Length of stay case study - Northumbria Healthcare Foundation Trust
October 2014

Northumbria Healthcare Foundation Trust (NHFT) is a highly integrated care organisation with very strong links to primary care. NHFT provides both acute and community services and social care services in some parts of the catchment, the Trust comprises of the following:

- Acute Care – 9 Hospitals, 3 DGH, 6 Community Hospitals. Soon to be 10 hospitals, then 12 hospitals.
- Community Service – The coming together of; North Tyneside community services, Northumberland community services and Northumberland social care. This created a single business unit within the trust comprising of £70million health and £140million social care funding.
- Social care - Partnership agreement maintained between the county council and Northumbria.

NHFT has a catchment population of around 500,000, spread over 2,500 square miles.

Approaches to reducing length of stay
There are over 40 initiatives that have contributed to reducing bed usage. Some of the initiatives are primarily targeted at reducing length of stay and some primarily focussed on reducing admissions and readmissions, but these initiatives interact and integrated with each other to focus on less bed usage.

The main approaches are outlined below -

Enhanced primary care services
This involves establishing a multi-disciplinary approach to high risk patients in primary care. A GP, social worker, district nurse, and community services lead meet and go through hospital discharge lists that have been risk scored and also discuss patients that are causing concern from any of the team members. Patients are identified who will need support or further assessment. The matron or district nurse then carries out an initial assessment, which then comes back to the MDT. Some patients need a medical assessment (by the GP) or a pharmacist assessment.

The patients have an identified key worker and a care plan is produced. This has been running for over 2 years and is very similar to the new enhanced service for primary care introduced since April 2014. The initial target numbers were that GP practices were to identify 0.5% of their elderly population who were most at risk, although most practices eventually had more than double this amount as the work program grew.

NHFT has also been working with 2 GP practices to explore new models of primary care delivery with a view to providing high quality services and improving access to primary care

Single point of access
There used to be over 20 ways to access community and social care services and we have gradually moved to one access number for all community Health and Social Care services. We still encourage GPs are others to directly contact community staff especially where we have increased co-location.

Short term support teams in the community
There is a responsive support team in the community that prevents admissions and readmissions. For example, if there is a frail patient who needs urgent support at home, the GP can call the team for a rapid response. In practice this means that if a call is made at 2pm on a Friday there will be someone there by 4pm even to the most rural areas, preventing a possible long admission. These were not new or additional staff but some of the existing Community rehabilitation service that were re-focussed to provide this service.

Ambulatory Care services and the Elderly Assessment Units
NHFT 's 0-1 day admissions have been dramatically reduced by organising ambulatory care services to be easily accessed in the hospital. The service aims to stabilise and get patients home. Some of the ambulatory care services are provided by existing community teams who were re-allocated to the hospital to make more efficient use of their time and ensure access to specialist back-up.

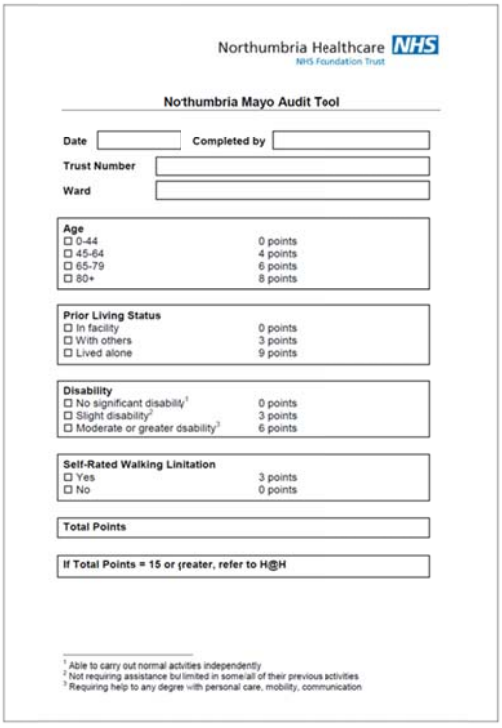
- There have been over 31,000 Ambulatory care attendances in the past months, 85% were medical cases and 15% were surgical.
- The numbers continue to grow and for the past 5 months there have been consistently over 3,000 patients a month through the service.

Elderly assessment Units were set up in preparation for the opening of Northumbria Specialist Emergency Care Hospital (NSECH) in June 2015. They are available at the local district general hospitals with the intention of treating older people closer to home without needing to go to the acute site. About half the patients are referred from A&E and half from GPs. Previously virtually all these patients would have been admitted, but now 50% go home, 20% go straight to a rehabilitation facility but 30% still need an acute admission to hospital, but they have had their care plan initiated by the Geriatrician at the beginning of their pathway

'Man marking' in the emergency department
There is a risk tool (Mayo Tool) to identify potentially complex discharges in the emergency department.

These patients are 'man-marked', given a comprehensive geriatric assessment and tracked through the hospital and district nurse and other community services lined up on discharge.

This was tested on some of the elderly wards last year, found to have an impact on reducing the average length of stay from 7.2 days to 6.5 days and the effect was considerably more than that for the individual complex cases.



Northumbria Healthcare NHS
NHS Foundation Trust

Northumbria Mayo Audit Tool

Date | Completed by
Trust Number
Ward

Age	
☐ 0-44	0 points
☐ 45-64	4 points
☐ 65-79	6 points
☐ 80+	8 points

Prior Living Status	
☐ In facility	0 points
☐ With others	3 points
☐ Lived alone	9 points

Disability	
☐ No significant disability[1]	0 points
☐ Slight disability[2]	3 points
☐ Moderate or greater dsability[3]	6 points

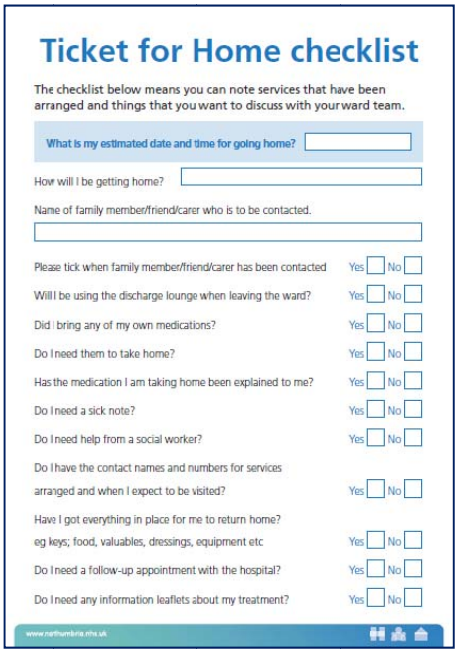
Self-Rated Walking Limitation	
☐ Yes	3 points
☐ No	0 points

Total Points

If Total Points = 15 or greater, refer to H@H

[1] Able to carry out normal activities independently
[2] Not requiring assistance bu limited in some/all of their previous activities
[3] Requiring help to any degree with personal care, mobility, communication

Ticket home
Patients are given an estimated discharge date on admission and a visual prompt of the ticket home (shown below) with supporting information leaflet outlining: when patients can expect to go home; what they will take with them; how they will get home; and who to contact if they have problems when they get home.



Nurse led discharge
The aim of nurse led discharge is to smooth out the variation in discharges across the week. Since starting nurse led discharges, the Trust has had on average two extra discharges per ward at a weekend, who would have otherwise stayed in hospital.

This process also smoothed out the discharges over the full working week, where previously very few patients were discharged at a weekend. This is now being rolled out to more wards in the Trust including some surgical wards.

Reducing LoS in surgery
All surgeons receive their performance monthly and are encouraged to adopt enhanced recovery programmes and best practice.

A redesign of pre-assessment is being implemented where;

- The Trust ensures the pre-assessment screening pathway is a safe and timely assessment
- Early pre-assessment generates a pool of patients who can fill gaps on operating lists
- Enough time is allowed for further investigations or interventions to be put in place prior to surgery
- Complex patients identified early and pre-planned to the hospital to home team
- Collaborative working between GP's, surgeons and pre-assessment

Gynaecology - Laparoscopic hysterectomy have been undertaken since 2008 and now 90% are carried out this way, 70% are now undertaken as day cases and 90% have less than a 24hr stay. The average LoS was previously 3.5 days. This approach has also halved the complication rate.

Colo-rectal - Laparoscopic surgery with enhanced recovery has led to an average 1.5 day reduction for these patients.

Orthopaedics - Hip and knee replacements are now fast track surgery with enhanced recovery programs and day zero mobilisation. Median LoS was 3.0 days , mean LoS was 3.8 in 12-13, this was nearly 2 days lower than the national average at the time.

Critical success factors

- **Consistent stable leadership** – The core executive team have all been in post over a decade.
- **Close working across the health system** - There is a shared medical director post between a GP and Consultant which provides a balance in approaching system wide issues.
- **Clear organisational and governance structure** – The Trust operates a clear semi-autonomous and accountable Clinical Business Unit model; each has a clinical lead (who is a ½ time clinician and ½ time business unit director), who is partnered with a Director or Deputy Director. They receive monthly performance data and are provided with the governance framework in which they can make decisions. In addition to the usual committees that you expect to find in any Foundation Trust there is also an integration committee chaired by a non-executive director and attended by the medical director and business unit leads. The committee has developed 18 Integration performance measures in a metric to monitor the effects of the Integration Care Plan.
- **Maintaining a focus on being the best** – The Trust maintains a focus on high quality and high performance. For example, they kept as an internal target that at least 98% of patients attending an emergency department must be seen, treated, admitted or discharged in under four hours.
- **Developing leaders** – The Trust continues to run a leadership development programme which began in 2000, for GPs, clinical acute leaders, Consultants, practice managers, trust managers and others across the health and social care system. The programme, which lasts 12 months, involves a two day residential component at the beginning and the end and then one day a month of lectures and peer support. The links made on the programme carry through the years and have fostered a growing sense of partnership working between stakeholders in the system.
- **Communicating across primary and secondary care** – The Trust has a number of approaches that enhances communication and engagement between primary and secondary care. There are regular visits from the chief executive, some directors and medical directors to practice manager groups, locality meetings of the CCG, GP federations and to both Local Medical Committees. This information about the trust performance forms the basis of a log of action plans for issues or pathways that need resolved. This also informs the agenda for the joint Clinical Leads Forum, which is where issues can be sorted. Individual practices are also visited as required where practice level referral data and any issues raised by the practices can be discussed with the GPs and practice teams. This can also inform the log of issues as above.
- **Having community and social care services under one Trust** – The Trust can identify a problem area and put in place the resources within a couple of weeks to trial and assess the new model and then roll out across the Trust (e.g. the Trust decided to put in social workers in the emergency department and it was implemented very quickly; they

also redirected community rehabilitation teams into testing the short term support care model, which was again implemented within a couple of weeks).

Challenges

There are two clear challenges identified: funding community services and organisational boundaries.

- Community services in the area had historic under-investment and based on a block contract and although there have been efficiency gains through improved service delivery there is a need to invest in community services to enable shifts of care from the acute services into the community. Hospital based services are mainly PBR based for payment and this combination does not fit well with the easily for of care being moved out of a hospital or bed based system. NHCFT have been working very closely with the local CCGs to overcome of these financial barriers and are exploring gain share and other models to deliver some of the shifts in activity.
- Organisational barriers, even within the same organisation, can create challenges to changing services. The Trust recognises this and actively challenges poor behaviours and supports development programmes that allow for cross sector engagement and integration.

Next steps

From June 2015 Northumbria Specialist Emergency Care Hospital (NSECH) will be open, which will take all the 999 ambulance and GP urgent referrals. This ‘hot’ site will have 24/7 consultant cover in the emergency department and on the acute take, backed up by specialist consultants working long days. Northumbria thinks this is the first of its kind in the UK. One of the aims of centralising emergency admissions on one site is to focus specialist resources to enable rapid decision making, which is likely to reduce Length of Stay.

A key aspect of the hospital reconfiguration was a comprehensive community engagement programme. From 2009 onwards clinicians from the hospital and local GP providers presented to over 130 community forums in a 3 month period (such as parish councils and patient groups) to actively encourage debate and discussion with the communities serviced by the hospitals. This helped to from the plans for the new hospital as well as what the existing hospitals should do in the future when the emergency cases are no longer there.

Another shift is that the Trust is the prime contractor for palliative care and working through what this could mean with the CCGs what could be done with muscular skeletal services, which it hopes will enable them to improve the efficiency and quality of these services.

Contact

Dr Derek Thomson, Medical Director
Derek.thomson@northumbria-healthcare.nhs.uk