Lanarkshire Operation FLOW

1. Purpose

The purpose of this paper is twofold and outlines the:

- Whole system actions required for our Firebreak to decompress and stabilise the system
- High level 4-layer rapid improvement sprint plan in response to our urgent and unscheduled care challenges

The strategic planning approach for the work has been named Operation FLOW. Language matters and consequently the use of the word FLOW within the context of this work has a clear purpose as outlined below:

- **F**ocused – a time limited intervention with exit to a sustainable service model
- **L**anarkshire– recognising the various geographies and demographics affecting our services across the County
- **O**ptimal – focusing on improvement rather than completely fixing the system during the project timescale, including learning from other systems
- **W**hole System – the project must be truly whole system covering the whole patient journey into and out of our health and social services

2. The Objectives of Operation FLOW

We know that recent years urgent and unscheduled care services across Lanarkshire have faced an unprecedented level of demand. Across the health and social care system, including acute, primary and social care, we are witnessing consistently high levels of demand. Consequently, we struggle to meet key targets and deliver the high standards of care we aspire to. Over the past few weeks the Urgent and Unscheduled care challenges have exacerbated due to significant challenges in establishing and maintaining system flow. This has had a significant negative impact of both patient safety and staff well-being.

The reason for our system's critical incident is multi-factorial and the objective of Operation FLOW is not to fix the system but is instead a project of limited duration which will allow the health and social care system to safely transition from escalation and full capacity.

Therefore, this will comprise of a set of well-defined and closely managed changes to service delivery and practice during the second half of winter and into spring 2023.

3. Stabilising our system through a Firebreak

We know that progressing improvement work across our system is exceptionally challenging when our 3 acute sites and community services continue to be in escalation and full capacity and consequently we need to attempt to stabilise and decompress our system through implementation of a "Firebreak" to allow sustained improvement work to progress at pace, following. In order

that we can offer hope and support to our frontline staff these actions need to feel different in their approach and pace.

However, we know that there isn't one specific action that will achieve this and it is further recognised that some of the action Firebreak actions are an amplification of actions and processes that are already in place.

The following 7 proposals have emerged from discussions with our whole system senior team to be mobilised across our system for a limited time period of 7 – 14 days:

- Commission a mobile MDT teams to undertake a daily review of all patients for a 7-day Firebreak to identify the criteria to reside for each patient in an Acute bed. The objective of this team is to facilitate discharge or transfer to a more appropriate location to reduce the number of additional patients across our Acute Hospitals. Work is underway led by the Site Directors working with HSCP colleagues to determine the appropriate composition and agreed roles and responsibilities of these teams.

- Commission a mobile MDT team to undertake a daily review of all patients for a 7-day Firebreak to identify the criteria to reside for each patient in an off-site bed. The objective of this team is facilitate discharge and create flow from our Acute sites. Work is underway led by the Site Directors working with HSCP colleagues to determine the appropriate composition of these teams.

- Create a Virtual ward for patients who are clinically stable but awaiting diagnostics. These patients will remain under the care of a Consultant and recorded on Trak within a virtual ward but will be able to wait at home and then attend on an ambulatory basis for their diagnostic test. This will require a co-ordinator overseeing this process and as a point of contact for patients and their carers.

- Create a team (Senior AHP/ Nurses) for the Firebreak period which supports assessment in care homes prior to conveying residents to hospital. This would include Kilsyth, Kello, Ladyhome.

- Due to the shortfall in AHP recruitment, use North and South Lanarkshire Leisure Physical Activity staff (PAS) in acute and community hospitals over the Firebreak period as they have the skills and expertise to take patients through exercises to support strength, balance, and improved posture. This approach will also free up some of the OT and Physio skilled resources to concentrate on priority patients.

- Create Treatment Room capacity for redirection of minor injuries from ED via FNC and direct from our front doors through the direction of the Firebreak.

- Increase senior clinical decision maker resource in Hospital @ Home to support more people in the community for the duration of the Firebreak period. The detail of this resource needs worked through.

4. Creating the right conditions for the Firebreak

We need to prepare the system for the Firebreak go live and consider services that need to be stood down to facilitate delivery of these intense actions. We would therefore propose that our communications outline the approach over a 2 week lead in time. The Firebreak period will be confirmed when our improvement sprint whole system actions are clearly defined and agreed **by 18 January 2023.**

The Firebreak period will require us all to work differently to decompress and stabilise our system. The key objective and measure of success of our Firebreak will be that our acute inpatient wards will transition safely from full capacity plus status.

Consequently, the need to create the right conditions are essential to success and the following actions are needed to ensure this. These include:

- Continue to stabilise community and primary care services
- Continue to embed and amplify our flow foundation work across all inpatient areas e.g robust PDD, use of discharge lounge, pre-noon discharge and standardised whiteboards
- Organisational agreement on services that can be be stood down for the Firebreak period
- Workforce and HR actions needed to facilitate re-deployment of staff
- Baseline measurement framework which includes outcome and process measures to demonstrate impact
- Secured support from data analysts, improvement staff, project support and daily senior escalation

5. Our 5 Layer Rapid Improvement Sprint

We recognise that decompression is key to stabilising our system. However rapid and sustained improvement for urgent and unscheduled care is a priority for the Lanarkshire system.

The Lanarkshire system has previously agreed the following 3 priority areas for Urgent and Unscheduled Care which are:

- Acute Front Door Model
- Redesign of Unscheduled Care and Community Urgent Care 24/7
- Discharge Without Delay

A number of key projects are therefore already underway across the key stages of the patient pathway and whilst the current pressures have made progress challenging it is essential that we prioritise the related elements of this work along with the immediate identified actions, noted below.

There are 4 specific layers of work to progress our improvement sprint outlined below:

- **Layer 1 - Supporting at Home** – service improvement actions that support people to remain in a community setting e.g telehealth, community care, pharmacy. Reablement and actions to avoid escalation. Expand the role alternative methods of care delivery including expanding the scope of Consultant Connect and Hospital @ Home, enhanced connections with Housing, Third and Voluntary Sectors
- **Layer 2 – Redirection/Triage at Front Door** – service improvement actions that direct people to away from front doors including FNC e.g. call before you convey,

scoping the concentration of staff resource at EDs to support re-direction for the 7 -14 day period (senior medical staff, pharmacy, ENP, SAS etc) Enhancement of ambulatory care models e.g OPAT, scope further opportunities for Hospital @ Home or to alternative methods of care delivery e.g Ambulatory Care

- **Layer 3 – Emergency Department Flow** – service improvement actions that revise our ED and Front door processes inc. REACT, Continuous Flow Model, Assertive Flow management, increased scheduling of minor injuries through 111 / FNC
- Review of ED processes, Implementation of REACT model across the 3 sites, Implementation of Continuous Flow Model and Assertive Flow management, Scheduling of minor injuries
- **Layer 4 – Discharging** – service improvement actions that enhance Ward Discharge Planning Processes including expanded use of the Discharge Lounge, PDD, AM Discharge, Criteria Led Discharge, Discharge to Assess across all localities, Diagnostic Virtual Wards, maximising the use of Home Assessment/Home First and Reablement as an alternative to prescriptive referrals, supporting assessment in the individual's own home and maximising rehab opportunities and independent living

Importantly, our improvement sprint process will require continued support from data analysts, improvement staff, project support and daily senior escalation along with checkpoint arrangements.

6. Adapted Governance and Agile Project Management Arrangements to support Firebreak and Improvement Sprint

Our current established whole system Urgent and Unscheduled Care Recovery structures require to be collapsed for the duration of the project. An adapted governance structure which consists of a three tier project management and implementation structure as described below:

1. Sector MDT/implementation teams meeting at UHH, UHW and UHM facilitated by Head of Planning and Development (as Project Lead) and USC Senior Service Improvement Manager. To oversee the in-sector whole system changes necessary to achieve the objective of the project.

2. Project Board meeting – meeting every Wednesday lunchtime. Review of key interventions carried from the previous improvement plan plus initiatives to bring acute out of full capacity to allow the implementation of the Lanarkshire flow model. Chaired by Director – Planning, Property and Performance. Membership to include Acute Director, Chief Officers, Executive Medical Director, Executive Nurse Director, Comms, Staff side, Head of Planning and Development as Project Lead) and others as required

3. Oversight provided by CMT – meeting each Monday. Undertake a status review based on agreed metrics and any escalated decision making required. Chaired by Board Chief Executive.

The Head of Planning and Development has agreed to provide a Project Lead function for the duration of this project. Key support will be provided by the Senior Service Improvement Manager who currently sits within the Planning and Development Team. NHS Lanarkshire currently has x 3 Service Improvement Managers (plus x 4 based in UHH until end March 2023) based and reporting operationally to within the 3 Acute sites. However, it has been agreed with the Director of Acute Services that

these posts will be centrally managed by the Senior Service Improvement Manager and work across the whole system for the duration of the project.

7. Demonstrating Impact, Managing Risk and our Communication Approach

We need to understand the impact of the actions that we take across and therefore a performance management framework which measures the impact of the Firebreak actions and Rapid improvement sprint will be developed to support Operation FLOW.

A risk management framework will also underpin this work.

Our communication across our system and to our public will be key throughout the duration of the project and the details of this will emerge as plans are finalised.

We will also need to be cognisant of the potential impact of any actions on our population from an equality and inequalities perspective and therefore appropriate assessments will be completed and updated throughout.

This will be underpinned by a series of changes to our patient management process across all elements of the patient journey as described above.

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