Health & Wellbeing Board
Buckinghamshire

Buckinghamshire Health and Care Integration Programme: progress, future plans, and what this means for residents

Date: 30th March 2023

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

Report Sponsor: Craig McArdle (DASS, Buckinghamshire Council); Philippa Baker (Executive Director for Place, ICB), Raghuv Bhasin (COO, Buckinghamshire NHS Trust)

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:

The Health and Care Integration programme has been focusing on hospital discharge. For this reason, it does not directly support any of the specific Joint Local Health and Wellbeing Strategy priorities but does significantly contribute to the health and wellbeing of Buckinghamshire residents.

1. Purpose of report

The report summarises the main outcomes of integration programme of work over the last year, plans for next year, and what this means for the experience of people using health and care services in Buckinghamshire.

2. Recommendation to the Health and Wellbeing Board

Report for information, no recommendation.

3. Content of report

3.1. The key statistics around patient experience and hospital admission and discharge referenced in the national media show that Buckinghamshire is roughly in line with national averages - for ambulance queues (19%), long waits in A&E (26%), and the proportion of patients admitted, treated or discharged within 4 hours (70%).

3.2. However, we know that these markers of patient experience have worsened nationally compared to pre-pandemic levels, and they reflect the ongoing recovery from the impact of Covid. The crisis across NHS and social care services has been well documented this winter - significant demand, capacity and workforce issues have affected all systems, and inevitably this can impact on the experience and safety of patients.

3.3. In Buckinghamshire, the recovery from Covid (in relation to hospital discharge) is being driven by the 'integration programme', seeking to ensure safe and timely discharge from hospital for the residents of Buckinghamshire – wherever possible back to their home. The objectives of the programme are to:

- Reduce delays experienced by Buckinghamshire residents at all points during their discharge journey, both in and out of hospital. The rolling back of the current 'discharge to assess' model (whereby patients who no longer need to be in hospital are discharged pending an assessment of their long-term care needs), is one element of supporting this, alongside others detailed in Sections 3.17- 3.19.
- Stabilise performance and patient experience – so that Buckinghamshire residents have their hospital discharge planned as soon as they are admitted, if they require an assessment for longer term care it happens in the best location for them and does not take longer than 28 days.
- Implement a new model for discharge and intermediate care in the County that drives even better outcomes for patients and staff. (Intermediate care are services such as occupational and physical therapy to help people become more independent after a hospital stay)

3.4. Sections 3.7 to 3.15 summarise the improvements to the Buckinghamshire system over the last year, and what this means for the experience of Buckinghamshire residents.

3.5. There is substantial work left to do to achieve the level of improvement needed. Sections 3.16 to 3.20 describe the plans in place for delivery next year (in part resourced by the national discharge fund, Buckinghamshire is expected to receive £2.4m via the NHS and £0.7m via the Local Authority, with partners coming together to decide how best to spend this).

3.6. The design of new and improved services next year will be based on an understanding of the current patient journey and experience. Workshops with Buckinghamshire residents in April and May will help to develop a better understanding of this, and all service designs will include

'personas' which describe (through the eyes of a patient) how the new design will improve on the current patient experience.

Improvements this year

3.7. Residents who need long-term care at home after they leave hospital are able to go home while they are assessed for their long-term needs, in line with our vision to get people home as soon as possible. This has been achieved through a new service called 'Home First' (launched in November 2020). Performance of this Service has steadily improved over the last year, meaning that Buckinghamshire residents on this pathway now can expect to be assessed at home within 28 days (in line with our target).

3.8. 94 care home beds in Buckinghamshire have been freed up since June 22, meaning they can be used differently (e.g. for long-term care addressing a gap in the market). This boost in long-term care capacity should mean that long-term care is easier to source for some Buckinghamshire residents, meaning they can be discharged from hospital more quickly.

3.9. The 94 care home beds referenced above were previously 'discharge to assess' beds. At the peak of winter, the average length of time a Buckinghamshire resident could expect to stay in one of these beds while waiting to be assessed was over 100 days. Although the intention of the national 'discharge to assess' model was to reduce the time patients waited in beds, it has not worked in Buckinghamshire. The impact on (generally frail and elderly) patients in these beds is significant - 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. The transition of 'discharge-to-assess' beds into long-term care capacity in the County is designed to address this issue – by the end of this year there will be approximately 30 discharge to assess beds in the County (compared to 140 in May 22), and next year we plan to phase them out as far as possible.

3.10. Barriers to assessing patients in hospital are being removed, and the system has started delivering more assessments in this setting. In the future this will mean that where a patient requires a relatively simple assessment, this can be done quickly in hospital, meaning they can be discharged directly to their long-term care placement, minimising the potentially disruptive effect of multiple moves for people. We are still at the early stages of this journey (new financial principles and processes have been implemented in March to support this new way of working, but there is more work to do next year to maximise the opportunity).

3.11. We have started to reduce the length of time Buckinghamshire residents spend waiting in 'discharge to assess' beds and on the County's medically optimised for discharge ward at Stoke Mandeville (Chartridge), although there is significant work left to do on this. Patients in these settings are being reviewed weekly for opportunities to accelerate their discharges. The average length of time a patient spent in a 'discharge to assess' bed in the month of January was 75 days, an improvement on December (over 100 days). It is too early to say if this is an improvement trend, and we know there is still substantial work to do to achieve sustained improvement – including around performance and culture (which can take time to embed).

3.12. Buckinghamshire residents may be treated and discharged from many hospitals including Stoke Mandeville, Wexham Park or Milton Keynes Hospitals (usually dependent on where they live in the County). There is now stronger partnership working with neighbouring systems – Frimley system (Wexham Park Hospital - which treats the largest proportion of Buckinghamshire residents after Stoke Mandeville Hospital), have representatives on the key groups that govern the County's integration programme (including the Buckinghamshire Executive Board), and are key participants in the design of our future model for discharge and intermediate care.

3.13. A new hub of twelve beds was opened in January to support discharge of patients through the most intense period of winter (funded by the additional £200m national fund announced on 9th January). This additional provision has supported more Buckinghamshire residents to be discharged from Wexham Park hospital (8 of 12 patients currently being cared for).

3.14. Six new short-term housing units (ground floor one bed units in High Wycombe) are now available to facilitate discharges where residents are waiting for longer term housing. These units act as a 'bridge' between hospital care and returning home for Buckinghamshire residents who are waiting to be housed. The initiative launched in February.

3.15. Similarly, a small number of residents needing to access homelessness services after a spell in hospital over winter have been temporarily housed in hotel accommodation during January – enabling them to be discharged from hospital and into more appropriate accommodation.

Improvements next (financial) year

3.16. Improvement activity has accelerated during January and February, supported by additional NHS funding (£500m national discharge fund – spending plans were agreed through the Health and Wellbeing Board on 15th December, and a £200m fund announced in January). These funding streams were announced very late in the year, meaning it has been challenging to plan and spend the money to impact on flow and patient outcomes this winter.

3.17. There are a number of improvement initiatives in progress, however, which we expect to have an impact in Spring/ Summer and improve the experience of Buckinghamshire residents through the coming year:

- Trusted Assessors – two new posts within the Hospital Discharge Team focused on improving the transfer of patients from discharge to assess beds into long-term care, working with our biggest care provider the Freemantle Trust. There is evidence of significant delays at this point of the discharge process. Our Trusted Assessors will drive improvements and build trust with care providers over a 6 month period, estimated to reduce the length of time residents wait in beds by 286 days. Going live later in March.
- Integrated discharge team – hospital staff and social workers becoming one team and working together with patients on the ward to plan their discharge from the point of admission. Discharge plans will be simplified, based on the strengths of the patient, and developed with residents and their families – this should reduce anxiety and help patients

feel in control. Better planning of discharge will reduce the likelihood of readmission, enabling people to remain at home. Going live from April.

- Better performance data – to drive better performance of our discharge services, we need high quality performance information that is easy to access. Work us underway to develop better performance information on patients delayed in hospital – this is particularly pertinent as more patients are assessed on hospital wards (mentioned in Section 3.9). Expected to go live in April, this information will identify where the longest patient delays are, enabling rapid action to be taken.

3.18. Our most substantial deliverables next year will be a 'transfer of care hub' (going live in October), and a new intermediate care bedded offer. The transfer of care hub will co-ordinate the patient's journey through the system - with hospital and social work staff working together in an integrated team to achieve this. There will be dedicated resource overseeing the patient journey, identifying delays quickly and driving accountability for resolving them. This will make Buckinghamshire residents' experiences of moving through the health and care system smoother and quicker.

3.19. Our new bedded offer will be better aligned to patients' needs (than the current 'discharge to assess' bedded offer), and will include:

- A 22 bedded intermediate care hub within Buckinghamshire Community Hospitals. This will support Buckinghamshire residents get home as quickly as possible after a stay in hospital by providing the right type of therapy and approach to reable them quickly. These beds will complement the intensive rehabilitation beds (35) that are currently provided in Buckinghamshire's Community Hospitals.
- Complex case bedded hubs providing 20 beds for people who need a longer stay (due to complex health needs, for example non-weight bearing) in order to be assessed for their long-term care.
- Two short-term interim bedded hubs providing a total of 20 beds which can be used flexibly to support discharge from acute hospitals. For example, if an assessment is particularly complex or there is a delay in sourcing a patient's long-term placement. Our ultimate aim is to operate without this type of short-term bed, however while we are still improving our processes and performance these beds will help to keep system flow moving and reduce the likelihood of Buckinghamshire residents facing long delays in bedded care.
- Up to 32 additional surge beds to support periods of increased pressure, anticipated to be open from October 2023 – March 2024.

3.20. Our final area of focus next year will be around culture and performance across the health and care system. For health and care services to operate effectively, hospital discharge must be a priority for all members of staff, and woven through the fabric of our partnership. In April we will be working on reaffirming a clear vision and compelling narrative for staff, helping all

colleagues to understand their role in improving the outcomes and experience of Buckinghamshire residents.

4. Next steps and review

4.1. The integration programme will continue to be governed through the Integrated Care System Executive Board, which meets monthly.