Lincolnshire COUNTY COUNCIL *Working for a better future*		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
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**Open Report on behalf of Andrew Morgan, Chief Executive,
United Lincolnshire Hospitals NHS Trust**

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**14 December 2022**
Subject:	**Lincolnshire Health and Social Care Patient Flow and Discharge Programme**

Summary:

This report provides an overview of the health and social care discharge programme, with a focus on United Lincolnshire Hospitals NHS Trust (ULHT). This includes the activities such as Discharge to Assess (D2A), as well as services provided by other organisations such as the rehabilitation and therapy at home and the re-ablement service.

The report outlines the initiatives that have been developed in order to improve patient flow in Lincolnshire's acute hospitals.

Actions Requested:

To note the information within the report on the whole system improvement work taking place to improve patient flow and discharge by all system partners

1.   **Background**

'Flow' is the term traditionally used to describe the progression of patients accessing Emergency Care through hospitals. It is often interchangeably used as both 'system flow' and 'hospital flow', reflecting the difference between the journey from presentation of condition to returning home and just the elements contained within an acute hospital.

Access to emergency care is measured in many different ways, reflecting different steps of the full pathway. Many indicators, such as ambulance response times [Categories 1-3], four-hour A&E target, ambulance handover times, twelve-hour trolley waits, at the beginning of a patient's emergency pathway are a symptom of overall 'system flow'. Specifically, they are directly impacted on by bottlenecks in the overall patient journey such as delays in discharge, availability of beds within the hospitals and in the community. Hospital bed occupancy has increased over recent years, as the length of stay in acute hospitals has increased. Overall demand and admissions have increased over this time, although have not consistently been any greater than levels of admissions seen pre-Covid. Although actual optimal bed occupancy is set at 85% to help reduce infection outbreaks, nearly every hospital in England consistently runs with significantly higher bed occupancy levels. At United Lincolnshire Hospitals NHS Trust (ULHT) we have been reporting occupancy levels of 93% over the last three months.

Poor flow across the system leads to poor outcomes for patients in acute hospitals. As congestion and overcrowding has risk, there is now published evidence (*Royal College of Emergency Medicine/British Medical Journal*) that this leads to both poor patient experience as well as increased patient harm. Overcrowding in Emergency Departments (EDs) specifically has had substantial research conducted, which showed a marked increase in mortality of patients that stay for more than six hours in a department waiting for a bed.

The other impact of poor flow across the system is outside of our hospitals where we are experiencing ambulance handover delays. These occur when emergency departments exceed their physical capacity to bring another patient in from the ambulance. Overcrowding in EDs can be partly mitigated by having larger departments, and at both Lincoln and Pilgrim Hospitals the EDs are being expanded. However, it is important to note the reference to the Royal College of Emergency Medicine publication on the impact of delays: whilst larger departments may create a temporary improvement, ultimately without adequate system flow and discharges, the effect will only ever be short-lived.

Another mitigation to reduce overcrowding and create more space is to open more wards. At ULHT we have increased the number of beds open for acute patients to more than 1,000 beds. Although the number fluctuates daily this represents a substantial increase in beds designated for emergency care compared to pre-Covid levels. There are limits however to how many physical beds can be safely opened. Insufficient staffing levels can lead to increased inefficiency as resources are stretched too thinly, and ultimately staffing levels have an impact on patient safety. As more beds are opened more staff are required and subsequently the dependency on bank and agency staff increases.

Total Medically Optomised </> 24hrs
Daily Average
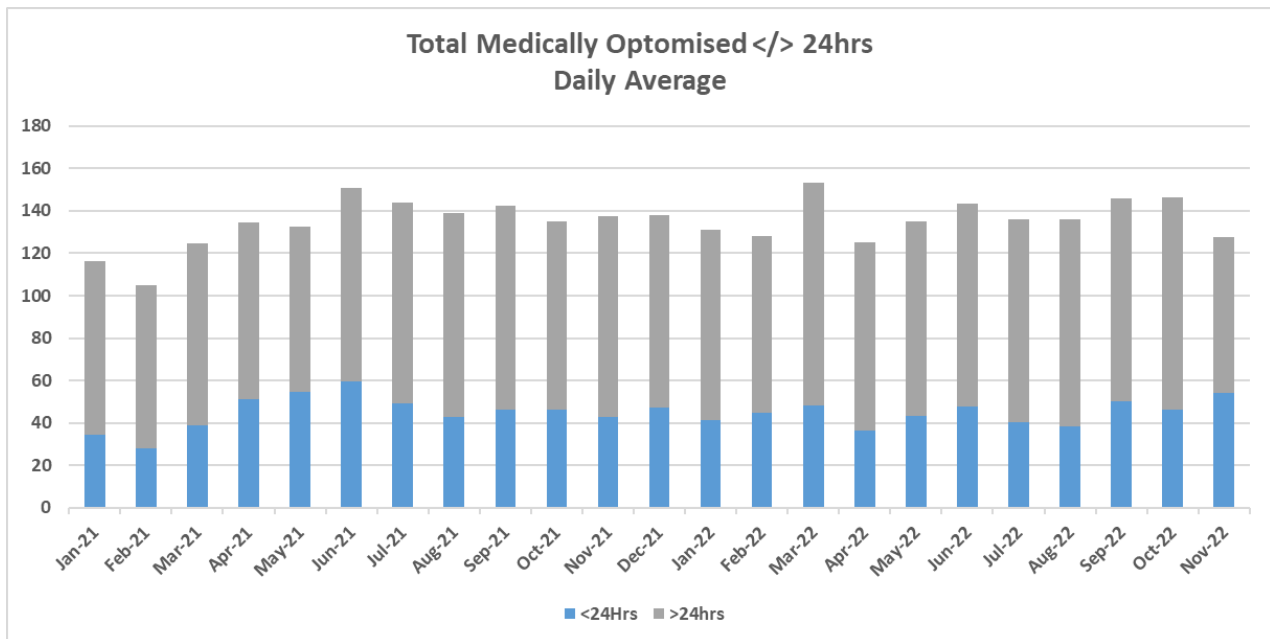
Although expansion of capacity in acute hospitals does often lead to a temporary solution in flow, the fundamental solution to flow and therefore access to emergency care is timely discharge of patients who do not require acute care into a more appropriate environment. Discharge delays has been an active debate for many years, however as acuity and dependency has changed throughout Covid-19, never has there been a time where this is more important to protect the health of patients in Lincolnshire. As can be seen from the data above, at any one time, up to 15% of all patients in our hospitals do not require acute care and should be in a different setting. Following publications by the Care Quality Commission and other journals to this effect, the Secretary of State for Health and Social Care announced on 18 November 2022 the allocation of a fund of £500 million to help reduce the number of patients in hospitals that do not require acute care.

2.   **Lincolnshire Patient Flow Improvement Journey**

The Patient Flow Programme has evolved from the group established to provide oversight to the urgent and emergency care system, winter preparation and response and patient flow across the Lincolnshire system throughout the Covid-19 response. In August 2021 it was decided to transition the group into a system wide programme of improvement work as a component of the return to business as usual structures.

The Patient Flow Programme is jointly chaired by health (system flow director) and social care (Head of Service, Hospitals and Special Projects) lead.

The HomeFirst Partnership (HFP) had been assigned by the Patient Flow Programme to lead on the development, delivery, and continuous improvement of Discharge to Assess (D2A) across Lincolnshire and full implementation of the national Hospital Discharge Policy. The programme will impact patients being discharged from the acute setting on Pathways 0, 1, 2 and 3 (Pathway numbers relevant to ongoing care needs) and result in assessments being performed (where applicable), ideally in the patient's home environment rather than in an acute ward.

The programme requires a collaborative approach across the entire Health and Social Care System to ensure that we have the resources and capability to provide support and assessments in the right place and at the right time for the individual and in accordance with the needs of our local population.

In October 2021 the system received the feedback from a peer review led by the Local Government Association and Emergency Care Intensive Support Team (ECIST) on the implementation of the national hospital discharge policy. A series of recommendations were presented which the patient flow programme has subsequently taken forward. The improvement work to truly implement and embed D2A processes can be summarised under three key areas: -

(i)   Build increased capacity in **Pathway 1**, delivered by health and social care, to offer patients reablement, rehabilitation and recovery in their own homes immediately after a hospital stay.

(ii)   Put in place an integrated discharge hub, (**Transfer of Care Hub**) at the interface of the acute and the rest of the system at the 'back door' to support continuous flow across the system.

(iii)   Improve the number of patients leaving the acute trust each day via **Pathway 0** (no support required) and **Pathway 1** (support provided in their own home).

(i)   Pathway 1

As a result of not having sufficient capacity to look after people in their own homes, the system was using a large number of interim beds in care homes for people to wait in until their package of care could be sourced to look after them safely in their own home. Last winter a peak of over 180 patients were in interim beds, many of whom should have been discharged from the acute hospital to their own home. As a result of the investment that has been made by the system in increasing the pathway 1 reablement, rehabilitation and recovery capacity, the use of short term interim beds has reduced, and more people are returning directly home.

Lincolnshire County Council - Home Care Waiting List Interim bed trends
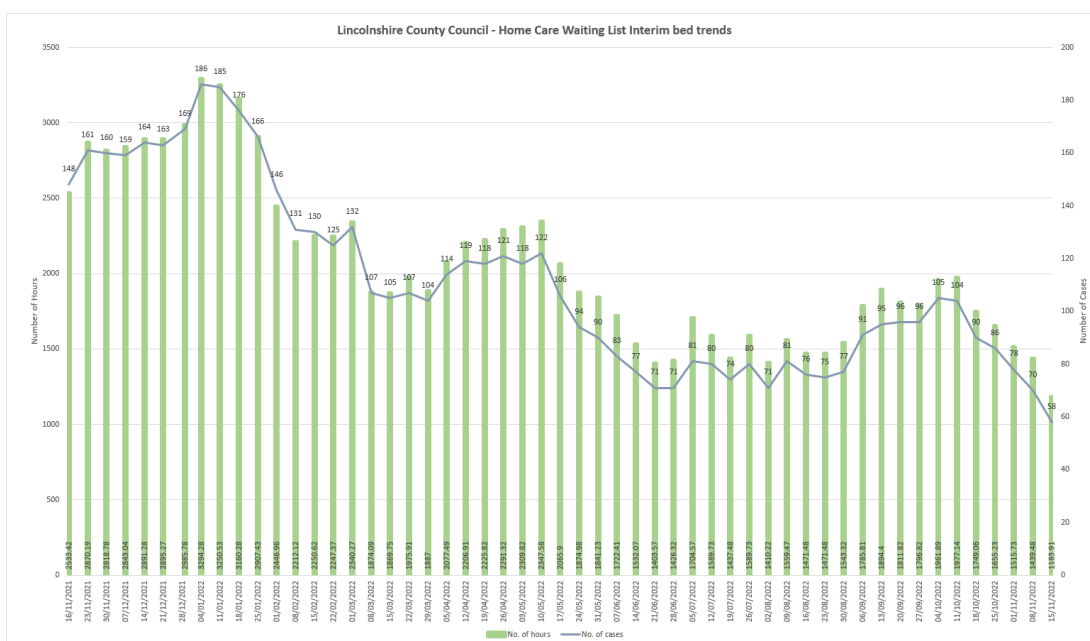
A new rehabilitation and therapy at home offer was stood up by Lincolnshire Community Health Services NHS Trust, offering increased capacity to look after people in their own homes and enabling a true discharge to assess service led by therapists. This started in December 2021 and after receiving further investment in July 2022 is on course to be able to care for up to 75 people in their own homes immediately after leaving a hospital bed. Current length of stay in the service is 16 days, resulting in over 100 patients every month benefiting from this service and outcome data is showing improvement in functional outcomes and reducing future care needs in most cases to no further care required. A trajectory is in place aiming to take 5 patients every day from the acute site in December.

The existing reablement service, commissioned by Lincolnshire County Council and delivered by Libertas across the whole geographical footprint of Lincolnshire, has also received increased investment and has ceased being used in mitigation as a provider of domiciliary care in most cases when the Prime provider is unable to pick up a new case. This has resulted in an increase in the total amount of reablement capacity available. In November 2021 over 50% of reablement capacity was being used to support the domiciliary care provision, this has now reduced to less than 25%. There is a planned trajectory to increase the number of people taken on each day by the service to 15, from baseline of 7, to close the current demand and capacity gap.

Pathway 1 investment to date = £3.7 million

(ii)   Transfer of Care Hub

The aim of the hub is to co-produce, design and operationalise a truly Integrated Discharge Hub. It is located within a single environment on each acute site and carries responsibility for all patients who have been medically optimised within the acute setting. It navigates organisational barriers and behaviours to facilitate the transition of care into the correct services, using a community pull model, for patients on Pathways 1-3, and supports patients identified as requiring discharge on Pathway 0 to access any necessary voluntary services.

- The hubs went live on site, in June 2022. The identified Strategic Lead for the Transfer of Care Hub (ToCH), established as per Hospital Discharge Policy guidance, is Adult Social Care. The service was co-designed across acute, community health and Adult Social Care with additional partner support virtually.
- They completed a re-focusing of services and triage processes to reduce the number of assessments undertaken within the acute hospital
- They re-developed the SPA (single point of access) form to better describe the patient's needs rather than prescribe the support package and reduced this to 2 pages.
- IMPOWER an external specialist advisor worked with teams to deliver strengths-based approach training.
- The hub oversees the discharge of all supported patients out of the acute sector, the number of patients medically optimised at any one-time ranges between 101 and 152, with an average 125 recorded on the WebV system as requiring a supported discharge.

- The hub receives on average 19 new SAP referrals every day
- Pathway 1 = 63% of referrals, pathway 2 = 8%, pathway 3 = 29%
- There is a rolling average of 25 patients who have waited in the acute sector more than seven days since becoming medically optimised – as a result we have appointed a senior case manager to oversee these complex individuals, many of whom require the support of several agencies to secure a safe discharge.

The leadership team for the ToCH are now moving to operationalise the phase 2 improvement plans and expanding their scope. They are working closely with Libertas at developing a new discharge to assess offer to move patients out of ED and assessment areas back to their own homes if an acute admission is not necessary, by providing intensive support at home for the first 72 hours.

The next steps will include a jointly agreed performance framework and to look at how they incorporate the flow management of community hospital patients.

(iii)   Acute Trust Flow Improvement

In June 2022 ULHT launched a new urgent and emergency care improvement programme. The main aims of the discharge and flow project/ward improvement programme was to reduce non-elective patients' length of stay, with a particular focus on the Pathway 0 patients (no support required on discharge) and improve the patient flow by increasing the total number of daily discharges.

The progress of the improvement programmes across the system are monitored via the weekly system early warning dashboard (EWD) introduced by the System Improvement Director. Subject matter and system improvement experts were brought in, including IMPOWER, ECIST and Dr Ian Sturgess an internationally renowned discharge specialist and medical consultant. This work focused on the ward improvement programme with the re-introduction of the SAFER patient flow bundle, mitigation of unnecessary delays and strong board discharge process improvement.

On 7 September 2022, facilitated by Dr Sturgess, a group of all the most senior consultants, clinical directors, senior operational leads, senior nursing teams, Allied health professionals and senior managers came together to agree a collective vision of how best practice flow would work within ULHT. The resulting shared clinical vision sets out the key outcomes and internal professional standards to deliver an aspirational future state of the non-elective flow. The key to the success of the work to date has been the engagement and leadership from clinical colleagues.

The clinical vision and the ward improvement programme came together and led to the development of the 60 day 'Breaking the Cycle' initiative which started in November 2022 aimed at delivering improved patient flow through the emergency departments, acute assessment areas and wards, with the initial focus on the introduction of a risk based continuous flow management model as advocated by the NHS national winter improvement collaborative.

The new approach to managing flow through the hospitals, has already led to positive results for our patients and for our services more widely in the first three weeks of operation. The approach, which sees the wards taking on additional patients to reduce the numbers waiting in ED has already had a significant positive impact on ambulance handover times. This in turn has reduced the risk to our patients waiting either in ED or in the community for an ambulance, something we know will have saved lives and prevented significant harm.

Data has shown a reduction in the average ambulance handover times at our hospitals from 52 minutes to 27 minutes, since the Breaking the Cycle initiative launched with a significant reduction in the number of ambulances who have waited more than 60 minutes.

SPC Chart showing ambulance handover delays over 60 minutes
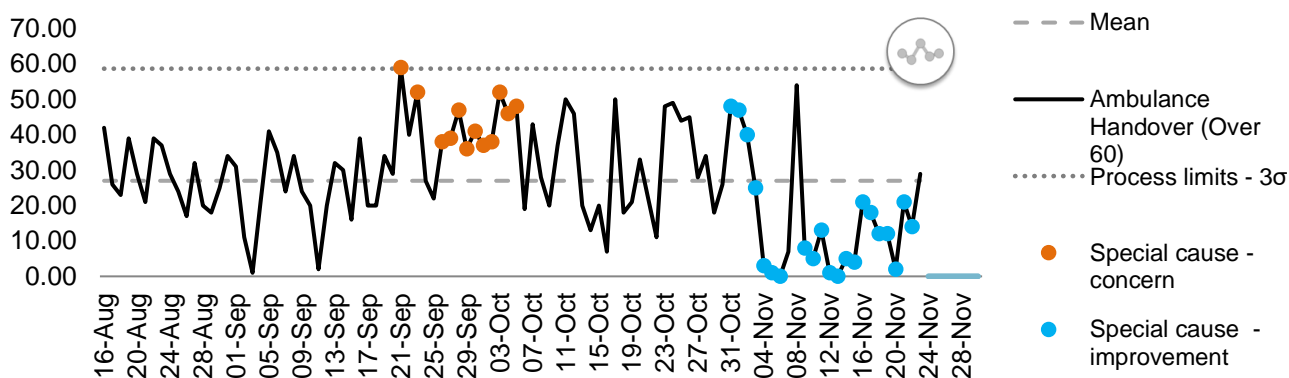
In a similar way to the temporary action of increasing bed numbers in acute hospitals, this new process will give temporary benefits to the Emergency Department. However, in the same guise its impact will cease to work if system flow and discharge does not improve. This has been shown at other Trusts where discharge delays have not been alleviated and bed occupancy reached a ceiling. The next step is to work collaboratively with system partners to extend the approach to create a continual flow of patients out of the acute hospitals.

Breaking the Cycle 2

Due to go live on 5 December 2022, we are now moving to focus on the interface between the acute hospitals and the rest of the system. The initial aim is to reduce by 24 hours the waits at the end of the pathway (discharge home/community) by maximising the existing capacity and starting to realise the benefit of the additional capacity being put in place for winter. The new daily operational process being put into place will focus on the identification and removal of constraints.

The questions we are seeking to answer are – can we move patients earlier in the day, can we better plan tomorrow's discharges today and can we rapidly learn from when we do not get it right and can we assure ourselves that a sense of urgency is in place for all patients awaiting a supported transfer of care, with rapid escalation of any delays.

3.   Next Steps

As a system we must now agree how best to utilise the additional discharge funding that is coming into the system across December and January. £2.09 million will be available to the NHS Lincolnshire Integrated Care Board (ICB) and £2.8 million for Lincolnshire County Council, with 40% coming in December and 60% in January 2023. The funding is being distributed to both the County Council and the ICB for pooling into the local Better Care Fund (BCF), in line with existing BCF requirements, and the use of both elements of the funding should be agreed between local health and social care leaders.

The focus of the funding is to reduce the flow pressure on all hospitals (including mental health) by enabling more people to be discharged to an appropriate setting with adequate and timely health and social care support.

3.   Consultation

This is not a direct consultation item.

4.   Key Strategy Documents

(1) *Going further on winter resilience plans* NHS England » Going further on winter resilience plans
(2) *Adult Social Care Discharge Fund* Adult Social Care Discharge Fund - GOV.UK (www.gov.uk)
(3) *Better Care Fund policy framework: 2022 to 2023* Better Care Fund policy framework: 2022 to 2023 - GOV.UK (www.gov.uk)

5.   Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.