Report to Health & Adult Social Care Select Committee

Date: Thursday 17th November 2022

Title: Health & Care Integration Programme

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Recommendations/Outcomes: Paper for information

1. Background

- This is an update following the presentation of the community hubs programme in February 2022 and the committee's request to understand more about developments in intermediate care.
- This paper presents a summary of the Health & Care Integration Programme, which was launched in June 2022 to deliver a new model for hospital discharge and intermediate care in Buckinghamshire.
- The background for this programme of work is presented in Section 1 – it summarises the expansion of our 'discharge to assess' model in Buckinghamshire during the Covid pandemic, which has contributed to rising numbers of Buckinghamshire residents waiting for long periods to be discharged from hospital.

2. Main content of report

– The report details the ambition, deliverables and timescales of the Health & Care Integration Programme (Sections 3 and 4).

– In summary, the programme is seeking to improve the flow of patients through the Buckinghamshire health and care system, in particular reducing long waits for discharge from hospital – so that Buckinghamshire residents can return home (or to the setting that best meets their needs) as soon as they are able. It will also demonstrate optimum capacity and usage of non-acute hospital beds across the

intermediate and longer-term care sector. This in turn will drive better value for money and improved staff wellbeing.

3. Next steps and review

- The programme will continue to be governed through the Integrated Care Partnership Executive Board, reporting delivery against programme plans and performance targets on a monthly basis.
- A new medium-term operating model is expected to be implemented by the end of March 2023; transformational deliverables are expected to be delivered between January and Summer 2023 (indicative timescales, pending full business cases).

Buckinghamshire Health & Care Integration Programme

1) Background

The flow of patients through health and care systems is critical to the quality of care received, and the effective management of capacity and resources. In line with the national average, around 70% patients attending Accident & Emergency (A&E) in Buckinghamshire are admitted, transferred or discharged within 4 hours (against a target of 95%). Nationally, this target was last met in 2015. Although this is a crude indicator, it gives a sense of the deeper challenges in moving patients onto hospital wards and through to the point of discharge.

From a patient perspective this can be critical, particularly for older frail patients. It is often said that for every 10 days of bed rest in hospital, the equivalent of 10 years of muscle ageing occurs (in people over 80 years old). We also know that frail elderly patients are more likely to need long-term bedded care after a period of deconditioning in hospital. For staff, poor patient flow creates pressure across the system, which can impact on working relationships and staff wellbeing.

During the Covid pandemic, optimising flow through health and care systems became even more critical in order to reduce risk of infection and enable systems to manage the unprecedented demand. Nationally, a model called 'discharge to assess' (D2A) was mandated (with a funding stream) to enable systems to move patients out of hospital quickly where they required social care support to return home. In Buckinghamshire, like many other places, this funding was invested in additional temporary bedded and home care. This additional D2A capacity enabled patients to be moved out of hospital while their social work and continuing health care assessments took place to determine their onward care provision. At the peak of the pandemic there were 180 D2A beds (spread across care homes in Buckinghamshire), and 11,000 hours of temporary home care.

Patient flow through the system today can be slow, particularly through our D2A bedded pathway. Here, the average length of stay in a D2A bed is 85 days. The average length of time spent receiving D2A temporary home care is 45 days. The reasons for this are complex – a high-level summary is provided in Appendix A. The impacts are significant – contributing to high numbers of patients waiting to be discharged ('medically optimised for discharge' – often exceeding 100 across the acute hospitals). The resulting pressure on hospital beds can result in patients not receiving the care they require and in some cases residing on trolleys for long periods (rather than in beds on wards). This also has the consequence of delaying ambulances whilst offloading at the hospital, with the corresponding pressures on how quickly they can respond to 999 calls.

2) Health & Care Integration Programme – what is it?

A key underlying challenge impacting on patient flow is the journey many patients take through multiple, fragmented health and care services. This has been amplified by the increasing complexity of health and care needs as our population ages – patient needs and journeys are more complex now than 30 years ago. Integrated Care Systems (ICSs) were implemented across the UK from 2016 to help address this challenge by supporting better integration of services. In July of this year these partnership arrangements became statutory.

Buckinghamshire is gripping the challenges around patient flow through a new programme of work called the Health & Care Integration Programme (herein the 'integration programme'). This programme is currently focused on implementing a new hospital discharge model for the county to reduce the length of time patients wait to be discharged. Alongside this, the Urgent & Emergency Care Transformation Programme at Buckinghamshire Healthcare NHS Trust is focused on improving flow through the hospital, including how alternative pathways to admission can help reduce the number of people having to attend hospital unnecessarily.

The new integration programme is managed by a small team of staff seconded from the partnership organisations, and reports into the Integrated Care Partnership Executive Board. It comprises of ten workstreams: five delivering long term transformation; four 'enabler' workstreams which provide support to the programme (functions like HR and IT); and an 'operational control' workstream which aims to grip current operational challenges and deliver improvement in the short to medium term.

3) Health & Care Integration Programme - ambition

Our programme vision is:

'Working together to keep the people of Buckinghamshire healthy, and ensure safe and timely discharge from hospital – wherever possible back to their home'

Our objectives are to improve patient outcomes and value for money by:

- Collaboratively driving better flow through the system
- Reducing the length of time Buckinghamshire residents wait to be discharged from hospital

Our programme principles are outlined below; they reflect the way we have agreed to work in partnership with each other across organisational boundaries. Relationships and behaviours are crucial to driving action and achieving our objectives in such a complex partnership environment.

- Open, honest communication
- Strong collaboration and focus on people – design things together, communicate regularly, support each other
- Evidence-based, what works, pragmatic
- Pace
- Customer-focus

4) Deliverables and timescales

The expansion of D2A during the Covid pandemic was not expected to be a long-term sustainable position. The retraction of national D2A funding earlier this year has sharpened our focus on moving away from this model, which is not working well for Buckinghamshire residents in its current configuration.

4.1 D2A beds and assessments

Earlier in the year, the Integrated Care Partnership Executive Board made the decision to start decommissioning the county's D2A bedded capacity (at that point in time approximately 140 care home beds spread across Buckinghamshire). Importantly, this process was not intended to remove capacity from the system, rather enable the care home beds to be used differently (to support long-term care), and address the long length-of-stay in this pathway that was impacting on patient outcomes. During the initial phase of the integration programme over summer, the number of D2A beds was almost halved (from 140 to 70 beds), while the flow through temporary home care was steadily improved.

We are now seeking to decommission all but 20 of our remaining D2A beds and return to a model where the majority of social work assessments (for ongoing care after leaving hospital) happen within the hospital setting (see key deliverables 1 and 2 below). This reflects the level of risk for patients currently within the D2A bedded pathway (with long average stays), and the cost which is no longer supported by a national funding stream. D2A beds will be decommissioned on a gradual trajectory ending in March 2023, and a risk-based approach will be used to manage the transition of assessments from the community to the hospital, ensuring clinical risk to patients is minimised. It should be noted that

approximately 50 Community Hospital Beds are available in the county to support rehabilitation and timely discharge (an increase from approximately 30 in spring), and an additional 22 beds in community surge capacity to help manage demand over winter.

The remaining 20 D2A beds will include an appropriate rehabilitation offer and will form part of Buckinghamshire's short-term post-discharge support offer. We are co-designing a new medium-term operating model with staff and patients to deliver this (to include a transition plan and system performance framework for all partners to sign up to).

4.2 Transformational deliverables

Deliverables 3-6 below refer to longer term transformational outputs which will deliver a more integrated approach to managing patient flow, supporting a further reduction in delays, improved patient outcomes, and better value for money.

In summary, the key deliverables of the programme, with timescales, are:

1. Reducing D2A beds to no more than 20 (with appropriate rehabilitation offer) – timescales to be determined through development of operating model, but no later than end of March 2023.
2. Transitioning majority of social care assessments into hospital (from community D2A pathways) – as above, timescales to be determined through development of operating model, but no later than end of March 2023.
3. Implementing a transfer of care hub (an integrated team with clinicians, therapists, social workers, and case managers working together to plan discharge effectively and manage the patient journey end-to-end) – indicative timescale to be delivered summer 2023.
4. Implementing an integrated digital offer (including a shared system to manage and track the flow of patients through the system) – phase 1 indicative timeline 8 months (pending agreement of proposed way forward at November Integrated Care Partnership Executive Board).
5. A business case for our future intermediate care offer (which will provide the right type of temporary post-discharge support to re-able patients and determine any onward care quickly, so that they can return home as soon as possible, or to the setting that best meets their needs) – delivery TBD (workstream being rescoped as a result of decisions made at October Integrated Care Partnership Executive Board).
6. Trusted Assessor (implementing a new model for assessing patients that increases assessment capacity and improves efficiency through building trust in the assessment process / quality) – initial roll-out January 2023.

5) Appendix A – summary of challenges impacting on patient flow

Rising demand and stretched capacity

- Hospital admissions increasing year on year (particularly older people), and higher than average in Buckinghamshire
- Increasing complexity of patient needs as population ages
- Social work and therapy capacity is thinly stretched across D2A care home beds spread across a wide geography county
- Capacity of local care market to provide the right type of care in the right area of the county – challenging to find long-term care for patients with more complex needs / specific health conditions; some geographies within Buckinghamshire are challenging to source care (more rural areas)

Stability of system

- Current system has been developed at pace in response to the Covid pandemic – as a result, processes, resourcing and workforce are temporary which has created instability. Our ability to influence and shape the care market has been constrained as a result.
- Partnership governance, resourcing and communications have needed to adjust to substantial and sustained change over the last 2 years – this has been a national challenge for health and care systems

Information, systems and processes

- No single IT system for case management / tracking flow of patients through the system; some parts of the system using Excel spreadsheets to manage patients
- Assessment and referral information not always high quality – can result in ineffective / inefficient management of patients. This issue can impact on relationships with long-term care providers.
- Processes are not always efficient – this issue is linked to the wider instability of the system and capacity deficits referenced above

Culture and partnership working

- Integrated Care Systems across the UK are still relatively immature, and it takes time to develop the right culture and behaviours to operate effectively across complex partnership environments