Appendix A - Urgent and emergency care capacity investment funding - December 2023

<table>
<tr><th rowspan="2">Name of scheme</th><th>Impact</th></tr>
<tr><th>Overview and key highlights</th></tr>
<tr><td colspan="2">Blackpool Teaching Hospital NHS Foundation Trust</td></tr>
<tr><td>Acute Frailty Unit</td><td>Acute Frailty Unit established, and comprehensive frailty assessment model developed which incorporates assessment and short stay capability.<br><br><u>Five key performance indicators (KPIs) monitored:</u><ul><li>The unit is supporting an increase in the number of frailty patients who are experiencing a length of stay less than 1 day.</li><li>Average length of stay on the unit in November is 3.3 days, plan is 1 day.</li><li>The number of monthly admissions to the unit has seen a significant drop in November, 40 admissions, plan is 85.</li><li>The unit continues to support flow within emergency department through streaming appropriate patients which will support reduction in the risk of overcrowding in emergency department.</li><li>Significant improvements seen in the average time in the department this month.</li></ul></td></tr>
<tr><td>Ward 4 Intermediate care beds</td><td>The model is providing dedicated nurse-led leadership, with specialist knowledge in discharge pathways 1-3, to ensure that patients remain medically optimised in a non-acute bed base whilst they await their next place of care, resulting in improved patient experience for patients.<br><br><u>Two KPIs monitored:</u><ul><li>The model is supporting the reduction of length of stay for patients (from 4.6 days at month 1 to 3.2 days at month 7).</li><li>Since the model was introduced, the not meeting criteria to reside has reduced from 14.30% in month 1, and continues to improve month on month, to 11.30% in month 7, however this is still under the planned trajectory of 10%.</li></ul></td></tr>
</table>

| | |
|---|---|
| **Home First maintenance** | The scheme aims to maintain the Trust's not meeting criteria to reside percentage under 10% by improving the availability of home first slots.<br><br>Home first continues to be BTH's most utilised discharge pathway.<br><br>Four KPIs monitored:<br>• Home first triage to discharge in November is slightly above the plan of 2 days at 2.3 days.<br>• The model continues to provide over and above the planned number of Home First slots available. This is enabling more patients to be discharged home sooner.<br>• The model is demonstrating a reduction in the number of home first slots that are not utilised.<br>• The model continues to consistently achieve >95% of patients remaining at home on a home first pathway. |
| **Lancashire Teaching Hospitals** | |
| **Acute Frailty Unit** | The Acute Frailty Assessment Unit (AFAU) is the first phase in the development of an Integrated Frailty Pathway spanning Primary, Community and Acute health care. AFAU has close links to social care services and the voluntary care sector and aligns entirely with the ICP vision to provide seamless, holistic, high-quality care, closer to home care for the population.<br><br>Seven KPIs monitored:<br>• The number of planned geriatric assessments is significantly under plan in quarter 2 at 42% below plan.<br>• The average time spent in the unit has been consistently above plan of 72 hours. However, October's position of 86.7 hours is a big improvement compared to October when it was reporting 117 hours.<br>• Direct access to elderly care ward following admission to the unit is considerably under the 10% plan with October's position at 26%.<br>• Total admission to the unit is consistently under plan of 100, latest data is October is 77, 23 under plan. |

| | |
|---|---|
| | • The scheme is achieving a reduction month on month in the percentage of 30-day readmission rates.<br>• The scheme is supporting improved multidisciplinary working across the whole frailty pathway (acute -community-primary care interfaces), and includes the provision of:<br>  ○ Hot clinics for outpatient capacity,<br>  ○ Daily MDT meetings,<br>  ○ Post Discharge Frailty Support Service (PDFS) provides support and help to avoid readmission. |
| **Community healthcare hub Finney House** | 96 bedded nursing home to provide time limited intermediate care support to:<br>• Support the reduction of number of patients who no longer meet the criteria to reside in an acute setting.<br>• Provide community step down NHS health led bed-based support accessible across 7 days.<br>• All beds are open.<br>• Maintained existing placements on permanent resident floor – income offsets part cost of total service provision.<br>• Value for money: cost reduction of care by providing in an appropriate, lower acuity setting - unfunded G&A bed closure plan aligned to capacity available at Community Healthcare Hub at Finney House (Avondale, Fell View, Cath Lab and RAU de-escalated).<br><br><u>Seven KPIs monitored:</u><br>• Occupancy levels are maintained consistently at >95%, which is supporting overall flow and cost reduction of care by providing appropriate, lower acuity setting via the healthcare hub.<br>• The 21-day length of stay continues to meet planned trajectory month on month.<br>• The 7-day length of stay is variable and is under plan averaging around 11 days across all months.<br>• Achieving a high percentage of patients reporting their experience of Finney House to be ‘good or very good’ (ranging from 93% to 100% consecutively for months 4-6) |

| | |
|---|---|
| | • Reduction to number of people NMC2R in hospital - seen a significant and sustained reduction from a high of 14% (c. 120 patients) to an average of 8% (c.68 patients) from the time all beds at Finney House were open.<br>• Reduced levels of readmissions - numbers of patients readmitted within 30 days is under Trust target of 7.7%.<br>• Improvement in Ambulance Handover metrics achievement of < 30 minutes through increased G&A bed capacity, supporting admission from ED where required and maintaining space in the department to enable timely handover currently often the best performing Trust in LSC for handover. |
| **University Hospitals Morecambe Bay** | |
| **Same Day Emergency Care (SDEC) at Royal Lancaster Infirmary** | Medical SDEC open 7 days a week for patients presenting at hospital with relevant conditions so that they can be rapidly assessed, diagnosed and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided.<br><br><u>Four KPIs monitored:</u><br>• The number of new non-elective presentations seen and treated in SDEC consistently met the planned trajectory and activity has significantly increased over time.<br>• The number of new presentations to SDEC from GP referrals, NHS 111 and NWAS is increasing and has consistently been over and above the planned activity.<br>• The number of new non elective presentations of patients who convert to an admission of at least one night is consistently well below the national average of 10-15%.<br>• The number of unplanned re-presentations of patients who have been managed by the SDEC within the previous 7 days is significantly higher than the planned trajectory. |
| **Minor Treatment Centre at Royal Lancaster Infirmary** | Open 7 days a week for 12 hours per day, providing an improved environment for the provision of minor injuries and illnesses.<br>Initial plans are to stream away from Emergency Department with longer term plans to have open access to the public and other services, e.g., 111/ NWAS/ appointments.<br><br><u>Four KPIs monitored:</u><br>• The unit is consistently achieving >95% 4-hour performance. |

<table>
<tr><td></td><td>

- The service is supporting a reduction in overall ED attendance between 08:00hrs – 20:00hrs. Improvements are being seen month on month with an average of 24% of patients being streamed to the Minor Treatment Centre away from ED with an ambition to achieve a trajectory of 30% by the end of the year.
- Attendances at the Minor Treatment Centre are variable, and activity is increasing over time. The monthly average for attendances is 924 patients (the planned activity ranges from 900-930).
- The number of ED attendances streamed to the Minor Treatment Centre is consistently higher than the planned target of 25%.

</td></tr>
<tr><td>Discharge to Assess</td><td>

To review the provision of the D2A function across the UHMB footprint and reduce the service to deliver within the recurrently funded budget.

<u>Three KPIs monitored:</u>

- Discharge Pathway 1 – The monthly average number of patients discharged is 224 (against monthly trajectory of 214.5).
- Discharge Pathway 2 – The number of patients being discharged via this pathway is, on average, higher than planned monthly trajectory and activity continues to increase over time.
- Discharge Pathway 3 – The number of patients discharged via this pathway has varied by month (planned trajectory = 42) but over the last two months, has experienced a significant increase (month 6 = 88 and month 7 = 95).

</td></tr>
<tr><td colspan="2">General</td></tr>
<tr><td>Extension of 2022/23 demand and capacity schemes</td><td>This was used to extend a number of demand and capacity schemes in to quarter one of 2023/24 from last year’s winter plan.</td></tr>
<tr><td>Virtual Ward</td><td>

Funding supports the development and growth of the virtual ward service offer across Lancashire and South Cumbria.

<u>East Lancashire Hospital Trust</u><br>2 generic wards established, Hospital@Home and Remote Monitoring.<br>November capacity = 160 beds.

</td></tr>
</table>

| | |
|---|---|
| | November average utilisation = 95.4%.<br>Focus is aiming to accept a higher level of acuity to support acute/inpatient provision.<br><br><u>Blackpool Teaching Hospital</u><br>4 wards established, Acute Respiratory Infection, Frailty, Paediatric and End of Life.<br>November capacity = 88 beds.<br>November average utilisation = 29.1%.<br>Action plan is in place to increase utilisation, this varies between the pathways. Actions include:<br>• sharing case studies with clinicians for education to encourage engagement<br>• in- reaching into assessment areas for case finding<br>• focus on referral pathways to simplify<br><br><u>Lancashire Teaching Hospital and Lancashire & South Cumbria Foundation Trust</u><br>3 wards established, Acute Medicine, Frailty and Respiratory.<br>November capacity = 60 beds.<br>November average utilisation = 53.4%<br>Action plan is in place to increase utilisation focusing on Care Connexion hub as the single point of access along with a focus on discharges to prevent re-admissions.<br><br><u>University Hospitals Morecambe Bay</u><br>4 wards established, Frailty, Respiratory, Acute Medicine IV and Remote Monitoring.<br>November capacity = 73 beds.<br>November average utilisation = 35%<br>Action plan is in place to increase utilisation, particularly from remote monitoring pathways by opening up to other clinical conditions. Other actions include a focus on NWAS referrals and a campaign for earlier identification in emergency department.<br><br><u>Mersey and West Lancashire Trust and HCRG Care Group</u> |

| | |
|---|---|
| | 2 wards established: Respiratory and Palliative Care.<br>November Capacity = 19 beds.<br>November average utilisation = 15.6%<br>Action Plan is in place to increase utilisation, particularly for Respiratory beds as average usage 4.5% of 14 beds.<br>Frailty beds are expected to go live in January.<br>There has been a recent change in leadership following the newly established Mersey and West Lancashire Trust. |