

Review of how COVID activity and system responses impacted Urgent Care in the North West, with specific reference to Acute Hospitals

**Midlands Analyst Network Huddle
22nd February 2024**

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Commission from NHS-E North West-Approach



- ✓ Desktop data and information analysis at Trust site level for acute Trusts with a Type 1 ED
- ✓ Request additional data and information from Trusts where data are not available from coded nationally available sources e.g. sickness rates, bank shift fill rates, vacancies.
- ✓ Develop KLoEs.



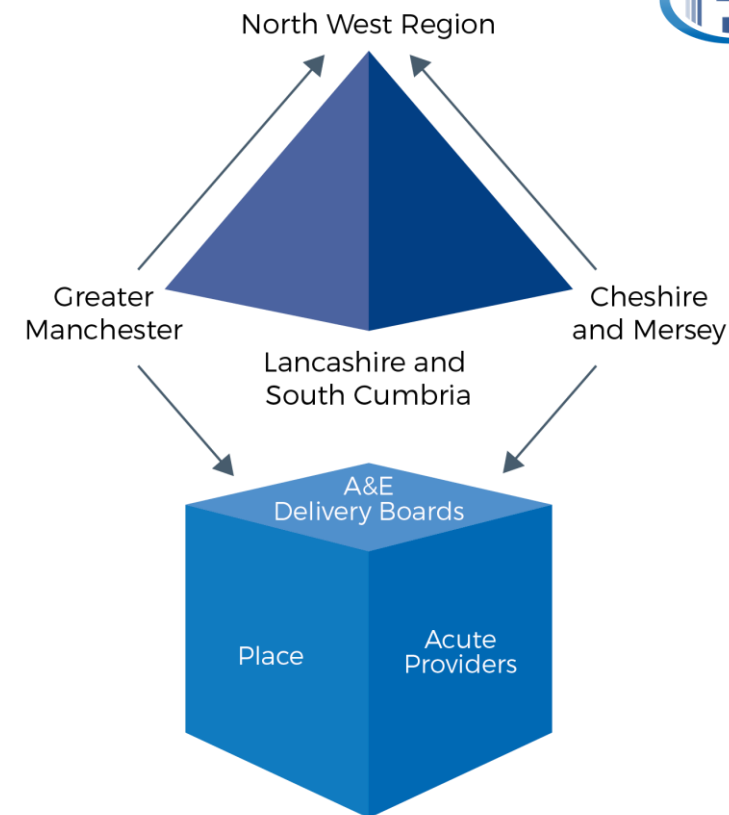
- ✓ Undertake a site walkthrough with key leaders to contextualise KLoEs from data and narrate the Trusts “felt reality”.



- ✓ Construct a hospital-by-hospital data report to share with key leads for triangulation and validation purposes prior to a final draft report, referencing standards and accepted best practice
- ✓ Share and communicate an agreed report with local stakeholders prior to aggregation of an ICS level report and a subsequent report to NHS England.



- ✓ Collate likely contributors to improved flow and outcomes at AEDB level, ICS level and aggregate NHS region level in the following format:



For each of the **25 sites** across the North West this consisted of a core data pack of **218** measures, so over **5000** data series, with additional data generated and analysed if felt useful by the review team as a key line of enquiry.

Sources included the UEC Daily, Covid & Discharge SitReps alongside SUS and ECDS data sourced from the National Commissioning Data Repository (NCDR).

Data packs were analysed by both the data scientists and review clinical team in collaboration. **Over 200 Key Lines of Enquiry** were drawn out for further exploration with the Trusts either via virtual meetings or on the site visit

High-Level Data Walkthrough

Urgent Care Performance



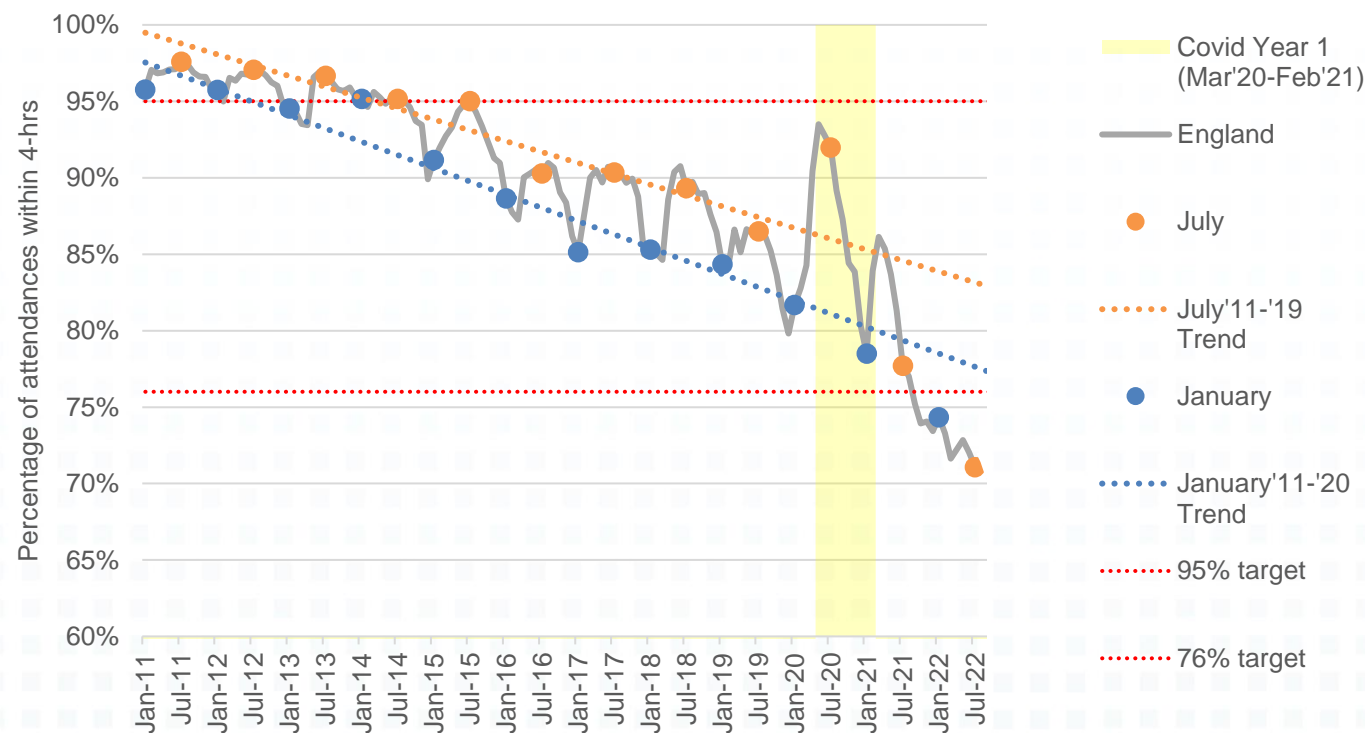
When we started this project, at the beginning of 2022, the conventional wisdom seemed to be that the Covid effects on urgent and emergency flow had, like the effects on the rest of the health system, been exclusively negative.

However, counter-intuitively, the first year of Covid actually saw the best 4-hour performance in five years.

For the whole decade prior to Covid, A&E performance had been on a clear downward trend (with a pronounced seasonal pattern).

As Covid hit in March 2020, 4-hour performance rapidly improved. Winter 2020/21 saw similar performance (though for different reasons) than the long-term trajectory and Spring 2021 again saw an improvement. It was only after April 2021 that performance fell below the levels of the long-term trend.

England Monthly All Types 4-hr Performance and Winter and Summer Trends



Source: MLCSU from public data at: <https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/>
Excludes providers undertaking the clinical review of standards May 2019-May 2023.

Urgent Care Performance



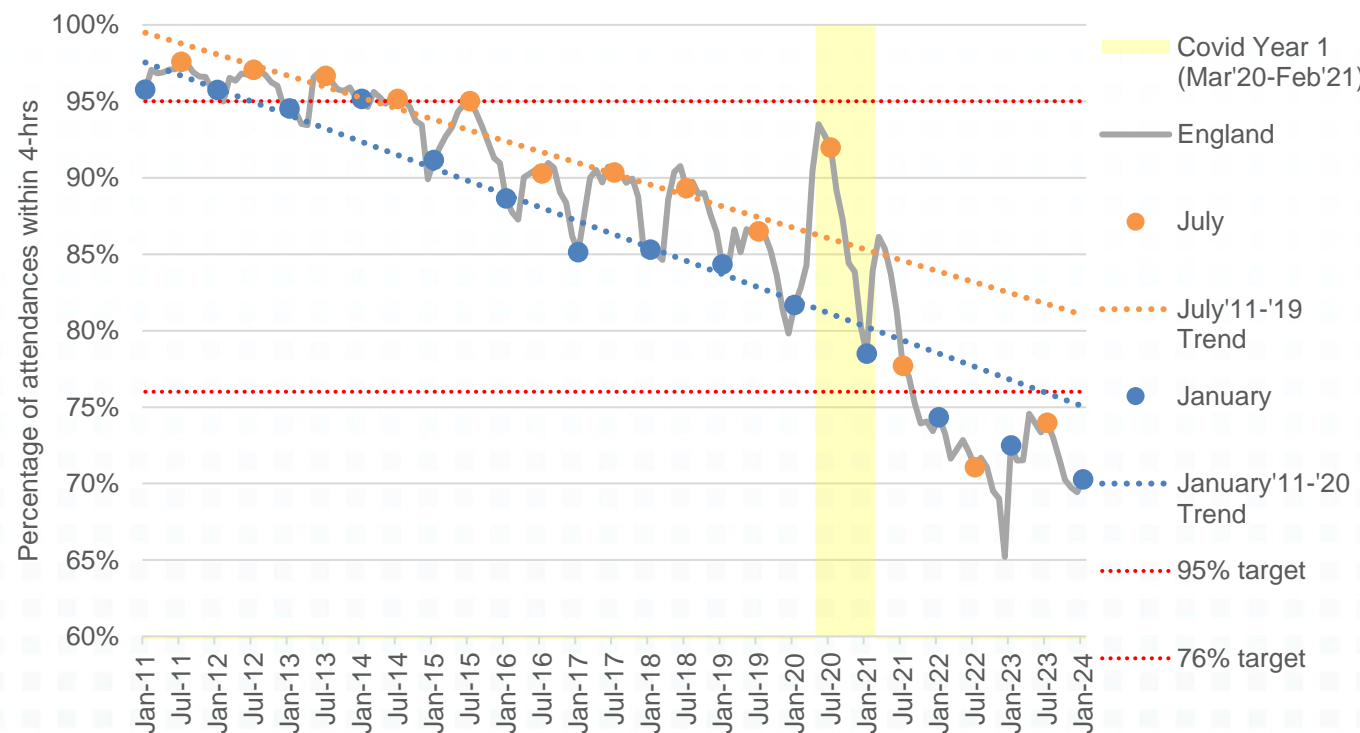
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Attendances & Occupancy



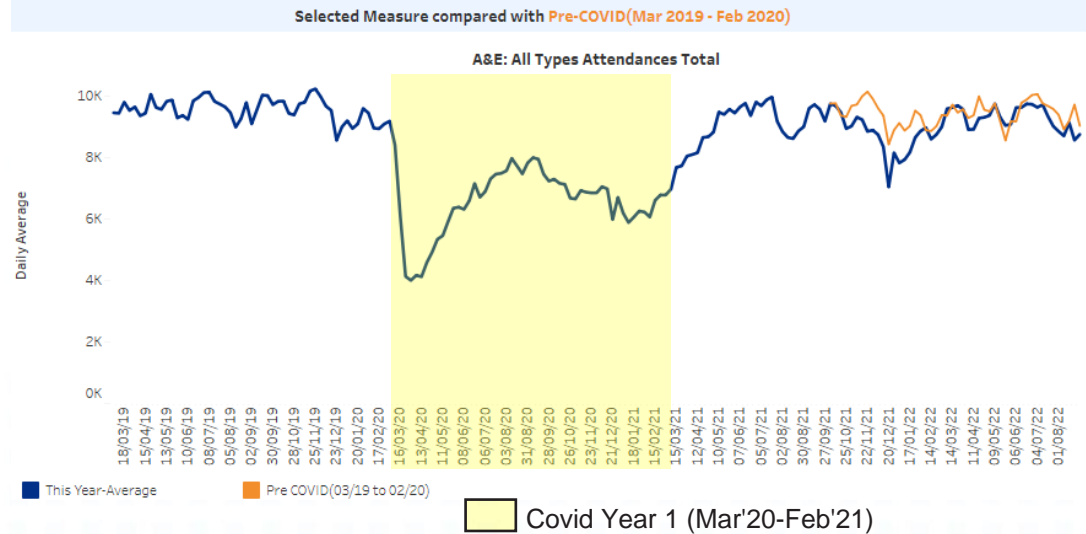
At the onset of the pandemic ED attendances in the North West more than halved and, crucially, G&A bed occupancy plummeted from well over 90% to close to 50%.

The initial effects on ED flow and hence ED performance were in fact therefore positive.

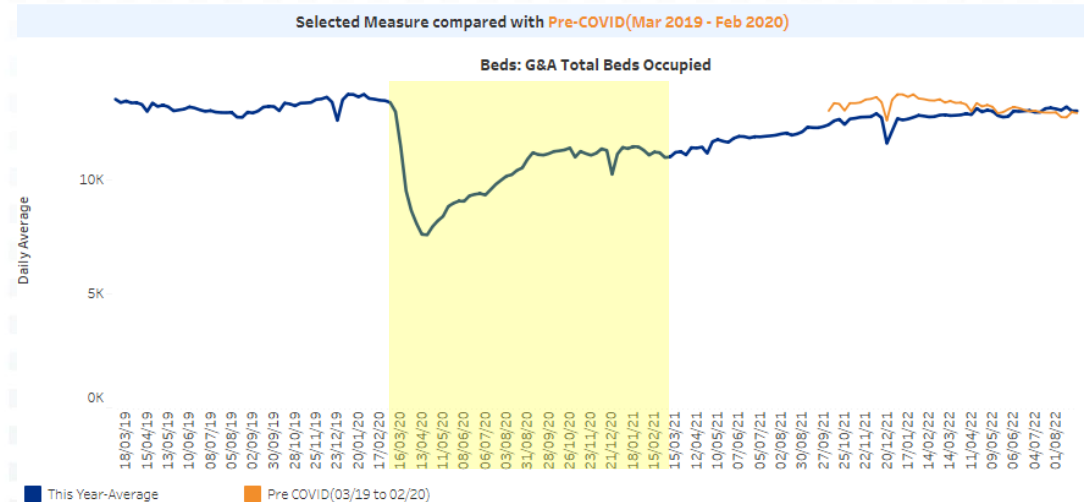
However, during that first year of Covid, circumstances began to evolve (the impacts of which were initially masked by this improved ED performance) which would impact ED and subsequent flow.

After April 2021, when the acute phases of the pandemic eased and attendances and bed occupancy increased, these pressures made themselves felt and performance fell below the levels of the long-term trend.

North West All Types Attendances (UEC Daily SitRep)



North West G&A Beds Occupied



Source: MLCSU from UEC Daily SitRep, data aggregated to weeks. North West trusts (excluding specialist trusts)
Occupancy excludes Clitheroe and Pendle Community Hospitals and Burnley General Hospital as coverage changed in Apr'21.

Increased Congestion ...



By late 2021, EDs were recognised to be experiencing unprecedented pressure.

Measured by the number of patients in the department at a point in time, this example ED was on average

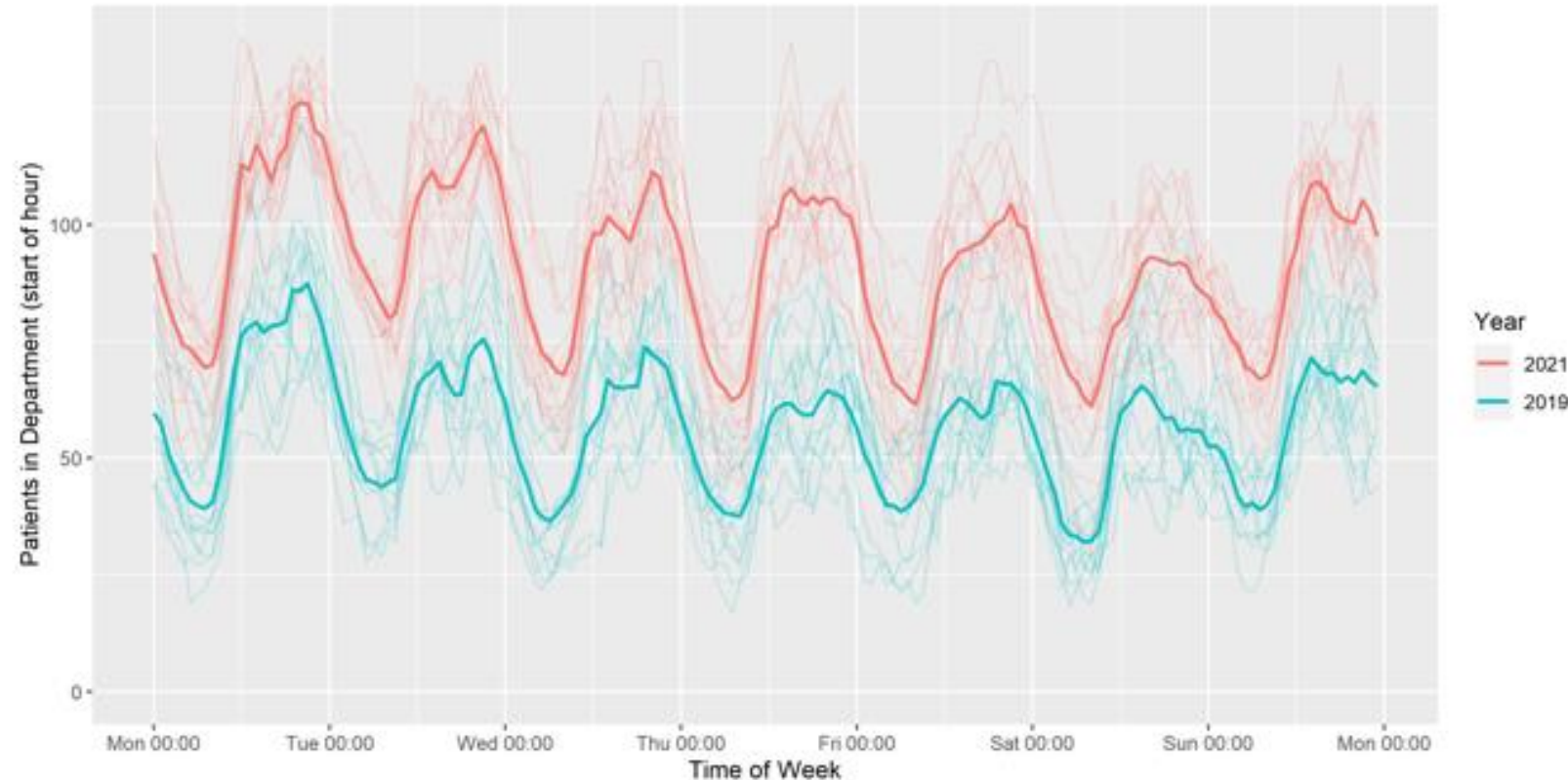
61%

more congested in late 2021 than it had been in late 2019.

Almost every week in late 2021 was 'busier' in terms of patients in the department than the busiest week in late 2019 and staff naturally felt pressured, often blaming demand and footfall.

Example Department

ED congestion, mid Sep-Dec'21 vs pre-Covid



Source: MLCSU from NCDR ECDS. Mon 13 Sep 2021-Sun 12 Dec 2021 vs Mon 16 Sep 2019-Sun 15 Dec 2019.

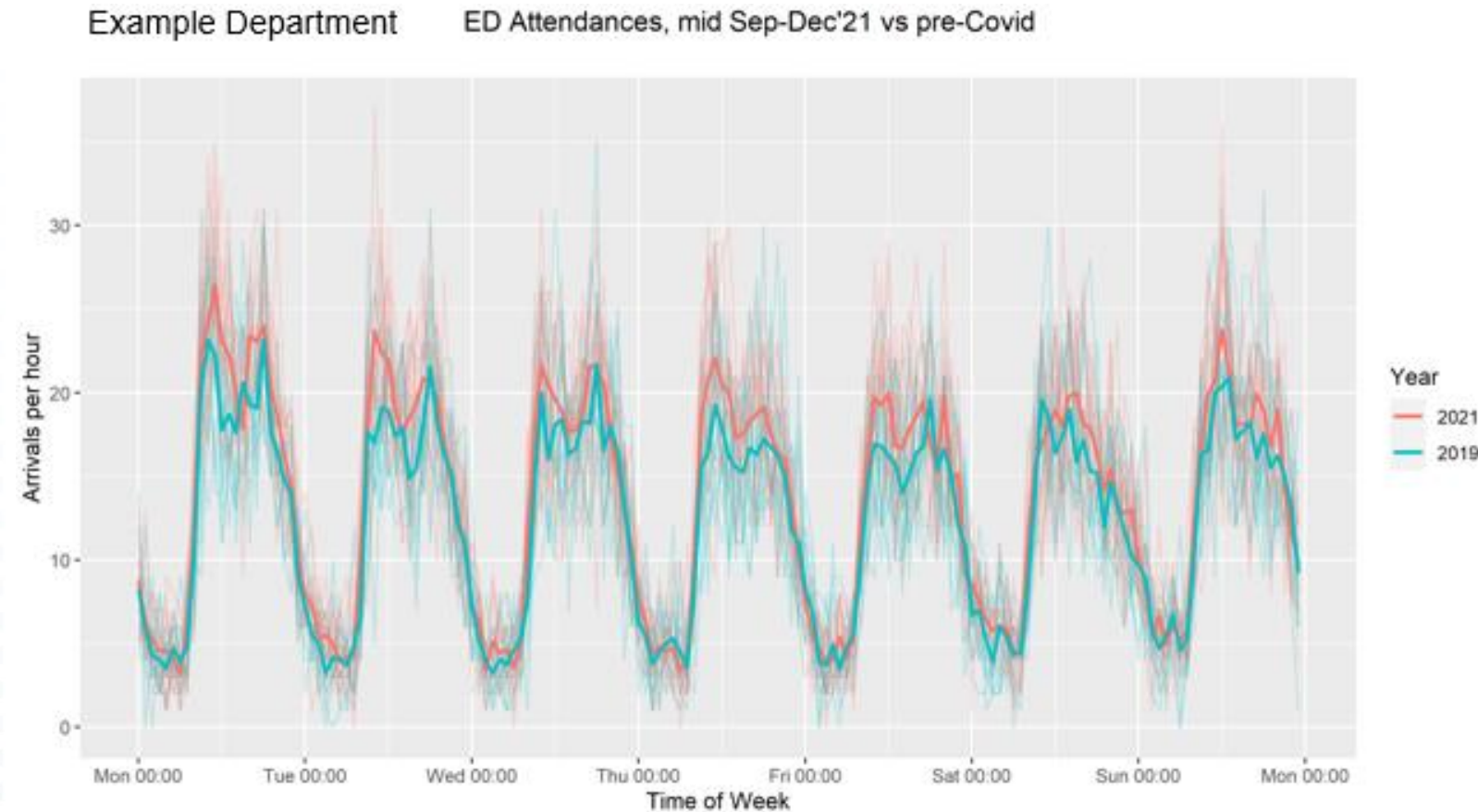
... far more than increased footfall



However, footfall has increased by far less than congestion. In this same ED, average attendances were less than

10%

higher in late 2021 than in late 2019.



Source: MLCSU from NCDR ECDS. Mon 13 Sep 2021-Sun 12 Dec 2021 vs Mon 16 Sep 2019-Sun 15 Dec 2019.

Congestion

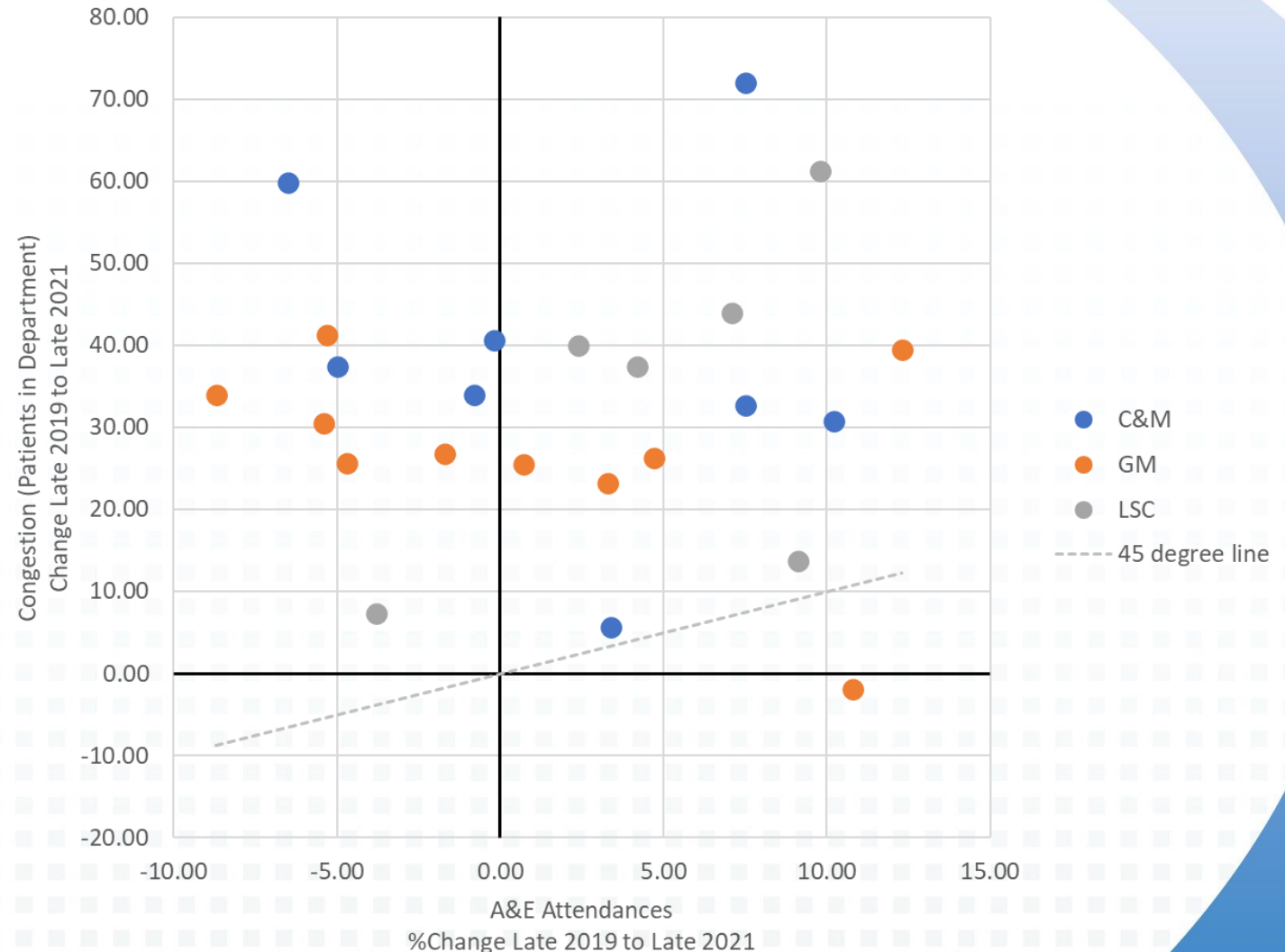


Emergency Departments are more congested and 'busier', not simply due to increased attendances but as a result of longer wait times and consequently **backlog build up**

In almost all of the EDs we studied, congestion had increased by far more than footfall (the exceptions were generally smaller departments, some of which closed overnight and so backlog was unable to build up).

In many cases, attendances were actually lower in late 2021 than in late 2019 and yet the departments still felt 'busier' because there were more patients in the department at a point in time.

Change in Congestion (Average Patients in Department) vs Change in Attendances, Late 2019 to Late 2021



Source: MLCSU from NCDR ECDS. Mon 13 Sep 2021-Sun 12 Dec 2021 vs Mon 16 Sep 2019-Sun 15 Dec 2019. Sites with a Type 1 department.

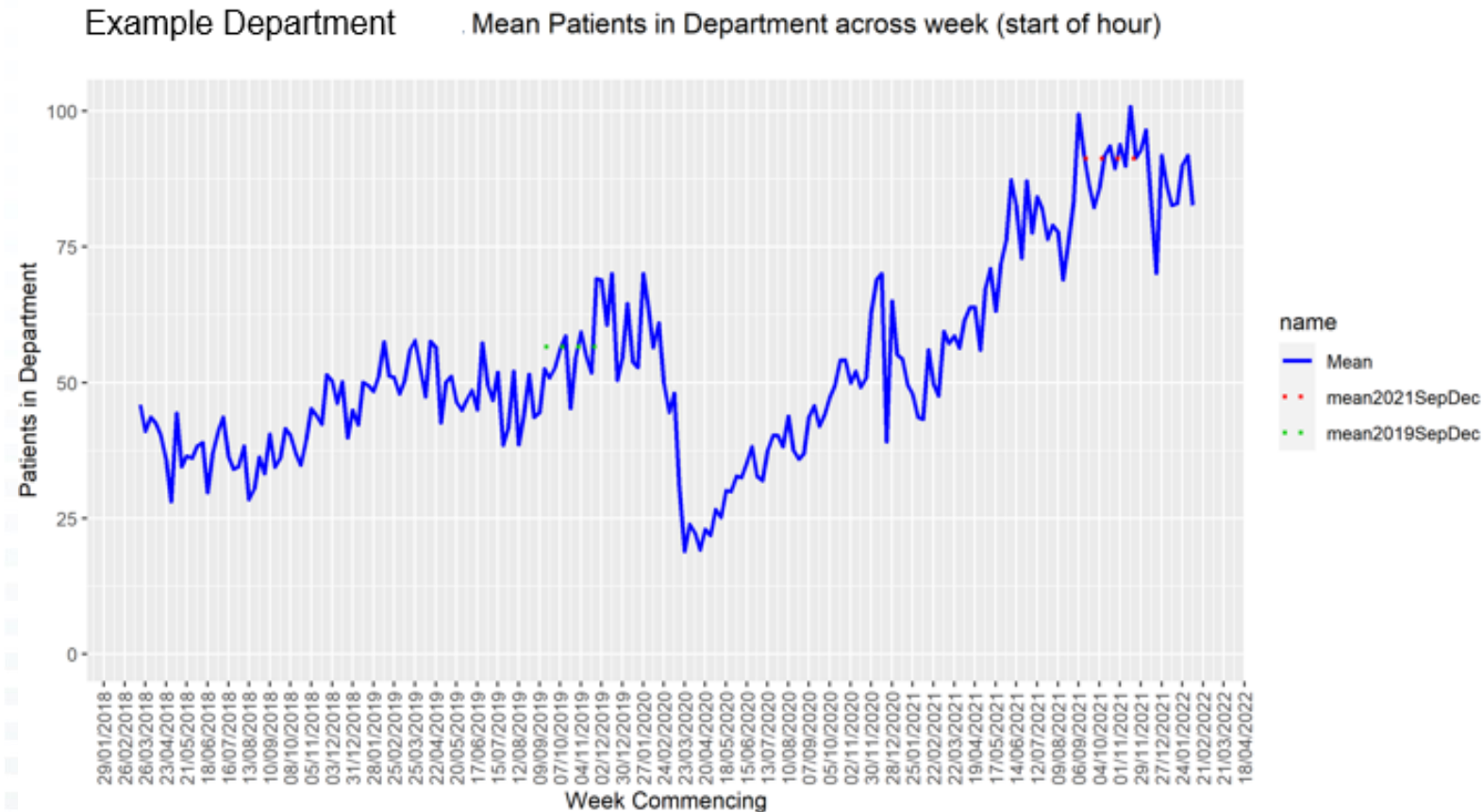
Creeping Normalisation



Between April 2020 and October 2021, the average number of patients in the example department grew (on average) by less than one per week, but the cumulative effect of this over eighteen months is a department that is more than four times as congested.

If the capacity of a system, whether to treat within ED or to discharge patients from beds or at any other stage in the process, is insufficient to deal with the flow of arrivals, then even a small deficit can lead to gradually increasing queues.

Perhaps partly because it happens gradually, congested departments, waits of over 12 hours and corridor care become normalised.



Admitted patients

Most of the increases in waits in ED have been for patients ultimately admitted.

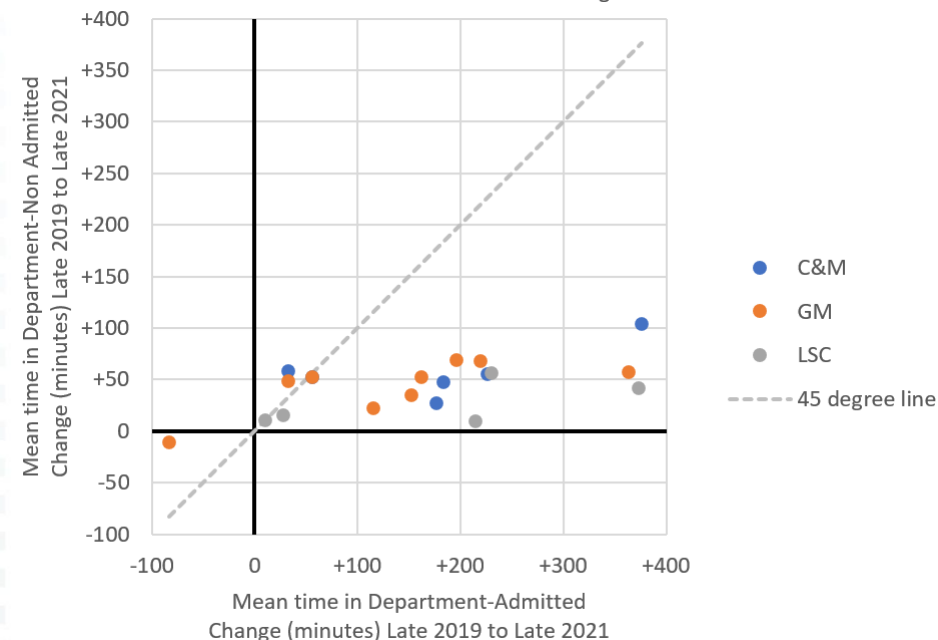
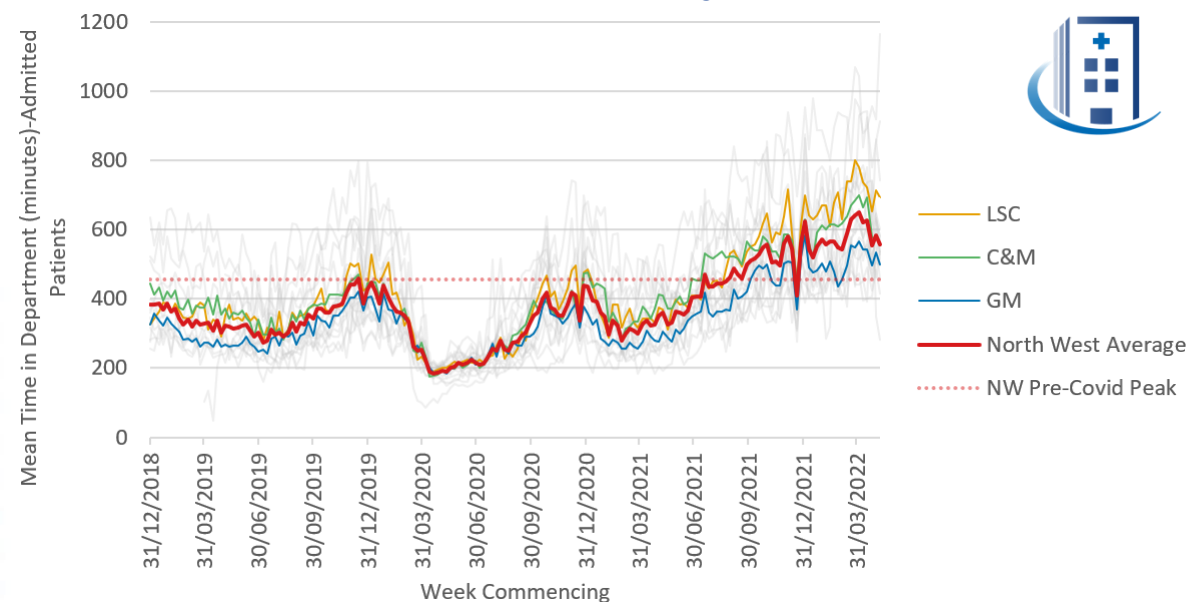
From May 2021 onwards, inpatient Length of Stay (LoS) increased inexorably, largely (though not exclusively) due to discharge issues. Longer LoS means fewer patients can be admitted to the same number of beds, one of the major factors impacting flow out of ED.

NON-ELECTIVE AVERAGE LENGTH OF STAY (EXCLUDING 0 LOS)



Source: MLCSU from NCDR SUS Inpatient data.

MEAN TIME IN DEPARTMENT-ADMITTED PATIENTS



Source: MLCSU from NCDR ECDS. Mon 13 Sep 2021-Sun 12 Dec 2021 vs Mon 16 Sep 2019-Sun 15 Dec 2019.

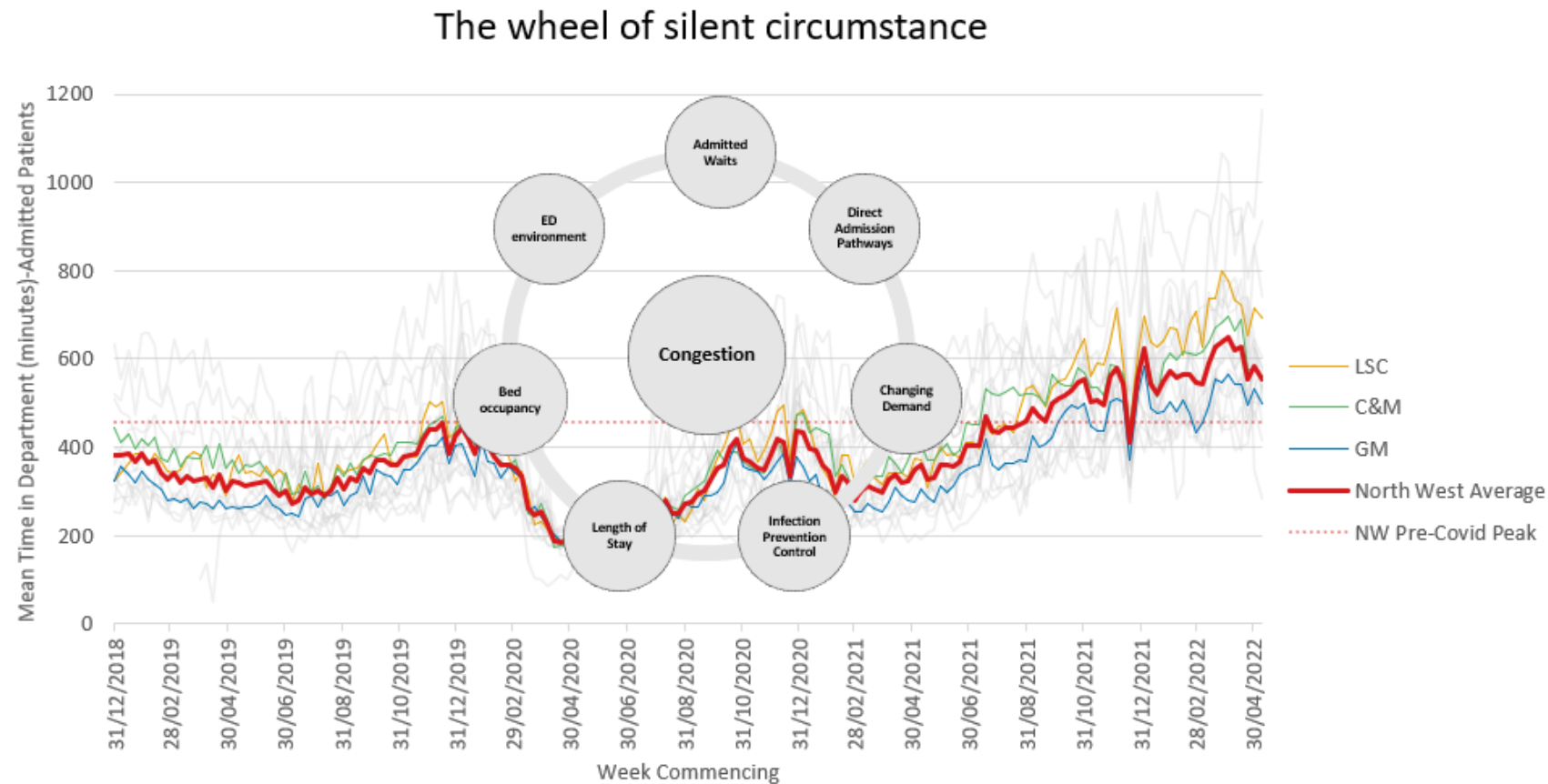


Clinical Insights from Site Visits and Recommendations

The wheel of silent circumstance



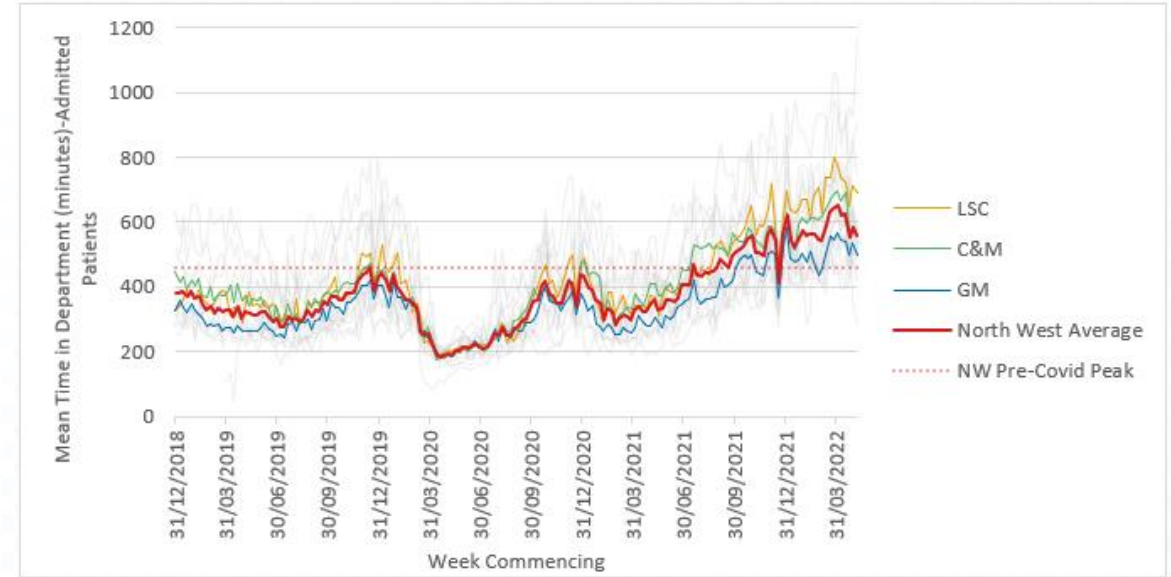
These quietly evolved seven circumstances; increased admitted wait times, reduction in direct admission pathways, changing demand, infection prevention and control, increasing lengths of stay, bed occupancy and the ED physical environment, began and continue to impact, ED performance and flow.



Admitted waits



MEAN TIME IN DEPARTMENT-ADMITTED PATIENTS-NORTH WEST TRUSTS WITH ICS
AVERAGES



Patients in the Emergency Departments are waiting longer for admission due to lack of flow through the medical assessment unit and to the specialty wards.

Many patients appropriate for or of under the care of acute physicians are now cared for in ED, this has evolved throughout the pandemic and has become more accepted practice.

Good practice observed

- To support MAU discharges doctors may bring patients back to SDEC for bloods and monitoring as an alternative to using Primary Care.
- Where the SDEC and AMU staff are one team this supports a shared commitment to using SDEC.
- Patients on MAU over 72 hours are escalated at the 10am bed meeting. These patients are given a high priority for movement.

Direct Admission Pathways



The Emergency Departments are more crowded because there is a shift to increasing numbers and proportion of patients being admitted via ED rather than via direct admissions pathways.

Same Day Emergency Care (SDEC) models differ across the Trusts with some more mature than others. Many SDEC units are newly established and developing clinical pathways were disrupted by the pandemic with the returned.

Site visits observed that there are patients being cared for in ED that were appropriate to SDEC, and staff agreed that more work was required to pull these patients from ED and ultimately deflect their ED attendance altogether.

Non-elective Direct Admissions

Source: MLCSU from NCDR SUS



Good practice for sharing

- Where SDEC and AMU staff are one team it supports a shared commitment to using SDEC to support where possible. This could be through avoiding admission to an assessment or ward bed or by bringing patients back for review to support discharge from AMU.
- Provision of an Acute Care at Home Service. This is an SDEC pathway delivered from the patient's home. A 'lab in a bag' enables point of care testing at home. There are currently 15 presentations following through this virtual pathway.
- Consultants spoke about documented pathways being a barrier and sometimes a limit to what they can do. Direct clinical conversations allow for the art of the possible

Demand

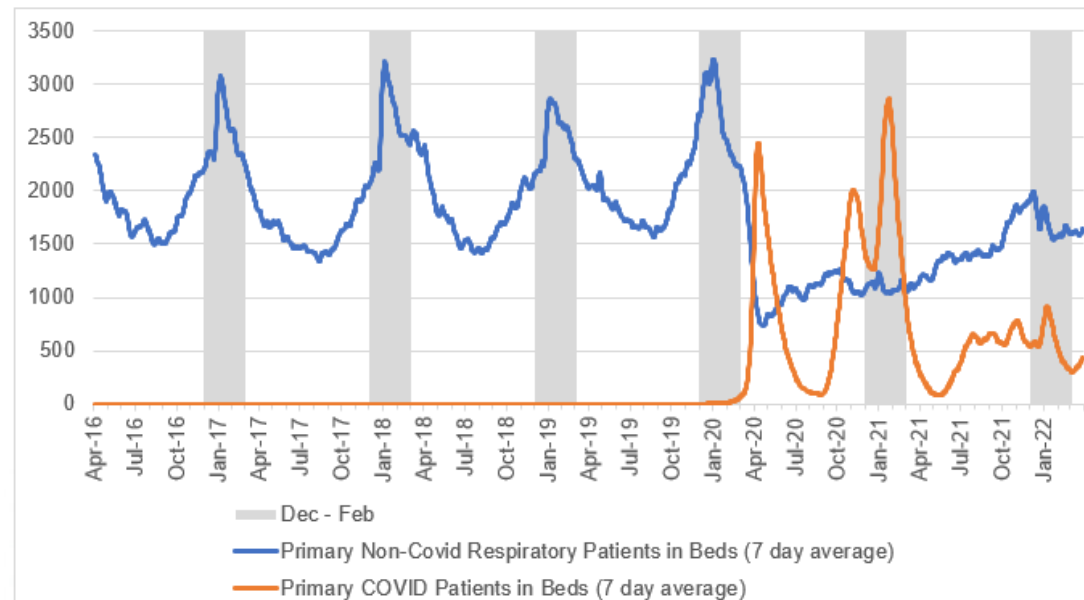
The demand on urgent care services has changed, patients no longer present with just acute illness but illness with underlying physical deconditioning.

- Staff describe that patient are sicker than pre-COVID, possibly waiting longer before accessing health services, this is confirmed in data.
- Many patients attending ED were already not meeting the criteria to reside at arrival i.e., demonstrably did not need to be in hospital but the right service was either not available or accessible.

Some examples of good practice observed

- A virtual frailty ward supported timely discharge from a physical frailty unit.
- Community teams worked within ED as one urgent care team to deliver care as close to home as possible.
- Community Nursing teams employed by the NHS supported care homes in crisis to enable safe care to be maintained and placed the patient, not organisations at the heart of decision making.
- End of life services in the community were supported by Specialist Palliative Care Teams from the hospitals and hospices to help people die in their place of choice with their family around them.
- GP out of hours services providing place-based support for patients at risk of admission with COVID e.g. long term respiratory patients.

NORTH WEST NON-ELECTIVE PATIENTS IN BEDS BY PRIMARY DIAGNOSIS, COVID VS NON-COVID RESPIRATORY DISEASE



Source: MLCSU from NCDR SUS Inpatient data. Non-Covid Respiratory Conditions those with Primary Diagnosis ICD10 code starting 'J' (Diseases of the respiratory system). Covid patients those with Primary Diagnosis ICD10 code starting 'U' (this is lower than the total of Covid patients from Covid SitRep as that includes patients whose primary diagnosis was not Covid).

Infection, Prevention and Control (IPC)



IPC requirements impacted ED flow. The need to test before admission and to follow separate red and green pathways meaning that the 'right' bed was often not available. The regular changes in policy caused confusion which was not always well communicated. Staff described frustration with the changing policy through COVID and those patients were not always placed in the right place for their clinical need. Extra ward moves likely impacted on Length of Stay.

Examples of good practice observed

- Due to challenging visiting restrictions and to support patients and their families the trust implemented the Family Liaison Service including 'FLOograms' alongside virtual visiting.
- Some sites have adapted the COVID red pathway and learning to follow for other increasing infection risks such as Monkey Pox.
- Administrative staff volunteered to be PPE checkers for staff before they entered the critical care unit. This enabled an important safety check that was highly valued by staff.
- A local firm provided blank name labels for use on PPE so staff could be recognised, this improved patient safety as staff could be identified quickly. The same principle has since been adopted in theatres by using named theatre hats
- Implemented viral air cleaners in clinical areas resulting in marked reduction in nosocomial infections.
- 24hr touch point cleaning
- Strong Director of Nursing network enabled sharing of advice and practice across organisations such as visiting criteria
- Day room cohorting for dementia patients with COVID.

IPC continued - Paediatrics



Paediatrics staff reported feeling disengaged and excluded from national IPC policy. They report feeling forgotten with a heavy reliance on local translation

Observations

Paediatric staff felt that there was little ongoing IPC guidance from the Government regarding children and family needs in a hospital. This has led to local interpretation with the below specific feedback:

- During COVID to comply with 2m guidance the team reduced each bay by 1 bed. They had also to account for a parent with the child of which national guidance did not account for.
- Play therapy was stopped, no PHE guidance on this and still none to restart. Play areas closed during peaks.
- COVID and RSV testing raised issues with air filtration on the wards which has resulted in the need for urgent estate work on some sites.
- Paediatric staff at larger sites reported that national guidance was not specific but not problematic interpreting. Smaller site staff felt this was a challenge.
- Community paediatric services delivered virtually and now managing a big backlog with increasing referrals, some of which perceived to have been caused by the isolation and lack of presence at school
- There is a SEND impact as not accessing schools during the lockdown and these children went unseen at times
- The national guidance was to step down children's services which had a massive impact on safeguarding, swallowing, feeding and speech development.

Example of good practice observed

- Use of remote working enhanced the ability for local paediatricians to attend specialist appointments at Children's hospital with the child and family further supporting continuity of care.
- Community childrens services continued, a vulnerable children list was created and the multi-disciplinary team wrapped around the family.
- Did child immunisations in the car park. Offered hot drinks to parents.

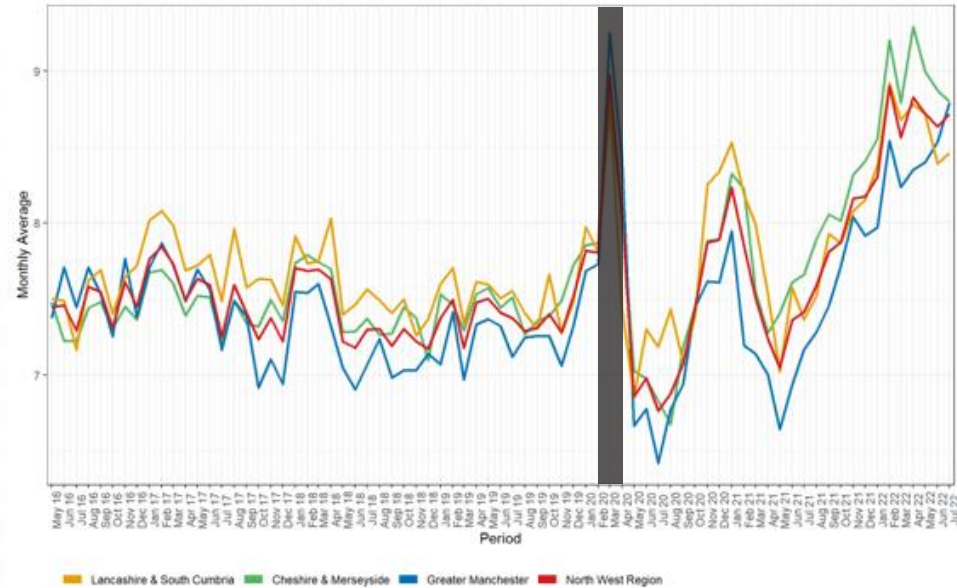
Length of Stay



Average non-elective length of stay (excluding 0 LoS) has increased to well above pre-COVID levels.

Increases in long stay patients and NMC2R data corroborate comments that discharge remains a major challenge. As length of stay increases, fewer patients can be admitted to the same number of beds.

NON-ELECTIVE AVERAGE LENGTH OF STAY (EXCLUDING 0 LoS)



Note: Period is month of discharge, not admission, and all LoS is counted at point of discharge. Hence peak in March 2020 is due to discharge of long-stay patients in that month at the onset of Covid.

Some examples of good practice observed

- COVID allowed a focus on home first as care home beds closed.
- Health and Social Care joining to provide a bigger workforce to provide rapid response care and reablement
- Implementation of a frailty at the front door team and an older patients clinic on the medical day ward to support admission avoidance.
- Discharge Hospitality Centre that takes around 50 patients a day from the wards and has own private transport
- Initiated Single Point of Contact for discharge

The Nightingale Facility



The purpose of the unit was to support hospital flow and place additional beds in the system during the Omicron wave. The unit had several limitations that should be considered in future planning.

- Referring site were asked to provide their own workforce to care for the patients which was problematic due to staff shortages and a choice not to travel far from home as often lived near employing site.
- Patient choice meant some patients did not want to be transferred away from their local hospital to the Nightingale site.
- No COVID patients could be transferred as there was no ceiling between bed areas, i.e., an open structure that did not contain air borne infections.
- Criteria to admit was strict due to environmental and fire risk. Suitable patients were hard to identify, which resulted in multiple patient moves within the hospital.
- Dedicated discharge co-ordinators and discharge assessment nurses within the Nightingale Unit resulted in a good turnover of patients.



Bed occupancy

G&A bed occupancy almost halved at the onset of the pandemic and remained below pre-COVID levels until July 2022.

Not all G&A beds are available to ED and IPC requirements have meant capacity pressures have been felt at lower occupancy levels

Good practice for sharing

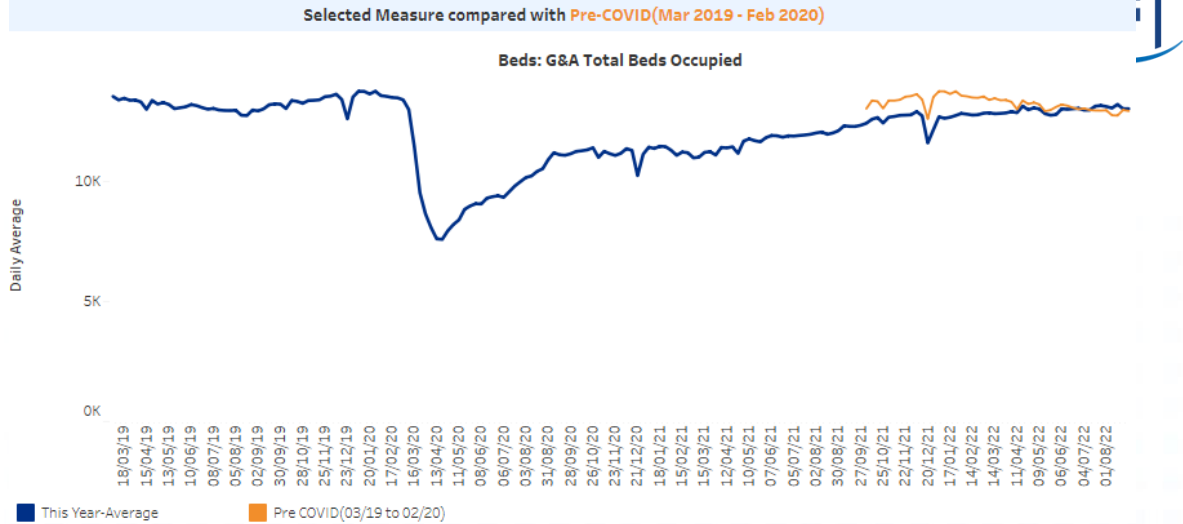
- At 8am on one site the discharge lounge team went to ED to review suitable patients.
- Discharge lounge staff attended board rounds and implemented a transfer team, with the aspiration that all discharges do transit through the discharge lounge unless there was a clinical reason not to.

ED Environment

The size, layout and flow of the Emergency Departments and wider estate has impacted on the ability of Trusts to provide timely care for patients

ED footprints have changed during COVID. Some have expanded, moving into neighbouring service areas that have now permanently relocated.

North West G&A Beds Occupied



Source: MLCSU from UEC Daily SitRep, data aggregated to weeks. North West trusts included in this study (excludes specialist trusts), excluding Clitheroe and Pendle Community Hospitals and Burnley General Hospital as coverage changed in Apr'21.



During the visit the review team collated workforce related feedback from staff that did not directly impact on urgent care performance, but offered a useful insight to other aspects of the LSC COVID workforce journey.

- Having a temporary workforce model due to a junior workforce, highlighted need for senior leadership on the ground
- Fast tracked recruitment supported the recruitment of much needed front-line staff quickly.
- There was a suggestion that for future planning staff-rotation through covid wards would help to manage staff fatigue
- A family liaison person assigned to each area would be good for future planning to support patient and family IPAD communications and queries.
- Staff request that trusts never stop visiting again for those receiving end of life care. Risk assess this individually with visitors in the future. Considerable distress resulted for all.
- Staff report that it was sometimes difficult to give the quality of care expected due the acuity and high mortality of patients - 17 deaths in one week was quoted on one ward.
- Chief Executive walkabout in the later waves including nightshifts. Senior team listened to feedback that staff felt isolated in the earlier waves.
- Re-deployed staff to areas such as Critical Care had peer support groups arranged. This reduced the stress of staff moving into new areas and to different working practices.
- Trusts have invested in health and well-being with the development of new facilities, well-being programmes, and additional counselling support.
- There was investment in practice educators in ED to support training at the onset of COVID. ED staff report that these now continue to support on-going training and simulation which in turn helps with staff retention.
- Some staff report that deployment to other areas was stressful as they did not receive training on the different equipment.
- The critical care unit passport to support staff competencies increased confidence and capacity in high acuity areas.
- There was resentment from some staff that had remained at front line when others worked from home.
- Executive led Command structure enabled joint rapid decision making to accelerate pace of change required.

Recommendations



Admitted Waits

A focused improvement initiative to reset the medical assessment unit to an optimum medical assessment clinical model

Direct Admission Pathways

Greater use of direct admission pathways as an alternative to ED.

Wider implementation of the Acute Care at Home Service, delivering Same Day Emergency Care at the patient's home

GP calls to direct admission units and Consultant advice lines to be answered quickly.

Demand

Long term planning which considers more complex, deconditioned, and older patients presenting to hospital.

Targeted interventions to support admission avoidance and reduced length of stay in those that are mildly frail.

Infection Prevention and Control

Standardised COVID testing protocols for patients referred to hospital via primary care.

Systemwide bulletins produced so the whole system responds in the event of changing patient pathways.

A deeper analysis into the impact of the pandemic and the number of ward moves, patient experience and nosocomial rates.

Work with the paediatric network and regional team to ensure children are better considered in national policy and planning

Systems should look to quickly establish or further develop an Innovation Council or similar to support the QI Directors, with clinical membership

Recommendations



Length of Stay

Investment in domiciliary care services to support Home First/Discharge to Assess flow.

Consider a Discharge to Assess framework for care homes to embed home first principles.

Make available dedicated capacity in care homes for individuals recently in contact with COVID.

Systems would benefit from whole system visibility of NMC2R data and community flow.

Assess options for future Nightingale facilities that manage patients with infections and deliver optimum privacy and dignity.

Bed Occupancy

The provider system should mandate and implement consistent bed management processes so that all parts of the system respond in step and in common with all other parts.

ED Environment

Front door triage and deflection directly to a COVID (or other infection) assessment area, beyond ED.

A review of the ED pathways and footprints will support a reset of ED capacity and decompression triggers moving forwards.

More booked appointments to Emergency Departments with open access to an Urgent Treatment Centre.

Formalised real time review of the services working within new single cubicle EDs as they embed in their environment.

Thank you for listening

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