Your community
Your care
Developing Buckinghamshire together

Improving hospital discharge and intermediate care in Buckinghamshire

HASC

20th July, 2023

Background to the discharge and intermediate care challenges in Buckinghamshire – recovering from the Covid Pandemic

During the Covid pandemic, helping patients return home as quickly and safely as possible was critical in order to reduce risk of infection. Nationally, a model called 'discharge to assess' (D2A) was mandated (with a funding stream).

In Buckinghamshire, like many other places, this funding was invested in additional temporary care home beds 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. At the peak of the pandemic there were 180 D2A beds, and 11,000 hours of temporary home care. The beds were commissioned individually and rapidly - across many different care homes in Buckinghamshire. Although this was the right decision at the time to manage the specific pressures of the Pandemic, it was not a sustainable model long term.

Due to significant demand and capacity pressures, which were reflected nationally as well as in Buckinghamshire, patient flow through the D2A bedded pathway was slow last year - the average length of stay peaked at around 100 days during the Winter period. The impacts were significant - contributing to high numbers of patients waiting to be discharged. The resulting pressure on hospital beds can result in:

- Patients waiting on trolleys for long periods (rather than in beds on wards)
- Delaying ambulances while offloading at the hospital and slowing 999 response times.
- Long stays in bedded care have a significant impact on frail elderly patients - for every 10 days of bed rest in hospital, the equivalent of 10 years of muscle ageing occurs (in people over 80 years old) which can later result in the need for long-term bedded care.
- A detrimental impact on the wellbeing of health and social care staff

(see Appendix 4 for Glossary)

The ambition in Buckinghamshire

- There is an ambition to move to a more integrated and efficient model for hospital discharge and intermediate care in Buckinghamshire to improve patient outcomes and experience. The new model is underpinned by the following principles:
  - ‘Home First’ approach – by default we should be focusing on people’s strengths and aiming wherever possible for them to get back to independent living at home as soon as possible
  - Integrating services (across organisations) around patients – to simplify the patient journey experience and make the most of limited public resources
  - Working in partnership – across the system, including with the voluntary and independent sector, to plan capacity for the longer-term
- This is being tackled through a range of programmes in Buckinghamshire, including:
  - Buckinghamshire Integration Programme (System-wide) – see Appendix 1 for summary
  - Out of Hospital Transformation Board (Place based) – see Appendix 2 for summary of Community Hubs
  - Urgent & Emergency Care Transformation Programme (BHT) – see Appendix 3 for summary of admissions avoidance work
- This paper summarises the key issues we are trying to fix within our current model, and the improvements we are making

Summary of key achievements in the last year

- 'Discharge to assess' **bedded pathway closed** (poor performance on length-of-stay and patient experience) which has freed up **140 care home beds** – boosting capacity for long-term care – see Fig 1
- **3 new care home hubs opened**, 4th due to launch in July – for more complex patients undergoing assessment for longer term needs, strict performance targets in place driving patient experience (see next slide for locations)
- **No patients waiting in hospital** to be assessed for their long-term care needs (compared to approx. 40 patients waiting on any given day this time last year)
- **New integrated discharge team working with patients on wards** to plan discharge and meeting daily to review referrals for discharge pathways, driving better decision-making
- **Patients waiting for discharge to short-term home care significantly reduced** (average wait-times reduced from 17 to 2 days April-Nov 22) – supported by Home First Service live dashboard, see Fig 2
- **Olympic Lodge surge supported management of additional Winter demand** – 547 patients admitted (Oct 22 to May 23) of which 457 were able to return home. Average length-of-stay was 10.4 days.
- **Three extensive stakeholder engagement events** at Marlow, Thame and Chalfont St Peter to inform how the community space is best utilised.

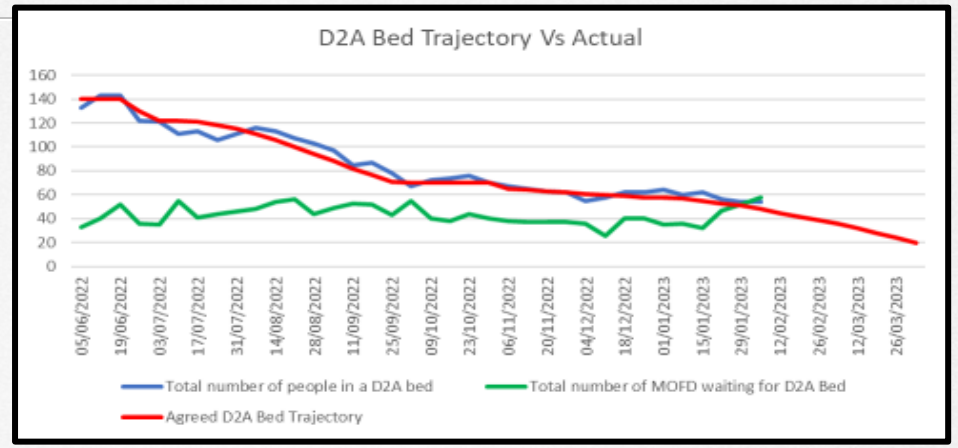


Figure 1: Reduction of discharge to assess beds Apr 22-Mar 23 – pathway now closed

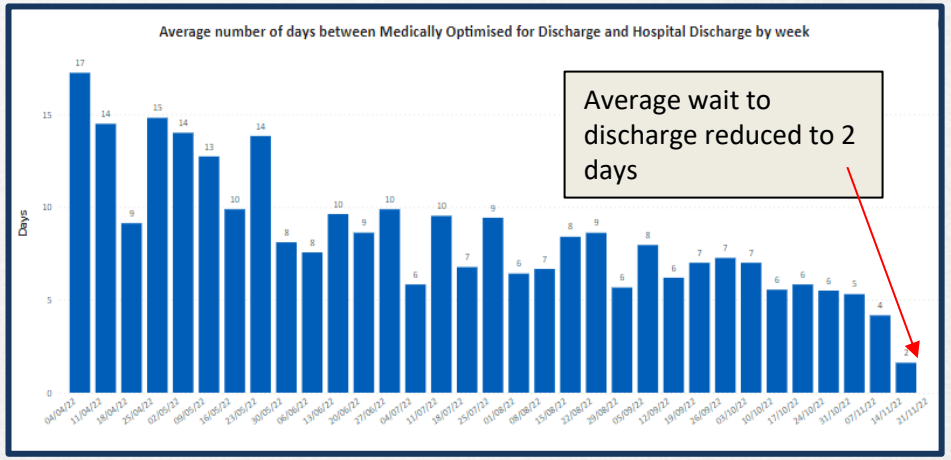


Figure 2: Home First live dashboard – showing reduction in waiting times April-Nov 22

Community bed-base 23-24

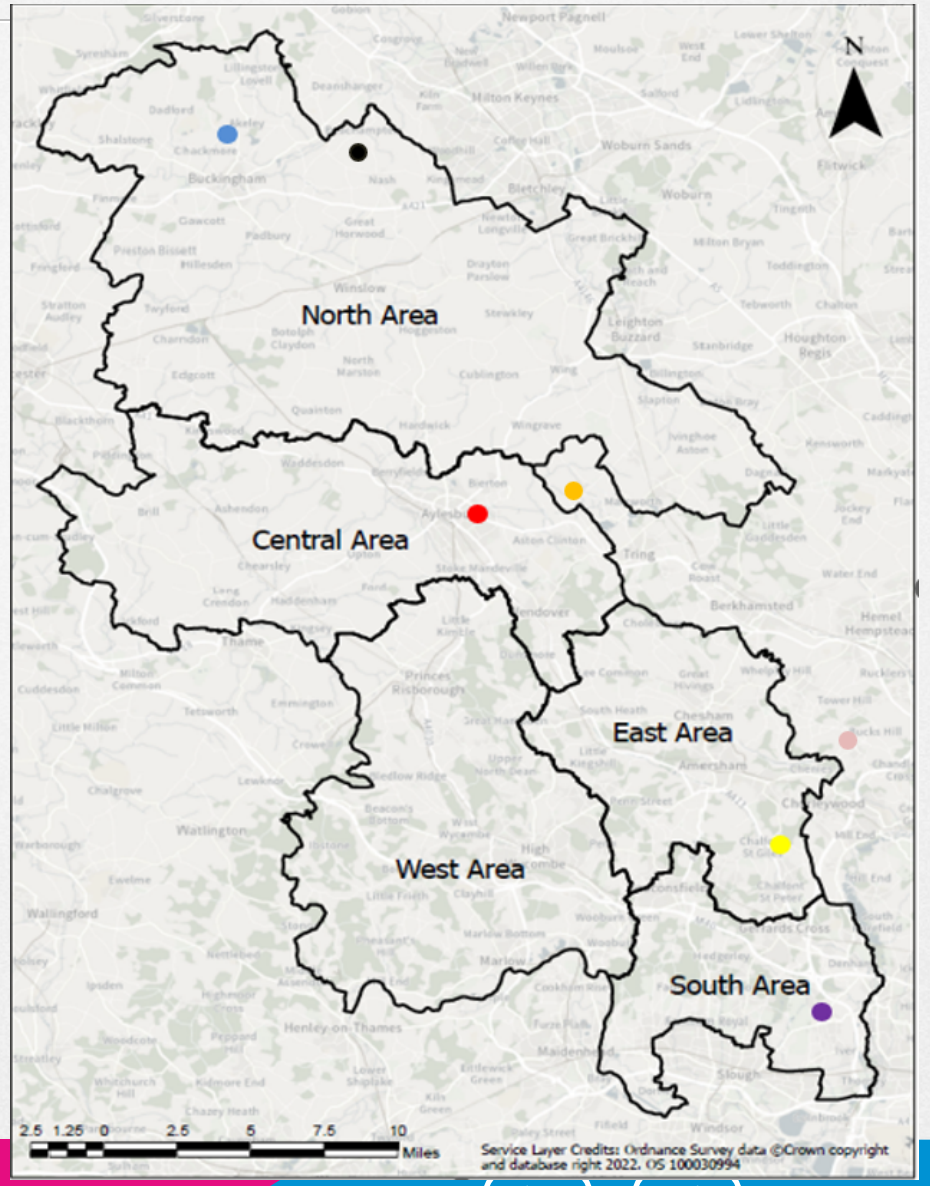
Acute Hospital

Intermediate Care Centre: 22 beds ***TARGET LOS: 28 Days***	Intensive Inpatient Rehab: 35 beds ***TARGET LOS: 21 Days***	**Care Home Hubs: 26 beds** **Target LOS: 28 days (Up to 70 Days for complex cases)**	Surge Beds:32 ***TARGET LOS: Up to 10 Days***	Home First: 120 ***TARGET LOS: Up to 28 Days***	Bedded discharge Capacity
Chartridge ward (Amersham Community Hospital): 22 Beds Re-purposed into a new intermediate Care Hub with on site MDT team. Therapy input, clear goal setting and focus on reablement to enable as many people to return home following time limited stay.	**Buckingham ward (Buckingham Community Hospital): 14 beds** **Waterside Ward (Amersham Community Hospital): 21 beds** Intensive inpatient rehab, person has to be able to engage with goals. Only accept if clear goals set to be achieved within 3 weeks	**Care Home Hubs (see next slide for map)** Four care home hubs across Buckinghamshire providing bedded support for two cohorts: 1) People with complex health needs that prevents assessment within 4 weeks and not appropriate to wait in acute hospital (i.e.: Non optimised CHC, Delirium, non weight bearing) 2) Flexible support for discharge from acute hospitals. For example if following hospital assessment there is a delay in placement.	**Olympic Lodge (next to Stoke Mandeville hospital)** Surge Capacity beds for periods of significant pressure (Winter). Open: April/ May 2023 Nov 23 – March 24	**Home First:** Home Care and therapy support to reable people in their own home to maximise a persons independence	Description of Capacity

Community bed-base 23-24

- Most people are discharged home from hospital, some go home with a package of care (aiming for 120 in this pathway at any one time) and a much smaller number into community beds (total 115 including Winter surge capacity at Olympic Lodge).
- This map shows the geographical coverage of our community bed-base (see previous slide for more detail on the patient cohorts supported):
  - Community hospital beds (including 22 beds on Chartridge ward at Amersham being transformed into new intermediate care centre)
  - Olympic Lodge (SMH) – Winter surge capacity
  - 3 Care Home Hubs launched in May
  - 4th Care Home Hub (Hamilton House) – in development (TBC launch in July)

Colour	Bed Location	No. of Beds
●	Buckingham Community Hospital - High Street, Buckingham MK18 1NU	**Buckingham - 14**
●	Amersham Community Hospital - Whielden Street, Amersham HP7 0JD	**Chartridge – 22 Waterside - 21**
●	The Olympic Lodge - Stoke Mandeville Stadium, Aylesbury HP21 9PP	**Up to 32 Surge Beds (winter)**
●	Hampden Hall Care Centre Tamarisk Way, Weston Turville, Aylesbury HP22 5ZB	**12**
●	Hamilton House Care Home -West Street, Buckingham MK18 1HL	**5 (TBC to open July 2023)**
●	Sunnyside Nursing Home -140 High Street, Iver SL0 9QA	**4**
●	Chalfont Lodge Nursing home - Denham Ln, Chalfont St Peter, Gerrards Cross SL9 0QQ	**5**



What problems are we trying to fix? (1)

- The next few slides talk through some of the key problems with our current intermediate care model, which we are seeking to fix through the following programmes of work
  - Buckinghamshire Integration Programme (System-wide) – see Appendix 1 for summary
  - Out of Hospital Transformation Board (Place based) – see Appendix 2 for summary of Community Hubs
  - Urgent & Emergency Care Transformation Programme (BHT) – see Appendix 3 for summary of admissions avoidance work

Examples are given of the progress being made and the impact this is having.

What problems are we trying to fix? (2)

Fragmented service provision & poor patient experience

Nationally, the population is ageing meaning more people living with multiple long-term conditions and complex needs. Health and social care services are typically structured around separate organisations working autonomously. Historically, they were set-up to deal with episodes of illness and care 'one-at-a-time'. This has resulted in a fragmented system that is not designed around the patient – and inevitably a complex patient journey and confusing experience that can drive anxiety and poorer health & wellbeing outcomes.

How are we fixing it? (see Appendix 1 for more detail)

Development of new integrated services designed around the needs of the patient – seeking to simplify processes and improve communication with patients. Some examples:

1) Integrated discharge team - working on the wards with patients to plan discharge more effectively, taking theirs/their families view into account
2) Transfer of Care Hub – new integrated team co-ordinating patient discharge effectively, including case managers to work with more complex patients, strong oversight of length of stay, and blockages will be escalated and dealt with quickly

What problems are we trying to fix? (3)

Covid pandemic and our short-term intermediate care model

In response to the Covid pandemic in Buckinghamshire we invested significantly in additional community capacity ('discharge to assess') and temporary staffing structures to manage this. Although this was the right approach to manage the short-term pressures of the pandemic, this resulted in an 'over-reliance' on care home beds, and not enough focus on getting people home and reabled to achieve independence. The most successful intermediate care models have the 'Home First' principle at their core and a strong focus on reablement – i.e. where a patient has the potential to return to independent living, providing the *right type* of bedded care with focused reablement support. As mentioned earlier, the rapid and sprawling expansion of D2A beds also resulted in long delays for some patients, and a poor experience.

How are we fixing it? (see Appendix 1 for more detail)

1) Driving a 'Home First' approach through our new Integrated Discharge Team (IDT) and developing Transfer of Care Hub (see glossary in Appendix 5 for definition). The IDT meets on a daily basis to review patient discharge referrals/ plans to ensure we are supporting patients to return home where possible
2) Implementing a new intermediate care centre at Amersham – repurposing c.22 beds to support patients to receive focused reablement over a short period to support them to return home to independent living
3) Phasing out 'discharge to assess' beds and replacing them with 5 'care home hubs' (with appropriate multidisciplinary team, performance targets around patient experience and strong management/oversight)
4) More social care assessments in Hospital – instead of waiting for a 'discharge to assess' bed, social care assessments are now started immediately in Hospital
5) Reviewing the longest delays and taking action - patients across all discharge pathways are being reviewed weekly for opportunities to accelerate their discharges. Delays in the 'discharge to assess' bedded pathway have gradually reduced over the last 6 months – Dec 100 days, Jan 75 days, May 59 days (the lowest since programme reporting began in July 22). By the end of July the last 'discharge to assess' beds will have been phased out and the new Care Home Hubs are delivering their performance target of 28 days

What problems are we trying to fix? (4)

Poor information

We know the flow of patient information through the system is poor and does not support good performance around discharge. Substantial investment is required to mature the digital infrastructure in the longer term, but here are some examples of how we are improving the flow and quality of information now:

How are we fixing it?

1. New Quality Assurance process in Integrated Discharge Team – daily meetings to review quality of patient assessments & ensure the patient voice has been captured and understood
2. New Trusted Assessment model – phase 1 building trust in the information collected on patients who are cared for at a Fremantle Care Home. Supported by a Trusted Assessor who will manage the flow of information between the patient, hospital and Care Home, ensuring their reassessment is rapid and robust, and reducing delays in returning to their placement.
3. Using an AI data driven approach to managing the flow of patients from hospital admission though to discharge

Driving a stronger discharge/ performance culture

To achieve excellent discharge services, all staff across the system need to understand their role and our aspirations as a system – and we need to have a clear line of sight across the performance of our discharge services

How are we fixing it?

1. Clear performance targets and monthly reporting for the new integrated services we are delivering this year – care home hubs, Integrated Discharge Team, Transfer of Care Hub
2. Staff workshops to hear views, development of comms plan
3. Management development programme

Appendix 1 – update on Integration Programme

Introduction

The current focus of Buckinghamshire's Health and Care Integration Programme is improving the County's hospital discharge and intermediate care model.

In November 22 we reported to HASC on the ambition, deliverables and timescales of the Programme, which had been launched earlier in the Summer (see Appendix 1.1 for list)

This section updates on progress since then, and highlights how the work that is being delivered this year will put the system on a stronger footing before next Winter.

Update on integration programme deliverables

Deliverables outlined in November HASC report	Progress
Reducing D2A beds to no more than 20	Completed. D2A beds were reduced to c.30 by end March 23 when referrals into this pathway ceased. There are now zero D2A beds in the system. Five new bedded hubs are being launched across Buckinghamshire this year – with multidisciplinary teams, robust management and oversight including a clear performance framework. Three of these hubs were launched on 22nd May.
Transitioning majority of social care assessments into hospital (from community D2A bedded pathway)	Completed. From 31st March 23 all social care assessments that previously took place in D2A beds are now undertaken in Hospital. The hospital social work teams have remodelled their approach and capacity to enable this.
Implementing a Transfer of Care Hub	On track to go live in October, before next Winter. Currently developing business case, design undertaken with staff, patients and VCS.
Implementing an integrated digital/information offer	On track to deliver an information management solution for the integrated transfer of care hub in October. Full system-wide digital offer still to be considered.
A business case for our future intermediate care offer	On track to launch a new intermediate bedded care centre at Amersham in October (transforming the Trust's ward for medically optimised patients waiting for discharge - Chartridge). Home-based intermediate care offer still to be considered.
Trusted Assessor model	Phase 1 completed. New Trusted Assessor in post, working with our biggest care provider Fremantle to reduce delays for patients returning to Fremantle Care Homes. Phase 2 to be delivered through the new Transfer of Care Hub.

Looking ahead – what will be different this Winter?

Key programme deliverables	What will be different this Winter?
New bedded offer (5 bedded discharge hubs across the County and a new intermediate care centre at Amersham)	- Patients who require relatively simple assessments will receive these in quickly in hospital and will be discharged directly to their long-term care. As opposed to waiting in hospital to be moved to a D2A bed before assessment starts. - Patients requiring a more complex assessment can be discharge from hospital to one of our five new bedded hubs where they will be supported by a multidisciplinary team (MDT) and assessed/discharged within 28 days. As opposed to being discharged to a D2A bed without MDT support, with the potential for a long stay. - Patients who require rehabilitation before returning home will be cared for at our new intermediate care centre where they will have clear goals set over a maximum of 6 weeks (where requirement is for more intensive rehab a community hospital bed may be more appropriate). This will mean patients are ready to go home and live independently, and should be less at risk of readmission to hospital.
Transfer of Care Hub and Integrated Discharge Team	- Social workers and discharge co-ordinators will work together with patients and their families on the ward to plan their discharge from the point of admission. There will be a single point/person for patients to liaise with during their stay– reducing anxiety and enabling the patient's voice to be heard. Patient information and the referral to onward discharge pathways will be quality assured, meaning patients will be set on the right pathway for their needs. - The transfer of care hub will co-ordinate the patient's discharge effectively, and case managers will work with more complex patients to ensure their discharge progresses smoothly. There will be strong oversight of length of stay, and blockages will be escalated and dealt with quickly.
Trusted Assessor model	- Patients who are cared for at a Fremantle Care Home will be supported by a Trusted Assessor who will manage the communications between the patient, hospital and Care Home, ensuring their reassessment is rapid and robust, and reducing delays in returning to their placement.

Appendix 2 – summary of Community Sites

Community sites

Create true integration	• Bring together health, care and community space for our local population to support their health and wellbeing
Improve health outcomes	• Deliver high quality integrated community services to improve health outcomes, support residents to live their best life and reduce known inequalities across the county
Foster partnerships	• Work in partnership with colleagues in Buckinghamshire Council as well as Primary Care Networks and other providers to develop new integrated community teams
Community Diagnostic Hubs	• Develop community diagnostic hubs which offer essential diagnostics such as phlebotomy, point of care testing and simple scanning which are easily accessible to residents and will contribute to reducing carbon emissions
Anticipatory Care	• Proactively target healthcare and support at people of all ages living with frailty, multiple long-term conditions and/or complex needs eg Parkinson's, to help them stay independent and healthy for as long possible
Inequalities in access	• Expand the places where we deliver a wide range of community care and services eg Health on the High Street – Unit 33, Aylesbury, Healthy Living Centre, Abbey Place

Appendix 3 - Summary of Admission Avoidance work

Admission avoidance

Hospital@Home	• Allows patients who otherwise would be in hospital to receive acute care, monitoring and treatment at home
Urgent Community Response	• Fast support to people in their usual place of residence as an alternative to being taken to or admitted to hospital
Onward Care	• A data driven, tech enabled service that aims to help stabilise frail people, with a high risk of readmission, safely at home by providing non-clinical support and monitoring for early deteriorating indicators
Same Day Emergency Care	• Introduced an ambulatory Frailty Same Day Emergency Care service in the Emergency Department
CATS and MUDAS	• Expansion of both of these ambulatory services to better manage more subacute care to vulnerable and frail adults
Admiral Nurses	• Linked with Dementia UK and are actively recruiting two Admiral Nurses to help people living with dementia stay independent longer and support the people caring for them

Appendix 4 – Glossary

Glossary

- **Hospital discharge** – the process of a patient leaving hospital once they are 'medically optimised' - most often patients return home, some patients return home with a package of care, and a small number move on to a community bed.
- **Medically optimised for discharge** – the point at which it is determined (by a clinician) that a patient requires no further acute medical input, and is therefore ready to be discharged from Hospital.
- **Discharge to assess (D2A)** – intermediate care model where people who are clinically optimised (ready to leave hospital) and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting – such as a care home bed. Assessment for longer-term care and support needs is then undertaken at the right time for the person.
- **Intermediate care** - services providing support for a short time to help a patient recover and increase their independence. These services can support patients to: return home more quickly after a hospital stay; remain at home when things become more difficult; recover after a fall, an acute illness or an operation; avoid going into hospital unnecessarily
- **Community services** - a wide range of services that support people with complex health and care needs to live independently in their own home for as long as possible. Many services involve partnership working across health and social care teams, made up of a wide variety of professionals including community nurses, allied health professionals, district nurses, mental health nurses, therapists and social care workers. E.g. District Nursing, Urgent Community Response, community occupational therapy, falls prevention, intermediate care services – including Home First, Home Independence Team and RRIC, Care Home Hubs
- **Integrated discharge team** - working on the wards with patients to plan discharge more effectively, taking theirs/their families view into account
- **Transfer of Care Hub** – new integrated team co-ordinating patient discharge effectively, including case managers to work with more complex patients, strong oversight of length of stay, and blockages will be escalated and dealt with quickly
- **Care Home Hubs** -