Humber and North Yorkshire Health and Care Partnership

NHS Humber and North Yorkshire Integrated Care Board (ICB)

Agenda Item No:	13

Report to:	Humber and North Yorkshire Integrated Care Board
Date of Meeting:	10 July 2024
Subject:	**Urgent and Emergency Care**
Director Sponsor:	Stephen Eames, Chief Executive
Author:	Shaun Jones, Director of Planning and Performance

STATUS OF THE REPORT:

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ A Regulatory Requirement ☐

SUMMARY OF REPORT:

This report briefly brings to the attention of Board members the latest Urgent and Emergency care performance and patient quality position across Humber and North Yorkshire and the steps being taken to improve the position, whilst bringing explicitly to the attention of Board members the recent correspondence received from NHS England regarding the oversight of patient safety and care.

RECOMMENDATIONS:

Members are asked to:

i) Note the current performance challenges and the actions being taken to address them;

ii) Seek assurances regarding the oversight of patient safety and quality as per the recent NHS correspondence.

ICB STRATEGIC OBJECTIVE

Leading for Excellence	☒
Leading for Prevention	☐
Leading for Sustainability	☐
Voice at the Heart	☐

IMPLICATIONS

Finance	Significant finance and other resources are dedicated to the provision of urgent and emergency care services across HNY.
Quality	Patient safety and quality is a key, underpinning consideration in relation to the delivery of urgent and emergency care.
HR	There are no direct HR implications from this report.
Legal / Regulatory	There are no explicit legal or regulatory implications from this report.
Data Protection / IG	The provision of data is crucial to understanding how we are performing across urgent and emergency care, though there are no IG implications from this report.
Health inequality / equality	There are no explicit health inequalities implications from this report though there are a number of high intensity users who tend to disproportionate attend urgent and emergency care services.
Conflict of Interest Aspects	There are no conflict of interests from this report.
Sustainability	There are no sustainability implications from this report.

ASSESSED RISK:

There are a number of risks outlined in this report. These include patient safety and quality risks, performance risks and reputational risks for individual providers and the ICB as a whole given the key regulatory focus in this area of work.

MONITORING AND ASSURANCE:

The monitoring of performance in relation to urgent and emergency care is a key part of the oversight and assurance arrangements across the ICB.

ENGAGEMENT:

Engagement has taken place with a variety of stakeholders in pulling this report together.

REPORT EXEMPT FROM PUBLIC DISCLOSURE No ☒ Yes ☐

If yes, please detail the specific grounds for exemption.

URGENT AND EMERGENCY CARE

1. INTRODUCTION

1.1 Urgent and Emergency Care is a system wide issue with multiple challenges and scope for improvement across many parts of the pathway. Emphasis is on making sure patients access the right service for the level of acuity that they are experiencing in primary and secondary care – and that they are seen in a safe and timely manner. Preventing patients from attending or being brought to ED, optimising flow in and through hospitals, and fostering early discharges, are crucial.

1.2 This report briefly brings to the attention of Board members the latest Urgent and Emergency care performance and patient quality position across Humber and North Yorkshire and the steps being taken to improve the position, whilst bringing explicitly to the attention of Board members the recent correspondence received from NHS England regarding the oversight of patient safety and care.

2 BACKGROUND

2.1 In January 2023, NHSE published their National Urgent and Emergency Care recovery Plan, which focused on improvement of UEC care for patients, reducing waits in ED and for Ambulances. The recovery plan set out 2 targets for achievement by March 2024: **A&E 4 hour standard of 76% and CAT2 response times of 30 minutes.** The Plan also outlined 10 High Impact Interventions which Systems should focus on, based on proven impact on patient care and performance. Each ICS undertook a baseline assessment to determine their maturity against each of the interventions:

1. Same Day Emergency Care
2. Frailty
3. In-hospital Flow
4. Community Bed Capacity
5. Care Transfer Hubs
6. Intermediate Care Capacity
7. Virtual Wards
8. Urgent Community Response
9. Single Point of Access
10. Acute Respiratory Hubs

2.2 Alongside the launch of the Recovery Plan, NHSE introduced a tiering system which placed ICSs into a Tier based upon their performance against 4 key metrics:

- **Ambulance Category 2 Response Mean:** 30 minutes
- **4 Hours in Department: Type 1** Performance to identify the trusts with the greatest opportunity to improve flow in major Emergency Departments – ECDS data was used to include trusts participating in the Clinical Review of Standards.
- **12 hours in Department from time of arrival**
- **Proportion of beds occupied by long stay patients (14+ days)**

2.3 The tiering was broken down as below:

- Tier 1 – Worst performing systems, receiving National oversight and mandatory support
- Tier 2 – Systems performing below expected levels with little assurance around improvement trajectories, receiving Regional oversight and support
- Tier 3 – Systems performing at, or close to, expected levels with confidence around improvement plans and trajectories

2.4 Following evaluation of ICS performance, Humber and North Yorkshire were placed into Tier 2. The arrangements for being in Tier 2 have been relatively light touch, though there will be a tighter focus over the next few weeks and months, alongside a review of the ICB's Tier status.

3 ASSESSMENT

3.1 The delivery of the national standards for Urgent and Emergency Care has historically been a challenge for Humber and North Yorkshire. This was reflected during 2023/24 where the delivery of sustained improvement against the 4 hour standard or Ambulance handover times proved to be challenging. The March 2024 outturn position was **69.6% 4 hour standard** against the target of 76%. This compared to a Regional position of 73.6%. This represented the best performance against the 4 hour standard for some months, though HNY were the lowest performing ICS in the North East and Yorkshire Region.

3.2 As set out in the separate Performance report elsewhere on todays agenda, the 4 hour standard performance for Humber and North Yorkshire reached 70.6% for April 2024 which represented the best performance since August 2021, with the exception of April and May 2023.

3.3 However the performance position for May and June 2024 has deteriorated, with the figure for the 4 hour standard dropping down to circa 65-66%. This compares unfavorably regionally and nationally, with the slides attached providing a summarized comparison for early June 2024.

3.4 In response to the above situation, and in recognition of the importance of the issue, a Chief Executive level meeting was held on June 19th across the ICS footprint to review the current position and instigate a number of immediate next steps. A high level action plan, coupled with greater clinical engagement and leadership, is being developed to help turn the dial in this important area of work.

3.5 Coinciding with the work initiated across Humber and North Yorkshire, a recent national correspondence was received from NHS England regarding the need to ensure an ongoing focus and oversight on quality of care and experience in pressurised services with a specific action for all NHS Boards to assure themselves that they are working with system partners to do all they can to:

- provide alternatives to emergency department attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence;
- maximise in-hospital flow with appropriate streaming, senior decision-making and board and ward rounds regularly throughout the day, and timely discharge,

regardless of the pathway a patient is leaving hospital or a community bedded facility one

3.6 The correspondence from NHSE goes on to emphasise the importance of a shared responsibility to ensure that quality (patient safety, experience, and outcomes) is central to the system-level approach to managing and responding to significant operational pressures and that Board members across ICS partners should individually and jointly assure themselves that:

- their organisations and systems are implementing the actions set out in the UEC Recovery Plan year 2 letter
- basic standards of care, based on the CQC's fundamental standards, are in place in all care settings
- services across the whole system are supporting flow out of ED and out of hospital, including making full and appropriate use of the Better Care Fund
- executive teams and Boards have visibility of the Seven Day Hospital Services audit results, as set out in the relevant Board Assurance Framework guidance
- there is consistent, visible, executive leadership across the UEC pathway and appropriate escalation protocols in place every day of the week at both trust and system level
- regular non-executive director safety walkabouts take place where patients are asked about their experiences in real time and these are relayed back to the Board

3.7 The letter has been shared with all providers across HNY and ICB Executive Directors and forms a key part of the ongoing assurances regarding patient safety and quality.

4 CONCLUSION

4.1 Urgent and Emergency Care is a key delivery priority for patients and HNY ICB. It is a key priority focus for improved delivery over the next few months with numerous steps being taken to address the recent challenges. Patient safety and quality continues to be the underpinning focus throughout.

5 RECOMMENDATIONS

5.1 Members are asked to:

i) Note the current performance challenges and the actions being taken to address them;

ii) Seek assurances regarding the oversight of patient safety and quality as per the recent NHS correspondence.

Appendices
Appendix 1 – slide deck showing recent comparative performance
Appendix 2 – Letter from NHS England re oversight of patient safety and quality

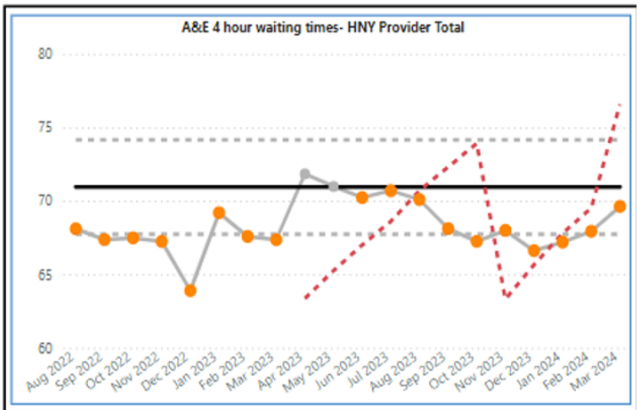
Appendix 1

Humber and North Yorkshire Collaboration of Acute Providers

UEC – Making a Case for Executive Intervention

[18/06/2024]

Background



ORGANISATION	LATEST	TARGET	ACTUAL	VAR.	ASS.	PLAN MET
HNY Provider Total	March 2024	76.6%	69.6%			
YSFT	March 2024	76.0%	67.4%			
HDFT	March 2024	80.0%	78.2%			
NLAG	March 2024	76.0%	66.4%			
HUTH	March 2024	76.0%	61.2%			

Latest HNY performance report shows performance over the last two years

No significant improvement in two years, though the performance at the end of March 2024 was the best seen since last summer

No Trust delivering their plan in 2023/24, and only HDFT meeting the national standard. Despite:

- Significant capital investment in York & Scarborough ED in 2023/24
- Significant capital investment in new UTC and NCTR unit at HUTH
- Substantial capital incetment in Discharge Lounges.
- Significant long term investment in out of hospital schemes related to BCF.
- Significant investment in community services including an increase in virtual ward investment in 2023/24.

Performance: Weekly NEY Performance and Quality Report - 3rd June

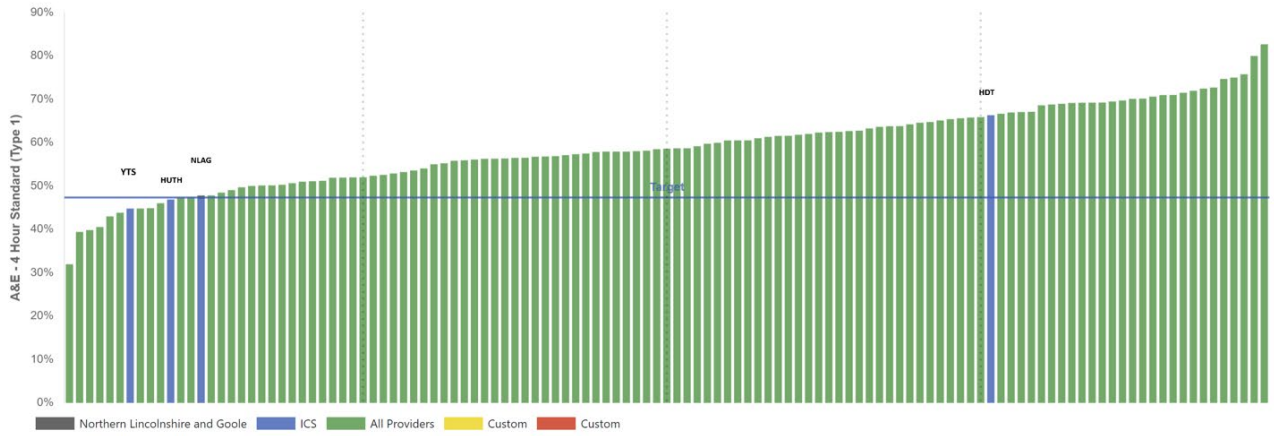
Average hours lost to ambulance handover delays (per day)		Ambulance Handover Delays > 60 mins as % of ambulance		12+ Trolley Breaches		>12 Hours from Arrival as % of total attendances	
North East and Yorkshire Region	289.3	North East and Yorkshire Region	8.3%	North East and Yorkshire Region	761	North East and Yorkshire Region	4.6%
Provider	Performance	Provider	Performance	Provider	Performance	Provider	Performance
Humber and North Yorkshire	170.8	York & Scarborough	30.8%	Humber and North Yorkshire	450	York & Scarborough	11.9%
York & Scarborough	80.8	Northern Lincs. & Goole	25.5%	York & Scarborough	202	North Cumbria	11.9%
South Yorkshire	51.3	Humber and North Yorkshire	24.3%	North East and North Cumbria	160	Northern Lincs. & Goole	11.5%
Northern Lincs. & Goole	45.6	Hull University	23.2%	Northern Lincs. & Goole	157	Co. Durham and Darlington	10.8%
Hull University	41.8	Sheffield Teaching	18.5%	North Cumbria	157	Humber and North Yorkshire	9.6%
North East and North Cumbria	35.1	South Yorkshire	8.6%	West Yorkshire	116	Hull University	6.8%
Sheffield Teaching	34.2	Doncaster and Bassetlaw	7.9%	Hull University	81	Bradford Teaching	6.6%
West Yorkshire	32.1	North Cumbria	7.7%	Leeds Teaching	43	Mid Yorkshire	6.2%
Doncaster and Bassetlaw	14.1	Bradford Teaching	7.4%	South Yorkshire	35	Airedale	5.6%
Bradford Teaching	11.3	Calderdale & Huddersfield	6.3%	Doncaster and Bassetlaw	35	West Yorkshire	5.3%
North Cumbria	11.0	Co. Durham and Darlington	5.6%	Bradford Teaching	35	Calderdale & Huddersfield	5.0%
Co. Durham and Darlington	10.7	Harrogate & District	4.1%	Airedale	31	Harrogate & District	4.2%
Calderdale & Huddersfield	9.1	South Tees	4.0%	Harrogate & District	10	Leeds Teaching	4.1%
South Tees	5.5	Airedale	3.5%	Mid Yorkshire	6	Doncaster and Bassetlaw	3.2%
Mid Yorkshire	4.5	West Yorkshire	3.2%	South Tees	3	The Rotherham	3.2%
Leeds Teaching	4.3	North East and North Cumbria	3.0%	Calderdale & Huddersfield	1	North East and North Cumbria	3.1%
S. Tyneside & Sunderland	4.2	Sheffield Children's	2.6%	Co. Durham and Darlington	0	Sheffield Teaching	2.8%
The Newcastle	3.2	S. Tyneside & Sunderland	2.4%	Gateshead Health	0	Gateshead Health	2.3%
Airedale	2.9	The Newcastle	1.9%	N. Tees & Hartlepool	0	South Yorkshire	2.3%
Harrogate & District	2.7	Leeds Teaching	1.1%	Northumbria	0	The Newcastle	1.1%
The Rotherham	1.4	Barnsley	0.9%	S. Tyneside & Sunderland	0	S. Tyneside & Sunderland	1.0%
Barnsley	1.2	The Rotherham	0.8%	The Newcastle	0	South Tees	0.8%
Northumbria	0.4	Mid Yorkshire	0.4%	Barnsley	0	N. Tees & Hartlepool	0.1%
Sheffield Children's	0.4	Northumbria	0.1%	Sheffield Children's	0	Barnsley	0.1%
Gateshead Health	0.0	Gateshead Health	0.0%	Sheffield Teaching	0	Northumbria	0.0%
N. Tees & Hartlepool	0.0	N. Tees & Hartlepool	0.0%	The Rotherham	0	Sheffield Children's	0.0%

Performance: Weekly NEY Performance and Quality Report – 3rd June

4 hour wait performance (incl. CRS pilot sites)		Average Time in A&E (Non-admitted patients) (minutes)		Average Time in A&E (Admitted patients) (minutes)		Percentage of beds occupied by patients who no longer meet the	
North East and Yorkshire Region	73.8%	North East and Yorkshire Region	190	North East and Yorkshire Region	407	North East and Yorkshire Region	13.6%
Provider	Performance	Provider	Performance	Provider	Performance	Provider	Performance
Northumbria	91.7%	Co. Durham and Darlington	283	North Cumbria	743	Northern Lincs. & Goole	29.2%
Sheffield Children's	90.6%	Hull University	244	York & Scarborough	659	North Cumbria	21.0%
N. Tees & Hartlepool	89.9%	Leeds Teaching	241	Northern Lincs. & Goole	637	Calderdale & Huddersfield	19.9%
Bradford Teaching	82.8%	York & Scarborough	237	Humber and North Yorkshire	595	Humber and North Yorkshire	19.0%
Barnsley	78.5%	Humber and North Yorkshire	215	Co. Durham and Darlington	576	York & Scarborough	18.2%
North East and North Cumbria	77.0%	Mid Yorkshire	214	Mid Yorkshire	514	Leeds Teaching	17.9%
Gateshead Health	76.0%	North Cumbria	213	Hull University	512	Doncaster and Bassetlaw	17.3%
South Tees	75.1%	The Rotherham	213	Harrogate & District	456	The Rotherham	17.1%
Sheffield Teaching	74.4%	Calderdale & Huddersfield	213	Gateshead Health	454	Airedale	16.7%
The Newcastle	74.3%	Northern Lincs. & Goole	211	Airedale	430	West Yorkshire	16.6%
South Yorkshire	74.1%	Airedale	211	Leeds Teaching	422	Hull University	16.5%
Leeds Teaching	74.0%	West Yorkshire	208	West Yorkshire	417	Sheffield Teaching	16.4%
West Yorkshire	73.0%	Doncaster and Bassetlaw	199	Doncaster and Bassetlaw	408	South Yorkshire	14.4%
S. Tyneside & Sunderland	72.9%	The Newcastle	193	Calderdale & Huddersfield	389	Mid Yorkshire	14.1%
Doncaster and Bassetlaw	70.8%	Sheffield Teaching	193	North East and North Cumbria	349	Bradford Teaching	13.1%
Mid Yorkshire	70.5%	South Tees	192	Sheffield Teaching	347	Harrogate & District	11.1%
Northern Lincs. & Goole	69.1%	South Yorkshire	188	The Newcastle	328	S. Tyneside & Sunderland	10.7%
Calderdale & Huddersfield	68.8%	Harrogate & District	180	South Yorkshire	317	South Tees	10.4%
York & Scarborough	67.7%	Gateshead Health	178	S. Tyneside & Sunderland	291	Gateshead Health	9.1%
Humber and North Yorkshire	67.1%	Barnsley	174	The Rotherham	289	North East and North Cumbria	8.6%
The Rotherham	66.8%	North East and North Cumbria	173	Barnsley	250	Northumbria	7.2%
Airedale	66.5%	S. Tyneside & Sunderland	159	N. Tees & Hartlepool	229	N. Tees & Hartlepool	6.1%
Co. Durham and Darlington	66.0%	Sheffield Children's	134	Sheffield Children's	173	Co. Durham and Darlington	5.4%
Harrogate & District	65.1%	N. Tees & Hartlepool	111	Northumbria	156	The Newcastle	3.2%
Hull University	65.0%	Northumbria	98	South Tees	101	Barnsley	0.0%
North Cumbria	60.9%	Bradford Teaching	0	Bradford Teaching	0	Sheffield Children's	-

Performance: Type 1 ED Performance

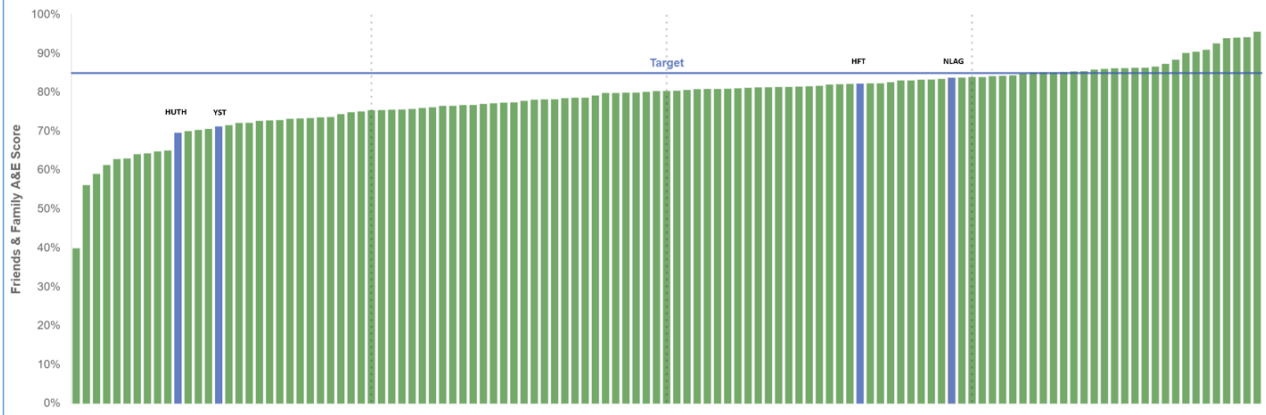
National reported 4 hour performance for Type 1 ED attendance only – May 2024.



Y&S, HUTH and NLAG all under 50% and in the bottom quartile.

Performance: Quality

1. Friends and Family A&E Scores – April 2024



2. SEDIT Report April 2024: Estimate of annual number of ED patients with delay related harm.

This is a nationally calculated number of admitted patients whose 30 day mortality is associated with an ED stay of longer than 8 hours. **National benchmark rate is 133.6 in April 2024**. HUTH estimated rate is 255.9 and York District is 200.4.

Summary

Average hours lost to ambulance handover delays. HNY worst performer at 170 hours per day, 5 times the amount in West Yorkshire the best performer

Ambulance handover delays over 60 minutes as a % of total handovers. HNY worst performer at 24.3%, 7 times worse than West Yorkshire and NENC at 3%

12 hour trolley breaches. HNY worst performer at 450 in the week reported, more than all other ICB's added together.

Over 12 hours as a % of attendances. HNY worst performer at 9.6%, second worst performer is West Yorkshire at 5%, nearly half our rate.

4 hour performance. HNY worst performer at 67%, second lowest performer is West Yorkshire at 73%, bearing in mind that Leeds and MYTT are two of the busiest EDs in the country.

Average time in ED. HNY worst performer, average time of 215 minutes compared to best performer NENC 173; and for those patients who are admitted, worst performer at 595 minutes, compared to West Yorkshire in second at 417 minutes (two hours less).

HUTH and Y&S are in the bottom quartile for FFS in A&E in April 2024.

Estimated harm due to delayed discharge from ED, HUTH and Y&S are in the worst quartile.

Appendix 2

Classification: Official-Sensitive

NHS England

To:
- Integrated care board:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
- Integrated care partnership chairs
- NHS trust:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
- Regional directors

CC:
- Local authority chief executives

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

26 June 2024

Dear colleagues,

Action required: Maintaining focus and oversight on quality of care and experience in pressurised services

Thank you for everything that you and your teams continue to do to provide patients, the public and people who use our services with the best possible care during the period of sustained pressure that colleagues in all health and social care services are experiencing.

Despite the hard work of colleagues, and everything they are achieving in the face of these challenges, we would all recognise that on more occasions than we would like, the care and experience patients receive does not meet the high standards that the public have a right to expect, and that we all aspire to provide.

However busy and pressurised health and care systems are, people in our care – as well as their families and carers – deserve at all times to be treated with kindness, dignity and respect. This week's Channel 4 Dispatches documentary, filmed in the Emergency Department at Royal Shrewsbury Hospital, was a stark example of what it means for patients when this is not the case. While Urgent and Emergency Care (UEC) is facing real pressures as a result of increasing demand, lack of flow and gaps in health and social care capacity,

the documentary highlighted examples of how the service some patients are experiencing is not acceptable.

We are therefore asking every Board across the NHS to assure themselves that they are working with system partners to do all they can to:

- provide alternatives to emergency department attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence
- maximise in-hospital flow with appropriate streaming, senior decision-making and board and ward rounds regularly throughout the day, and timely discharge, regardless of the pathway a patient is leaving hospital or a community bedded facility on

These interventions are clearly set out in the UEC recovery plan year 2 document, and it is evident from the data that those systems with fewer patients spending over 12 hours in an emergency department are doing a combination of all of them, consistently, with direct executive ownership.

In addition, wherever a patient is receiving care, there are fundamental standards of quality which must be adhered to. Corridor care, or care outside of a normal cubical environment, must not be considered the norm – it should only be in periods of escalation and with Board level oversight at trust and system level, based on an assessment of and joined up approach to managing risk to patients across the system (through the OPEL framework). Where it is deemed a necessity – whether in ED, acute wards or other care environments - it must be provided in the safest and most effective manner possible, for the shortest period of time possible, with patient dignity and respect being maintained throughout and clarity for all staff on how to escalate concerns on patient and staff wellbeing.

While these pressures are most visible in EDs and acute services, they are also wider issues which need whole-system responses, including local authorities, social care and primary and community services. There is therefore a shared responsibility to ensure that quality (patient safety, experience, and outcomes) is central to the system-level approach to managing and responding to significant operational pressures.

In achieving this, Board members across ICS partners should individually and jointly assure themselves that:

- their organisations and systems are implementing the actions set out in the UEC Recovery Plan year 2 letter
- basic standards of care, based on the CQC's fundamental standards, are in place in all care settings
- services across the whole system are supporting flow out of ED and out of hospital, including making full and appropriate use of the Better Care Fund
- executive teams and Boards have visibility of the Seven Day Hospital Services audit results, as set out in the relevant Board Assurance Framework guidance
- there is consistent, visible, executive leadership across the UEC pathway and appropriate escalation protocols in place every day of the week at both trust and system level

- regular non-executive director safety walkabouts take place where patients are asked about their experiences in real time and these are relayed back to the Board

In line with the NHS operating framework, regional COOs, chief nurses and chief medical directors will continue working with ICB colleagues across systems (CMO, CNO, COO/CDOs) and trusts to support a planned approach to clinical and operational assessment of system pressures and risks, ensuring an integrated approach to any tactical response and balancing clinical risk across the system. This collaboration should include provider CEOs, system executives, local authority, and third sector partners where applicable.

Where any organisation is challenged we will work with you to use the improvement resources at our disposal, including clinical and operational subject matter expertise from the highest performing organisations, GIRFT, ECIST and Recovery Support. We also have a joint improvement team with the Department for Health and Social Care for complex discharge led by Lesley Watts, CEO of Chelsea and Westminster. If you are unclear how to ask for help in any of these areas, please do so via your regional COO in the first instance.

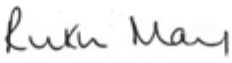
We recognise that all colleagues across health and social care are working extremely hard in very difficult circumstances, and that UEC is not the only pathway in which this is the case. However, there are interventions and standards that do make a difference and can address much of the variation in quality and waiting times across the country, and it is incumbent on us all to do everything we can to ensure that the poor quality of care we saw on Monday evening is not happening in our own organisations and systems.

Yours sincerely,

Sarah-Jane Marsh
National Director of Integrated Urgent and Emergency Care and Deputy Chief Operating Officer
NHS England

Dr Emily Lawson DBE
Chief Operating Officer
NHS England

Professor Sir Stephen Powis
National Medical Director
NHS England



Dame Ruth May
Chief Nursing Officer
England