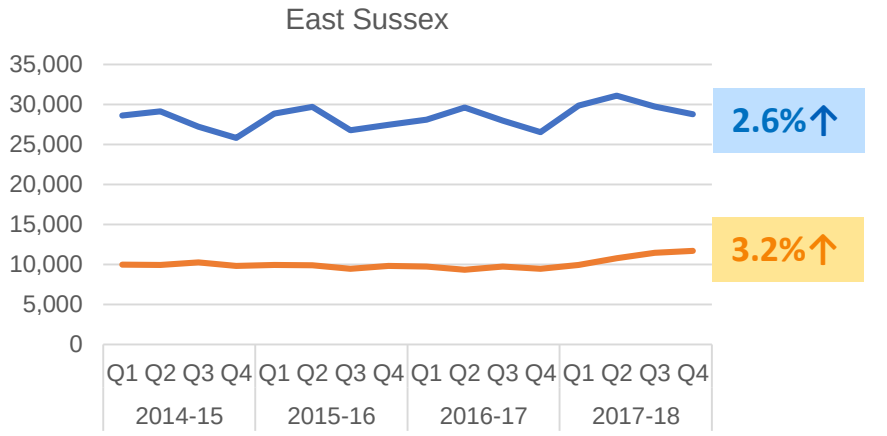
Notes: 1. The figures are not necessarily comparable as each provider will have different practices for admitting patients and recording admissions. 2. All percentage growth figures are a Compound Annual Growth Rate, which measures percentage changes in activity from 2014-15 as a whole year to 2017-18 as a whole year.

Total attendances and admissions









Our observations connect to key principles for performance

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10 principles successful providers follow ---- *in achieving these, no one size fits all*	
1	The whole hospital owns the problem, not just leaving it to the front line
2	Has the right capacity plan that understands both elective and UEC needs
3	NHS 111 is fully supported by the system, with clinical input and access to services
4	Being able to stream patients back to primary care and other pathways
5	Having enough staff across the hospital along the emergency care pathway
6	Having just enough space in emergency departments
7	A standard and consistent operating protocol
8	Have physicians in the departments working as part of the team
9	Having the basics right across the hospital – bed flow and bed management
10	Focusing on length of stay and patients who are in hospital who don't need to be there

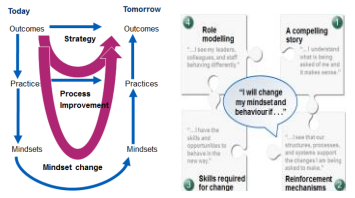
There are wider system working principles that we found important to emphasise

Supporting people to move out of hospital before they deteriorate

Drawing on the efforts of acute, mental health, community, social care and primary care partners

System providers and commissioners having a shared understanding and agreement of patient demand and capacity issues facing them. Each must have an appreciation for one another's constraints, including how they can collectively manage the flow of patients around their system

In making changes to providers and wider systems, staff culture and behaviours are crucial (overleaf)



There are practical frameworks to manage change through looking at behaviours, mindset and organisation culture

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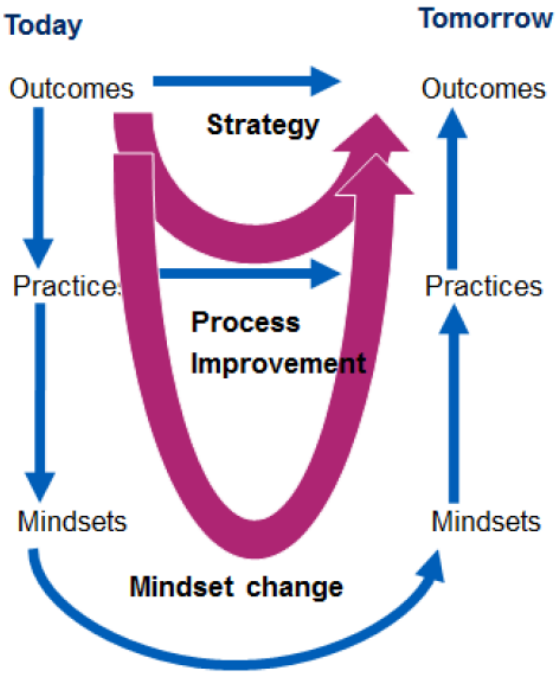
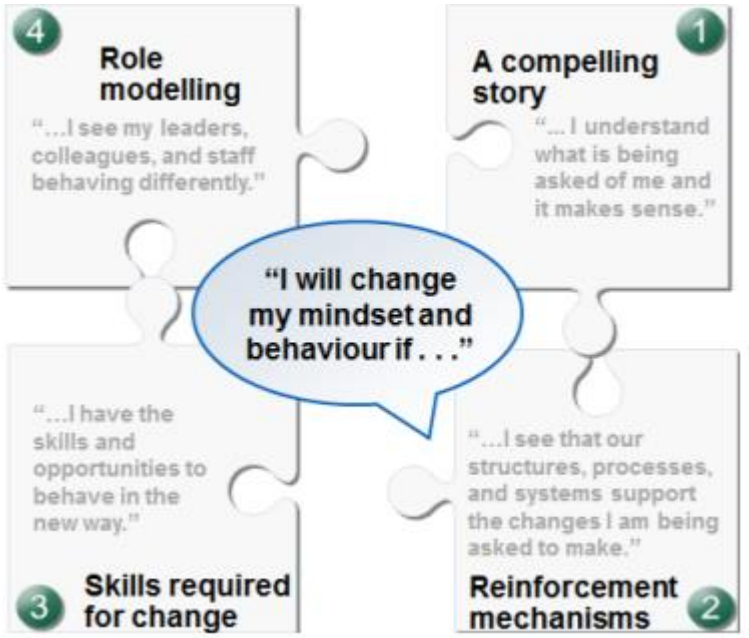




Successful change led through a clear strategy, setting out desired outcomes, processes and behaviour change. For example:

- setting a strategy to reduce bed days
- using board rounds and bed management meetings
- ensuring that wards own the processes, understand their value and celebrate success

Behaviour change led through building motivation, staff capabilities and by setting clear leadership and direction.

To boost motivations, in particular, staff will need to understand a clear objective and see the compelling reason behind it (for instance, seeing senior leaders behaving differently) to reinforce the change needed.

Managing beds and patient flow in the ward

What

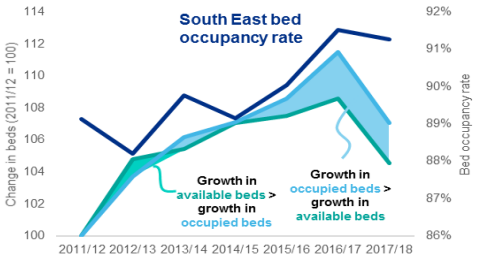
Board rounds, ward rounds, MADE events, outliers and full capacity protocol

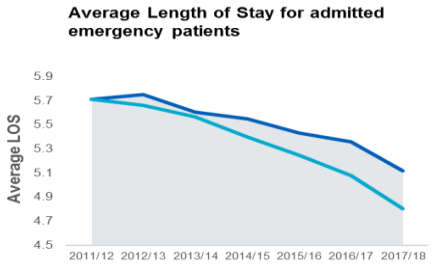
- **Board rounds** are essential to run daily have become well-established. In one provider, the site nurse reviewed progress across all wards and set clear expectations. Board rounds follow principles to support discharge – for instance, the SAFER patient flow bundle.
- **Setting principle to avoid outliers –** one trust found moving patients between wards added up to six days to their stay. Another found a correlation between few outliers and low length of stay over winter. All medical outliers cause problems, though a common example is elderly patients arriving on wards that do not specialise in geriatric medicine.
- **Multi-Agency Discharge Events (MADE)** – multiple systems brought together social care, therapy, community and acute staff to collaborate in improving discharge. These can run in several different ways. One trust ran them monthly at most, focusing on specific cohorts and discharge issues, which had long-standing impact and avoided becoming a 'second board round'.
- **Full capacity protocols –** running this was best when the emergency department was crowded. Discharge nurses who aren't part of the wards enact the protocol to be neutral, bring up patients and turn-around beds quickly.
- **Planning for the weekend is essential to mitigate the weekly build of pressures as seen in slide 14.**

Why – 10 key principles

- *Length of stay –patients who are in hospital who don't need to be there.*
- Freeing up bed capacity to help improve patient flow through the hospital

It is essential that systems manage beds and patient flow to the best of their ability, to maximise the number of available beds and continue to sustain reductions in length of stay while patient complexity rises.





Mindset is crucial to making change

One provider changed its consultant job plans to require their presence at board rounds. This was unpopular, but has now become normal practice and staff see it as progress.

The trust reinforced this change by encouraging medics and other clinicians to celebrate when wards had empty beds. This helped consultants to understand their contribution to freeing up beds.

Lessons learned

A new 'medically fit' ward at one site led to increases in LOS rather than for the short term.

Reducing outliers takes time and will increase delays to start with, though this is necessary to overcome.

Recommendations for regional teams

The region can encourage systems to embed patient discharge processes in wards. This should frequently happen from admission and, if necessary, be an explicit part of senior clinician's job plans.

Monitor and support trusts on their number of outliers.

Support trusts to develop and enact a full capacity protocol when pressure is high.

Ongoing support from third parties, such as ECIST, which ensure that the trust and local system partners receive feedback on managing beds and patient flow.

Discharges and system working

What

Discharge to the community, logistics and proactive planning.

- **Discharge to assess,** alongside SAFER, is important to apply. Most trusts used a discharge lounge as effective space to hold patients ready for discharge. One trust used discharge nurses to take patients to the lounge, and take a more objective view on their needs to expedite discharge.
- **Patient transport services (PTS)** – One trust booked ambulances in advance to ensure PTS. Another tightened its processes to quickly book and delivery transport. People are often content to wait a few hours for transport, and this can lead to delays where people staying on the wards longer, possibly overnight. Actively seeking out these delays can prevent them.
- **Community** – We visited a system that had difficulty transferring patients to community providers. Delays are particularly common for geriatric, respiratory and cardiac patients. To consider good practice on patient flow to community providers, see our previous report.
- **Social care –** The care home market is constrained across multiple systems. One system lost 100 care home beds from October. This forced a change where it focused on frailty pathways and tackling peoples' crises out of hospital, for instance working closely with care teams to visit patients.
- **Teams focus on discharges throughout the trust.** Teams, including therapy, plan discharge on a patient's admission**.** Board rounds on the wards all work through patients with a multi-disciplinary team and assign actions immediately to make discharge happen quicker.

Why – 10 key principles

- *Length of stay –patients who are in hospital who don't need to be there*.
- Freeing up bed capacity to help improve patient flow through the hospital

Mindset is crucial to making change

Medics pushed back on prompts to discharge patients quicker, feeling these were threats to their training and independence. They changed their attitude where the positive consequences of beds becoming free were clear**.**

Staff have centred around knowing their bed numbers, and knowing available beds are good for patients and the whole hospital. Staff aversion to taking on new, urgently in need, patients when beds free up needs managing.

Trusts encouraging planning on admission found it **difficult to get people to 'think ahead'.** Executives need front-of-house staff to recognise their contribution to blocked beds, and to troubleshoot what staff need at their disposal to make plans (details, logistics, contact to inpatient wards etc.)

Lessons learned

One provider with lower A&E performance still reduced its DToC to near zero in parts of winter, showing what is possible.

Recommendations for regional teams

One provider found guidance and support for reducing DToC unclear. Similarly, the length of stay ambition is unclear in which beds to focus attention on. While we can highlight this to national teams, the South East region can keep a clearer sight on 'what good looks' like for them in reducing DToC and LoS.

Reducing admissions at the front door and system working

What

- **Same day emergency care –** one trust we visited set out a business case to move from five- to seven-day ambulatory care. The trust moved experienced nurses and consultants to establish this model, and specifically asked a consultant with good leadership to run it. System partners supported the case, with the commissioner using a block contract to balance risk and build incentives.
- **Building capacity** – One trust expanded its ambulatory care facilities, using PDSA cycles to build a new modular unit over nine weeks. This unit streams 50% of attendances during the day, cutting patient waits with good experiences. It also handles GP referrals. The team maintain a presence in A&E throughout the day, streaming patients into their large seating-only unit.
- **Relying on a flexible workforce** – One of the trusts we visited was among the first to use physician associates, which has created a more flexible workforce. This has allowed them to free up doctor time and focus in on specific tasks – including the medical 'take' from A&E.
- **In anticipation of winter, all trusts set up streaming, though in different ways.** Two sites we visited ran GP streaming though with mixed opinions on its impact. Streaming services can work in different ways, so long as they have good throughput to draw in specific cohorts of patients for quick review and referral onwards. Some systems would need a greater abundance of GPs, and a close working relationship with primary care, to make streaming work.

Why – 10 key principles

- *Being able to stream patients back to primary care and other pathways.*
- *Having just enough space in emergency departments*

Lessons learned

The system that implemented same day care put in place a temporary financial agreement to ensure it could kick-start, while it works through a more permanent funding model.

Providers need to avoid keeping A&E as a triage service for patients. Hospitals can create a 'queueing mentality' which is detrimental for staff and patients.

Mindset is crucial to making change

One trust's approach to running same day emergency care focused clearly on outcomes, processes and mindset.

Outcome: patients go to a not-admitted pathway in same day emergency care, freeing space and putting people in the best clinical setting.

Process: Rolling-out a new way of working with experienced clinicians.

Mindset: The trust needed to generate credibility for same day emergency care with clinicians, to enable faster implementation and delivery. The trust put hand-picked individuals in place to ensure clinical leaders were bought in and encouraged the changes. It was also important for trust leaders to ensure they allowed clinicians the time to work through the transformation as well as focus on day-to-day tasks.

Recommendations for regional teams

Avoiding admissions can reduce bed occupancy. The region should support trusts to develop new ways of working quickly by freeing up time for senior clinicians to bring about changes, particularly those that require buy-in and are needed urgently.

Use finance expertise to support providers in making quick capital bids to expand streaming facilities.

Integrating services across boundaries

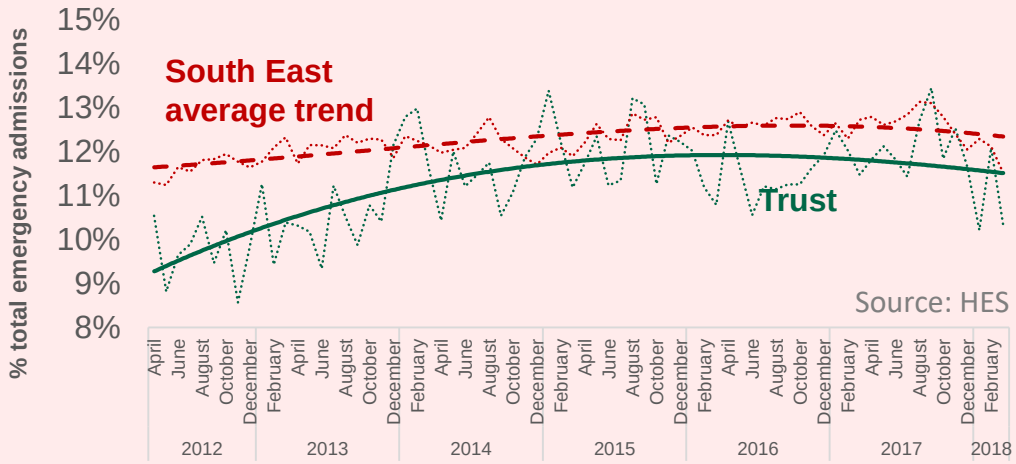
What

- **Working with the ambulance service –** One trust worked closely with the ambulance service to reduce conveyance of mental health patients from 60% to 20%. Alongside 'hear and treat', and 'see and treat', SECamb also now streams directly to GP services, avoiding A&E altogether, and works with practices care to change GP visit times, to smooth out patient attendance times.
- **In addition…** trusts are most effective in handover when they have substantive staff on duty, the estate (eg bays for assessments) is well-set up, good practice such as *Fit2sit* for lower acuity patients is in place, and the trust works closely with the ambulance service's operations hub.
- **Repeat admissions** – While they are a small group of patients, repeat admissions add much pressure to capacity. One trust reversed the growth it was seeing in admissions, by hiring a committed GP to resolve problems for repeat attenders, complex patients and end-of-life care patients. The GP ran multi-disciplinary sessions with a range of staff to problem-solve these issues. The GP moves across all care settings to profile attenders and set actions.
- **Demand management for calls –** The ambulance service uses a surge management plan to manage patient expectations and is able to say 'no' when a caller is ambulant.

Why – 10 key principles

- *Being able to stream patients back to primary care and other pathways.*
- *Having just enough space in emergency departments*

Repeat emergency admissions (>= 4 times within 12 months) have started to fall as a share of total emergency admissions



This trust's repeat admissions were increasing rapidly in 2012 and 2013, and approaching the regional average. However, the trend stopped increasing in 2015 and has started to reverse.

Lessons learned

It is tricky for ambulance services to prioritise where they bring patients, given the varying escalation levels trusts apply. There needs to be a simpler single point of access with clearer protocols for which people can be treated in different scenarios.

Recommendations for regional teams

Having a case management system – even one as simple as a flagging system – meant that staff, even those who don't know the patient, can immediately recognise patients who have particularly intensive needs – and can see what was done previously, rather than needing to start from scratch.

This work is key to meeting another key principle: **Designing a standard and consistent operating protocol**, in this case for the ED specifically.

Engaging with staff

What

Setting up a positive and open culture, where senior executives listen to staff and involve them actively in transformation schemes.

- **Including staff in initiatives** – One trust ran competitions alongside local businesses to award prizes, boosting staff morale as well as their resilience. The same trust also ran an effective social media campaign and built a social network group to support staff and coordinate when issues arose.
- **Developing and applying problem solving methodologies –** the 'lean' and the Virginia Mason Institute are examples of empowering staff to problem solve. One trust used 'lean' to run ward-specific improvement work over winter. While the tools vary, all let staff frame, own and solve their problems effectively.
- **The chief executive and other executives are visible** and on-the-ball with performance in ED, keeping senior clinicians and divisional directors on their feet. Executives tend to be visible, such as in daily bed capacity meetings. In the best cases, executives make an effort to be visible on all days – good and bad – so as not to intimidate staff when under pressure.
- **Putting the right people, who are high performers and motivational, in the right places and jobs. P**utting motivational staff in charge of in-reach and ambulatory services are all good examples of this. Hiring acute physicians with a particular way of working and mindset is another example.
- **Communications focus is consistent –** whether or not the four-hour standard gets a mention, the key focus for staff must be safe and effective work in the ED and across the UEC pathway.

Why – 10 key principles

Urgent and emergency care delivery is best achieved when the whole hospital owns the problem and doesn't leave it to a few people on the front line.

Mindset is crucial to making change

One trust exemplified 'problem solving' by giving staff sessions where they air grievances with the chief executive. The executive team turn these into opportunities to collectively solve problems. When people 'own' their issues they have the motivation to see the solutions through.

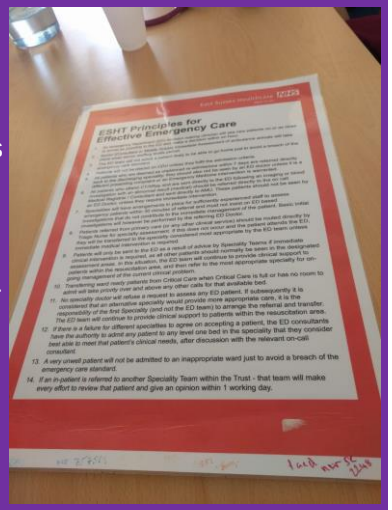
Over time, through goodwill, support, and empowering staff to 'make things better', this trust has created a culture where staff do not want to move across to other sites. The trust focuses in great lengths on its staff survey outcomes, as good staff morale is good for maximising the quality of care delivered.

Lessons learned

The principles of a quality improvement method are most important, and all trusts should implement one or another so long as it commits and executives give time for it to work.

Communicating clear emergency department standards

In one provider's A&E, the team felt it had clear principles for effective emergency care, and with necessary clinical director buy-in, developed these as **'14 commandments'**. These were then in view on the wall in the emergency department to maintain clear standards – for instance not admitting patients to an inappropriate ward. This has become a regular aid for staff, for instance letting junior staff challenge senior colleagues.



Recommendations for regional teams

Staff own changes and improvements when they see them through from start to finish. The good practice of the '14 commandments' is worth sharing – though in equal measure the region can promote hospitals to, on their quieter day, rally staff to set standards through their own creative process. External input to do this may be beneficial.

Data, demand and capacity

What

Effective planning in advance, using data as part of operations

- **Demand and capacity planning** – resilient systems started planning much earlier this year. One system modelled its whole capacity to inform bed planning. One trust set its rotas hourly to match demand - as a result, it introduced a 4pm to 2am shift for consultants, which successfully matched supply to changes in demand.
- **Using data to support operations** – additional data support enabled one system to introduce a raft of measures to support operational planning, such as: ambulance arrivals, a real-time bed management system and live data dashboard screens. Rather than hold beds open overnight ahead of elective admissions, the trust now matches admissions directly to discharges, saving the need to keep a bed empty overnight.

There are several factors that make good planning effective – all of which are important:

- Year-round demand and capacity planning
- Sophisticated and proactive technical input
- Data are formatted in an intuitive way, ideally automated, visible and well understood
- Whole system operational planning. Embedding operational basics into processes and procedures for system working builds relationships.

Why – 10 key principles

Have the right capacity plan – understand elective needs and urgent and emergency needs (basics like staff and beds) and how to close the 'capacity gap'.

Mindset is crucial to making change

Multiple resilient systems got their clinicians to appreciate *operations management as* a priority alongside providing safe, effective care.

One trust made operations visible throughout the using visible management data, and engaging staff in operational issues ahead of winter. Another recruited a nursing director with operations experience, who has built the connection between good patient flow and compassionate care.

Lessons learned

Some trusts set demand forecasts using historic data, missing some surges from weather and flu. When predicting demand, trusts need to be vigilant and flex capacity as needed.

The move to automate data collections within each provider, to share across systems, is tricky and still needs progress in most systems. It requires a level of standardisation and understanding that can be difficult to achieve at system level.

Colleagues in NHS Improvement are exploring whether we can develop and share a tool to predict attendances over the next 7- and 21- days for providers, taking into consideration weather patterns and public health data. We will share further information on this in due course.

Recommendations for regional teams

Set standards for data, informatics automatic data collection, and work with the central analytics teams to test these standards.

Run sessions with execs to help extend operations focus.

Support trusts to foresee surges beyond predictive modelling.

Local system decision-making and funding

What

- **There is a single, thorough source of data and analysis.** One system shares demand and performance data manually using the software Alamac. The tool would work better if data automatically appeared on it, and not all partners have their data on the system, but this tool has helped to give a single system view of pressures.
- **There is dedicated resource on behalf of the system.** The A&E delivery board has jointly appointed a project management resource who tracks priorities, delivery and risks. The A&E delivery board has good representation from all system partners: Mental health, the trust's integrated community services, primary care and the local county council. Complicated governance structures and an unwillingness to raise and appreciate crucial issues tend to still hinder other A&E delivery boards, which needs reflecting on.
- **Open dialogue.** Well-performing delivery boards transparently worked through their issues (such as sharing data between A&E, primary care and mental health services) with healthy, open discussion. In having this level of trust, delivery board meetings saw good attendance.
- **Routes for governance and funding are clear and straightforward.** In two of the system groups we sat in on, the group could collectively agree on business cases if they could see the system benefit. For instance, moving care out-of-hospital despite reducing the acute provider's income margin (systems nevertheless have to balance their financial position with these decisions). In one system, the coming together of three CCGs vastly smoothed decision-making. Systems which found it challenging to agree actions and discuss key problems also tended to have more convoluted governance for local decision-making.

Why – Focus on the system

All system providers and commissioners need to have a shared understanding and agreement of the patient demand and capacity issues facing their system, with an appreciation for one another's constraints, and how they can collectively manage the flow of patients around the system

Lessons learned

Some systems have a more difficult geography to work across, such as multiple boundaries for commissioners and local authorities. One system we visited performed well in spite of this through its straight-to-the-point communication and escalation, and good coordination and expectation setting.

GP membership (such as through a GP federation) was typically the trickiest system partnership to work up. This needs working-up from both sides, with local A&E delivery boards inviting GP representatives actively and monitoring attendance.

Mindset is crucial to making change

In the systems we visited: the dedication, competence, and goodwill to work collectively that operations and clinical leaders demonstrated made the relationships more trusted and outcomes aligned.

Recommendations for regional teams

Consider the current relationship with system partners and presence at A&E delivery boards. Can the region extend challenge and support in getting other partners present, and representing a system view on issues?

Advise systems on how they reconcile funding with making mutually beneficial business cases.

Getting value out of non-acute services

What

- **Community capacity–** Resilient systems managed to keep **t**he capacity and availability of their community services high. One system worked well with its independent sector partner, while another trust's community partner did not face closures over winter. Community services need to interface well with social care services, where housing is still the main constraint. Sending care workers and night service teams into care homes can, for instance, reduce dependency on the acute sector. While flu was a concern, some acute providers challenged their community partners on closing beds, and interrogated into risks around flu on the wards. The most resilient systems recognised that funding for community services was crucial and so used extra funding initially received by the acute provider.
- **Primary care –** Having close relationships with primary care services are essential. For example, acute providers keeping track of GP training days, which might lead to spikes in demand. Relationships with GP federations tended to be less developed, though there is more coordination in some systems, including GP in-reach and case-working.
- **Managing demand and expectations in primary care –** one of the systems experienced significant patient demand when there was poor coordination between NHS 111, GPs, and acute services. Opening hours for GP services over the holiday period was a catalyst for this problem. The system is now focusing efforts on public and patient engagement to make clear what services are available and when.

Why – Focus on the system

Managing people out of hospital before they deteriorate, and facilitating return to the community is essential, This requires the concerted effort of all acute, mental health, community, social care and primary care partners.

Lessons learned

Leadership, visibility and good governance in community services is crucial and isn't all about integrating organisations. The key focus needs to be on good relationships across system partners, including commissioners, social care and primary care.

Some acute staff focusing on discharge had little oversight of how community services ran.

System relationships need to remain healthy. When there was a sense of blame across organisational boundaries, communication suffered and it became very difficult to solve problems and deal with winter pressure.

Mindset is crucial to making change

Strategy – improving the flow and discharge pf patients in the system

Process – integrating discharge team with the acute provider, means that staff are working across boundaries and developing relationships with key people across the system.

Mindset – staff were able to bypass lengthy formal processes and build trust in the capabilities of each other to make decisions together about patients throughout the entire pathway.

Recommendations for regional teams

Build rapport with the full range of system partners, including CICs and independent providers which often interface with the acute trusts, but do not experience the same level of oversight.

Acting as a problem solver for softer issues as well as performance, to help systems to become more resilient.

Summary points from the work

NHS Improvement

In summary…

- **The South East region faces increasing pressures in both the number and acuity of patient admissions.** The ageing population is increasing complex clinical needs across all systems to varying degrees. Some systems have particularly complex social needs to address.
- **Systems make use of different ways to treat patients.** To start, non-elective pathways will differ across systems. Systems should consider the range of services and good practice available to them. They should take what works while recognising the need to fit services to their local context.
- **The systems we visited demonstrated a large amount of good practice.** These ranged from solutions to a common problem – for example, how one system organised its repeat attendees with case work led by a GP – to widespread changes in local system working, communications and behaviours.
- **Resilient providers have grip on the basic principles for operations.** For example, where staff use and understand their data. This allows senior leaders to visibly interact with daily challenges and successes. Another example is having clear principles for working in the ED, with zero tolerance for outliers and queueing.
- **Good communication and culture is key to encourage the right staff behaviours.** Putting in place a policy to eliminate outliers does not work on its own. The policy must be owned and worked through by staff, overcoming a 'so what' response when pressure increases. Staff need a positive, supportive culture to maintain their own personal resilience over winter.
- **Working as a system is crucial.** Beyond having good working relationships, partners need to cut down time needed to make decisions. There needs to be clear, honest, healthy debate over issues that can arise at short-notice.

Good practice we saw

Culture, engagement ownership

- Positive **no-blame** culture at all levels
- Staff have **permission** to resolve issues and take initiative
- Leaders spend time engaging on good and bad days
- **All hospital staff own** the challenges that come with winter
- Clinicians can **define and solve problems**
- Good use and ownership of data
- **Staff are put into the right roles**, with the energy to succeed

Operations management

- Having **dedicated central resources** to prompt action
- Support from the centre and new technology help though staff need to be in place first
- Suitable streaming is in place
- Having clear boundaries in place to deter outliers and delays
- System partners fit into operations (e.g. in-reach across partners)
- Accurate **forecasting** and bracing for pressure all winter

System working

- **Dedicated project manager** working for the whole system
- Common view on needed system flow
- **Single system narrative** emerging from a co-commissioned analysis
- Stable, frequent attendance at all meetings
- Streamlined governance and decision-making
- Healthy and open discussion of known issues (e.g. data sharing)

Takeaway messages for regional teams to consider

NHS Improvement

Ensuring basic operational processes are in place

- ✓ **Use simple tools** such as 'flagging' attenders and checklists to share important messages with other clinicians.
- ✓ **Challenge trusts to do everything they can to manage patient flow**, such as using the full capacity protocol. It will be crucial to oversee the **prevention of outliers**, including through encouragement with frontline staff and executives.
- ✓ **Ensure that discharge processes are built into daily and weekly cycles**. Use **ward rounds, board rounds and MADE**. Help trusts troubleshoot where these events don't have their maximum impact.
- ✓ **Check that leaders at all levels are visible** and are making clear decisions to support staff, on bad *and* good days.
- ✓ **Use centrally collated data** to predict and identify trends that are only noticeable through comparing data across all providers. *Our analytics team is leading on this.*

Ensuring providers are laying the groundwork for continuous improvement

- ✓ **Checking that clinical leaders dedicate time** to transform services (all year round including winter)
- ✓ **Developing a clear plan for workforce engagement and communication.** Different communication strategies and messages worked in different places and so the key is being **consistent** in messaging and recognising what staff in a local system respond to most.
- ✓ **Pushing QI tools – whether lean, six sigma, VMI or otherwise…** the key success factor is that staff are **involved** and able to use the tools to formulate, own and solve problems.
- ✓ **Identify positive and negative sources of culture**. Work with providers and systems to challenge where negative behaviours prevent improvement. Pinpoint where the personal resilience of staff is stretched.

Making sure there is strong governance and system working

- ✓ **Give thought to each systems' current setup and governance.** Do systems have joint appointments and **dedicated project managers** to ease system working? Is communication and data sharing as good as it can be? Is the process for agreeing action **streamlined** and governed through a simple and small set of decision-makers?
- ✓ **Checklist key elements that contribute to resilience,** acting as a **sounding board** by attending regular A&E Delivery Board meetings that focus beyond operational performance
- ✓ **Ensure that partners within the system are aligned** in their identification of, and approach to solving, problems within and beyond the acute provider.