Health & Wellbeing Board Buckinghamshire

Overview of Health & Care Integration Programme

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Author/Lead Contacts: Jo Baschnonga, Programme Director Health & Care Integration, Buckinghamshire Council & Buckinghamshire NHS Trust

Report Sponsor: Gillian Quinton, Corporate Director Adults and Health, Buckinghamshire Council

Consideration: ☒ **Information** ☒ **Discussion**

☐ **Decision** ☐ **Endorsement**

Please indicate to which priority in the Joint Local Health and Wellbeing Strategy, Happier, Healthier Lives Strategy (2022-2025) your report links to.

Start Well	Live Well	Age Well
☐ Improving outcomes during maternity and early years	☐ Reducing the rates of cardiovascular disease	☒ Improving places and helping communities to support healthy ageing
☐ Improving mental health support for children and young people	☐ Improving mental health support for adults particularly for those at greater risk of poor mental health	☐ Improving mental health support for older people and reducing feelings of social isolation
☐ Reducing the prevalence of obesity in children and young people	☐ Reducing the prevalence of obesity in adults	☐ Increasing the physical activity of older people

None of the above? Please clarify below:

N/A

1. Purpose of report

To update on the Health and Care Integration Programme – including scope, deliverables, timescales, who is involved and what benefits patients can expect.

2. Recommendation to the Health and Wellbeing Board

No recommendation; report for awareness and discussion.

3. Content of report

3.1 Introduction

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% A&E patients 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.

Buckinghamshire is gripping the challenges around patient flow through a new programme of work called the Health & Care 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 BHT 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.

3.2 Who is involved?

The new integration programme is managed by a team of three staff, including a Programme Director, seconded from the partnership organisations and reports into the Integrated Care Partnership Executive Board (Chief Executives of the partner organisations). The Corporate Director for Adults and Health at Buckinghamshire Council, Chief Operating Officer at Buckinghamshire Healthcare NHS Trust, and the Place Director at Buckinghamshire Integrated Care Board provide senior leadership to the programme. A core group of operational staff from across the system are involved in designing the future model for the County, further engagement with a wider group of staff, patients, carers and the Voluntary and Charity Sector will happen in the first quarter of 2023. The programme 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.

3.3 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 & focus on people – design things together, regular communication, support each other
- Evidence-based, what works, pragmatic
- Pace
- Customer-focus

3.4 Scope of programme, 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.

3.5 D2A beds and assessments

Earlier in the year the Integrated Care Partnership (ICP) 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 23, 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 codesigning 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).

3.6 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 20 (with appropriate rehabilitation offer) – end of March 2023
2. Transitioning majority of social care assessments into hospital (from community D2A pathways) – planning in progress, current expectation from April 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 in Quarter 1-2 2023

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 to be decided (workstream being rescoped as a result of decisions made at October 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) – from January 2023, pending agreement of business case in December 2022

3.7 What are the benefits for patients?

Ultimately, the programme is aiming to get patients home (or to the setting best suited to their needs) as soon as possible once they are medically fit to leave hospital. Prior to going home, we are aiming to ensure patients have the smoothest journey possible through the health and care system, with the fewest possible hand-offs and touch points. This should result in the best patient experience, improved staff experience and the best use of health and care resources.

In summary patients can expect:

- An improved journey leaving hospital with fewer hand-offs
- Less time in hospital and therefore less time away from their own bed
- Reduced likelihood of deconditioning, infection, confusion/disorientation, institutionalisation or increased dependence
- A named worker for discharge planning for every patient
- A person-focused approach to intermediate care which enables independence

4. Next steps and review

- To update on progress at the next Health and Wellbeing Board

5. Background papers

None