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Academy of Medical Royal Colleges

The future is out there
Additional case studies

Rebalancing the money and measures with joint commissioning in the Royal Borough of Greenwich

The Royal Borough of Greenwich Council and ICB Directors recognised a need to redesigning their commissioning framework across their children and adults services. This was driven by the desire to achieve better value for money and outcomes for residents, operational efficiency and effectiveness demands plus a desire to improve governance and financial stability. Over a 14-month period, IMPOWER worked alongside the South East London Integrated Care Board (SEL ICB) and Royal Borough of Greenwich (RGB) leaders to co-design their integrated commissioning function.

Where these system changes impacted staff, colleagues across RBG and SEL ICB with the support from IMPOWER, managed the complexities of Local Government and NHS legislation relating to staff restructuring; including aligning the consultation process across the Council and the NHS, time period to consult and liaison with Unions – aligning different policies in the NHS to RBG.

Key Impact Statistics

- 25% increase in knowledge on best practice approaches to implementing the new framework following training.
- Designed 23 NHS and Council integrated outcomes focused job descriptions and person specifications.
- Supported HR in the ICB and the council in relation to job evaluation.
- Developed the staff consultation document and responded to staff FAQs for ICS and Council staff.
- Developed a detailed restructure implementation plan.

How the Royal Borough of Greenwich drove change

A number of focus groups were run. Sessions included a focus on co-design and co-production required to deliver the new approach, a review of 'as is' functions and 'to-be' functions and best practice examples of commissioning across the country plus the co-design of roles, responsibilities and functions.

Stemming from the work, the team developed a commissioning functions options business case for the Executive Directors in the NHS and council. The business case laid out the proposed new approach and detailed next steps to implement. Once approved, the team established a 'weekly cross organisational senior leader's programme board' which included Integrated Directors of Commissioning, Human Resources Directors and business management to oversee the next phase of work.

The team developed:

- A co-designed vision and set of principles for integrated commissioning.
- A report that assessed existing staff skills and arrangements against good integrated commissioning practice. Based on the IMPOWER Horizon 3 commissioning skills audit tool. The report identified the skills needed to deliver the vision for commissioning and how these can be developed.
- Co-designed a co-production model – the new joint commissioning approach.
- Using the team's knowledge of the current complex provider market climate in Adults and Children, develop a shared understanding of the right behaviours/culture required to deliver change, and how these can be developed.
- Delivered six targeted learning and development workshops covering a range of skills, from applying behavioural science to supporting a commissioning culture of continuing learning and development, to how to commission for outcomes and the latest legislation and the NHS Provider Selection Regime.
- The cross-functional teams now have an increased understanding of the importance of relationships and the role they play within the future of commissioning and how they can be developed. And have a better understanding on how to approach market development to ensure sustainable and high-quality provision, and how it can be delivered.

Supporting health and care professionals to deliver more home and community-based care in Lincolnshire

United Lincolnshire Hospitals Trust (ULHT), which serves a population of around 750,000 people, was experiencing ongoing issues around the implementation of national hospital discharge policy. Too many patients were spending too long in acute beds, and then being discharged to bedded care services. An initial review found a significant number of patients, with the right support, could – and should – have gone home. After an initial evaluation, the team identified targeted interventions that could bring about immediate impact and lay the foundations for a longer term shift towards community-based care delivery.

Key Impact Statistics

- £3.2m annual cost avoidance during the initial 12-month project.
- 4 additional people discharged daily from Lincoln County Hospital's medical emergency assessment unit equating to £2.3m. Based on year-on-year figures.
- 120 surgical admissions avoided at Lincoln County Hospital in December 2022 alone equating to £0.5m.
- Double of proportion patients discharged directly home rather than to inpatient wards.
- Average length of stay in winter 2022 to below summer levels.
- 1 patient per day additionally discharge from Pilgrim Hospital in Boston by introduction of midday board rounds equating to £0.4m.
- £1.1m additional annual cost avoidance identified through a range of interventions.

How Lincolnshire drove change

Working alongside staff at Lincoln County Hospital's medical emergency assessment unit and Pilgrim Hospital in Boston, IMPOWER co-produced a different approach and culture that embedded new ways of working and ultimately delivered better patient outcomes. The team adopted a 'test and learn' approach, evaluating current practices, building better and new relationships to develop interventions that could be implemented immediately.

The key to success was ensuring staff felt a sense of ownership around these new ways of working. The team embedded a strengths-based approach that focuses on what patients and their support networks can do; built leadership in the wards; empowered ward

managers to establish further new ways of working to drive improvement; and facilitated workshops for each ward and fostered a collective ambition across all wards.

- Introducing standardised multidisciplinary team board rounds where a range of practitioners come together on wards to consider the health, care and ultimately discharge support needs of each patient.
- Capturing and addressing reasons for failed patient discharges.
- Developing performance dashboards to monitor improvement.
- Introducing set times for specialists to visit wards for patient reviews and for senior medics to attend ward rounds to challenge inappropriate referrals.
- Introduced a Flow Co-ordinator role (now permanent position).

East Surrey: Implementing a new discharge operating model across an acute hospital that puts the patient at the centre of decision making.

East Surrey Hospital, part of Surrey and Sussex Healthcare NHS Trust (SASH) is one of the major acute providers in both Surrey and Sussex. Serving two systems, the hospital receives a high number of ambulance conveyances and maintaining flow is essential to ensuring patient safety.

A hospital-wide improvement programme called Let's Get You Home was set up to tackle barriers to safe and timely discharges by optimising behaviours and processes through:

- Standardised ward and board rounds; embedding national best practice, criteria to reside and SAFER standards.
- New high-quality, accessible information for patients and carers upon admission to enable them to make informed decisions about their discharge.
- Setting clear and realistic discharge dates for all patients.
- Developing a fair and consistent approach to managing patient choice.
- Allocating executive sponsors to each ward to provide additional support and rapid resolution to delays.

Key Impact Statistics

— 32% reduction in patients spending 14+ or 21+ days in hospital.

— 88% increase in discharges home (on Pathway 1) rather than to bedded care.

— 16% increase in ambulance handovers in 30 minutes (to 96%) and a 13% rise in emergency dept 4-hour performance (to 74%).

— 42% reduction in bed occupancy by those who do not meet criteria to reside.

— 44% fall in referrals to the hospital adult social care team.

How Surrey drove change

The team worked closely with frontline staff, including doctors, nurses, therapists, discharge coordinators and social workers to discharge patients in a safe and timely way with the right care and support. Alongside maximising independence, avoidable pressure and costs to health and social care have decreased.

Through trials and pilots, the hospital discharged more patients per day and increased flow through from the emergency department:

— On the Acute Medical Unit, average daily discharges out of hospital increased by 75%, (=3 people per day).

— On the older persons assessment unit, there was a 36% increase in average weekly discharges out of hospital, (=4 people per week).

A new intermediate care ward was introduced on the acute site with aligned social workers to support the reduction of patients being discharged to residential and nursing care and maximising patient independence.

An accreditation scheme was also set up to drive behaviours, setting the foundation for the Trust, and wider system, to confront future pressures with confidence and togetherness.

Demonstrating how shifting priorities, changing culture and transforming delivery delivered better outcomes that cost less in Manchester.

Creating virtual ward capacity is a critical part of NHS England's plan to increase access to urgent care, while improving outcomes, managing demand for hospital beds, and improving productivity by treating patients in their own homes. Post Covid-19 the mandate was set that all local systems had to establish condition-specific virtual ward pathways for respiratory, frailty and heart failure.

System partners in Manchester and Trafford decided to go further and make virtual ward care a core part of their urgent care offer. They supported system leaders to identify an opportunity to safely transfer acutely unwell patients out of hospital and back to their own homes which equated to 6 inpatient wards from across Manchester Foundation Trust (MFT).

Key Impact Statistics:

- 14 day reduction in length of stay for frailty patients when referred to Hospital at Home.
- 35% reduction in readmission rates for patients referred to Hospital at Home.
- 92% of patients on the service who were surveyed were extremely likely to recommend Hospital at Home to a relative or friend.
- 11% reduction in the rate of mortality for patients with advanced frailty.
- £1.1m financial benefit from supporting these patients at home when compared to inpatient care.

How Manchester drove change

Realising the huge potential of Hospital at Home required clinicians to feel confident that the service was safe and appropriate for the patients in their care. Building this confidence was complex and required strong leadership at every level of the health and care system.

The most senior leadership came from MFT's executive directors and the MFT Medical Director Group. Consistent commitment from this group set the tone for the whole organisation, and the Medical Directors championed the clinical benefits of the model of care. This really empowered the Hospital at Home teams in each hospital and community to make the model work.

The second level of leadership came from clinical champions on the ground. Frontline professionals who really believed in the model took responsibility for setting up teams. IMPOWER supported the changes with applied behavioural science and change methodologies, working alongside clinical leads in each of Manchester's three hospitals and in the three community health localities around the hospitals.

Change specialists provided on the ground support for Hospital at Home teams, working with them to overcome the practical challenges of mobilising new services as well as becoming trusted advisers, providing the encouragement to teams to successfully complete tasks. The teams co-produced a programme management structure so that teams were connected into the right support from the wider system.

Notes

In January and February 2024, IMPOWER supported the Local Care Organisation to review the impact Hospital at Home to help build a case for MFT to further invest in the service in 2024/25.

The review was conducted by doing a deep dive into the impact of the service during the period 1 September 2023 to 31 December 2023.It compared groups of patients who had been through the Hospital at Home service with patients who had been to hospital but had not been through Hospital at Home and made sure that this second group had the same characteristics and clinical indicators as the Hospital at Home patients.