HEALTH AND WELLBEING BOARD: 15 SEPTEMBER 2016

REPORT OF THE LLR DISCHARGE WORKSTREAM

UPDATE ON PROGRESS OF THE DISCHARGE WORKSTREAM ACROSS LLR

Purpose of report

1. The purpose of this report is to provide a progress report of the LLR discharge workstream including the discharge summit and 8 high impact interventions for discharge.

Link to the local Health and Care System

2. Link to Better Care Together:-

Workstream	Relevance	Workstream	Relevance
Maternity, neonates, children and young people		Mental health	√
Long term conditions	√	Frail and older people	√
Urgent care	√	Planned care	√
Learning disabilities	√	End of life	√

The report applies to all patients who have an acute hospital stay and for whom discharge arrangements may be complex.

The majority of complex discharges however apply to frail older people, those with long term conditions, those with complex mental health problems, and those at the end of life.

Recommendation

3. The Health and Wellbeing Board is asked to receive the progress report which highlights a deterioration in performance in 2016/17 in terms of delayed transfers of care from hospital and the role of the discharge steering group in leading focused work to:
   - Address remaining gaps/barriers in implementing the 5 new discharge pathways for LLR;
   - Supporting additional analysis of the current performance, taking immediate remedial action to improve in year performance;
   - Providing assurance to the LLR Urgent Care Board and Chief Officers on the delivery of sustainable discharge improvements in the medium term.

Policy Framework and Previous Decisions

4. In January 2016 the Leicestershire Health and Wellbeing Board received a progress report on delayed transfers of care which introduced the eight high impact changes for reducing delayed transfers of care and new discharge pathways.

5. The report proposed that the eight high impact changes document was presented back to the Board later in 2016.

Background

6. The Health and Wellbeing Board received a paper in January 2016 regarding progress made to reduce the number of delayed transfers of care across LLR which resulted in Leicestershire achieving the required rate of improvement on delayed bed days per 100,000 population in 2015/16, making an important contribution in tackling the ongoing pressures affecting the performance of the Urgent Care System as a whole in LLR.

7. Delayed transfers of care across LLR have however increased in 2016/17. The BCF target of 236.66 days per 100,000 population for April – June 2016 (Quarter 1) has been missed, with the actual number of days being reported during Q1 as 287.04.

8. Detailed analysis has shown that the number of days delayed at UHL has risen from 778 in 2015/16 Q1 to 1,685 in 2016/17 Q1. This accounts for 36% of all days delayed in this quarter. Delays have also risen at Kettering General from 132 in 2015/16 Q1 to 497 in 2016/17 Q1. This is a further 11% of the total days delayed in this quarter.

9. UHL has seen increases in the number of days delayed due to the following reasons:-
   - public funding (all patients whose assessment is complete but transfer has been delayed due to awaiting Local Authority funding or NHS funding);
   - residential homes (all patients whose assessment is complete but transfer is delayed due to awaiting Residential home placement, because of lack of availability of a suitable place to meet their assessed care needs. This does not include patients where Local Authority funding has been agreed, but they or their family are exercising their right to choose a home);
   - nursing homes (all patients whose assessment is complete but transfer is delayed due to awaiting Nursing home placement, because of lack of availability of a suitable place to meet their assessed care needs. This does not include patients where Local Authority funding has been agreed, but they or their family are exercising their right to choose a home);
   - care package in home (all patients whose assessment is complete but transfer is delayed due to awaiting a package of care in their own home).

   The proportion of delays attributed to each organisation has not altered since 2015/16 Q1, except for delays in arranging care package in the home where 74% are attributed to the NHS in 2016/17 Q1 (e.g. the services of a district nurse, an occupational therapist or physiotherapist), compared to 58% in 2015/16 Q1.

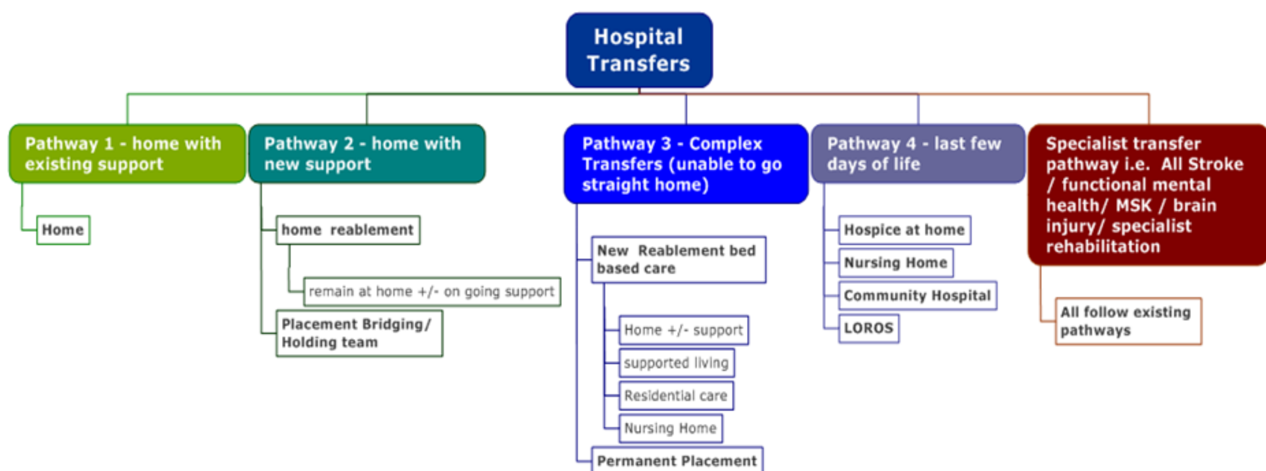
10. Kettering General has seen a large increase in days delayed due to the category ‘further non-acute NHS’ (which means further NHS care is needed in the community)

from 86 in 2015/16 Q1 to 400 in 2016/17 Q1. This type of delay can only be attributed to the NHS.

11. A further analytical piece of work is underway to examine the range of data and metrics being captured across the LLR health and care system to better align the reporting and target setting to allow for improved discussions about targeted areas for improvement.

12. The 5 new discharge pathways that were designed for LLR in 2015/ are currently in varying stages of implementation/completion. Each pathway is designed to avoid ongoing eligibility assessments taking place while the patient stays within the acute trust, instead aiming for ‘home first’ with access to a trusted assessor in the community, plus a period of reablement for up to 6 weeks. These principles aim to reduce the wait for assessments whilst in hospital, reduce the number of people who require a health and/or social care package and reduce the complexity (number of calls and level of dependence), and reduce the number of people who need a new or increased level of care in a care home.

13. The information below describes progress made towards implementing the pathways:



Pathway 1 – home with existing support
This pathway is ready to be launched. Communications messages have been agreed with UHL to support staff to restart existing care or services or to increase care packages by one call per day. Go live date to be agreed with UHL in the next 2 weeks.

Pathway 2 – home with new support
In the county this pathway is called Help to Live at Home. The procurement phase has recently been concluded with 9 new providers appointed to deliver domiciliary care and the new service is on track to be mobilised in November 2016. City CCG are actively seeking to link their services with pathway 2 and an initial discussion is planned at the end of August 2016. Discussions are also progressing with regards to Intensive Community Support which is provided by Leicestershire Partnership Trust and how it forms part of the pathway 2 offer. Communication messages about the pathway are starting to be circulated.

Pathway 3 – Complex transfers
This pathway is expected to be a replacement for the existing discharge to assess (D2A) pathway. The existing pathway is accessed and monitored by UHL. Pathway 3 is an

improved and recognisable D2A pathway with quality gains including a reablement focus in a care home, dedicated therapy resource and health and social care case managers. Initial procurement earlier in 2016 did not attract the market leading to no bids for the bed based service, however a recent market engagement event to discuss potential changes to the service specification was well attended by a range of care home providers and therapy providers, with helpful feedback given on why the initial procurement wasn't successful.

Service specifications for both the bed based service and therapy service have been amended as a result of the feedback, with a clearer definition of the the expected patient group (medically stable for transfer, able to participate in reablement, unable to initially return home). The new procurement plan will be for a total of 60 beds across LLR (as planned) but commissioned in two blocks of 10 beds rather than one block of 20 beds per CCG area.

Pathway 3 has been issued for re-procurement (16th August 2016) with a 3 month phased service mobilisation period, starting in January 2017. Planning for the mobilisation period has commenced and clarification questions have been received from potential bidders.

Pathway 4 – last few days of life
This pathway forms part of the wider end of life strategy currently being developed by the LLR End of Life team. However in the short/medium term, to achieve a robust last few days of life pathway that supports a person to die in their place of choice may require a capacity review of existing services. This pathway is due to be scoped during Autumn 2016 with progress reported back through the discharge steering group.

Pathway 5 – specialist transfer pathway
A pathway for people with severe dementia requires development. This will also commence scoping in Autumn 2016.

Trusted Assessment (formerly minimum data set – MDS)
The minimum data set project has been renamed 'trusted assessment' as it better describes the aims and process. The trusted assessment has electronically replaced several paper documents used in the assessment of patients between hospital and ongoing services in the community. It is now uploaded to UHL's "nervecentre" IT platform as an 'app' and is due to be trialled across a number of wards to ensure it works smoothly.

The aim of using the trusted assessment is to avoid multiple assessments taking place and to move towards a 'trusted assessor' principle across all of the pathways.

A stakeholder meeting was held at the end of July about this piece of work however it was clear from this that the LLR IT landscape has moved forward since the trusted assessment idea was originally conceived, so a task and finish group will now review the available solutions to make the app interoperable with other health and social care IT platforms. Links with existing prioritised IT projects (summary care records, etc) will be explored to ensure no duplication of effort. The nervecentre app can currently print to PDF, send information to another user via secure NHS email or can be accessed by a select number of hospital social care staff via virtual/remote access.

14. An LLR wide discharge summit was held in May 2016 to review what was working well and what required further improvement. The summit produced five priority areas to for partners to focus on:
    - Responsiveness and timeliness of the discharge process (UHL internal processes)
    - Staff training and support
    - Step up / step down navigation hub
    - Shared risk
    - Single assessment

The projects were reviewed at the Discharge Steering Group in June and were amalgamated where possible with existing projects eg single assessment links clearly with the trusted assessment project.

Responsiveness and timeliness of the discharge process (lead Julie Dixon) has been amalgamated with the ward workstream and SAFER care bundle work at UHL. SAFER is:

S - **Senior Review**. All patients will have a Consultant Review before midday.

A - **All patients** will have an **Expected Discharge Date** (that patients are made aware of) based on the medically suitable for discharge status agreed by clinical teams.

F - **Flow of patients** will commence at the earlier opportunity (by 10am) from assessment units to inpatient wards. Wards (that routinely have patients transferred from assessment units) are expected to 'pull' the first (and correct) patient to their ward before 10am.

E – **Early discharge, 33%** of our patients will be discharged from base inpatient wards before midday. TTO's (medication to take home) for planned discharges should be prescribed and with pharmacy by 3pm the day prior to discharge wherever possible to do so.

R – **Review**, a weekly systematic review of patients with extended lengths of stay (> 14 days) to identify the issues and actions required to facilitate discharge. This will be led by clinical leaders supported by operational managers who will help remove constraints that lead to unnecessary patient delays.

UHL are completing an interactive baseline of SAFER across the medical wards with an action plan due to be written in September which will inform future actions to ensure SAFER is embedded in practice. The ward workstream and SAFER report progress to the Discharge Steering Group.

Staff training and support (lead Helen Crossley - UHL) - a group met on 18th July to describe the scope of the project and agree membership to ensure a well rounded programme can be drawn up. The group plans to design and deliver multidisciplianry, multi organisational learning about discharge which will be a mixture of group learning and e-learning.

Step up/step down navigation hub (lead Sam Merridale/Tamsin Hooton – LLR Urgent Care Vanguard team) is being scoped and reviewed to see if it links with the vanguard clinical navigation hub or whether it's a different issue to be addressed.

Shared risk (lead Mandy Gilhespie - UHL/Claire O'Donohue – LLR Urgent Care Vanguard Team) is more about developing principles than delivering a project. It will aim to describe clear principles about clinical risk management that be embedded into other aspects of LLR work, including organisational development, training and communications messages.

Single assessment (lead Claire O'Donohue) will amalgamate with the trusted assessment project and be reported as 'trusted assessment' via the task and finish group.

15. The 8 national (Department of Health) high impact interventions for discharge were well received by the LLR Discharge Steering Group earlier in 2016 however it proved difficult to complete the self assessment tool and then identify gaps in provision, without a lead officer to drive this. The new service improvement manager in the Urgent & Emergency Care Team (Claire O'Donohue) was tasked to complete this piece of work from July 2016.

    The 8 high impact interventions are:

Change 1 : Early Discharge Planning. In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected dates of discharge to be set within 48 hours.

Change 2 : Systems to Monitor Patient Flow. Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual.

Change 3 : Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector. Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients

Change 4 : Home First/Discharge to Access. Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.

Change 5 : Seven-Day Service. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs.

Change 6 : Trusted Assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.

Change 7 : Focus on Choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.

Change 8 : Enhancing Health in Care Homes. Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.

Representatives from UHL, LPT Community Services, City Social Care, County Social Care, Rutland Social Care, Mental health and EMAS have each contributed to the self assessment document. The next steps are to present the document to the next Discharge Steering Group in September to review the gaps at a system level and then describe actions that may need to be taken.

The actions will be placed on the system wide Recovery Action Plan (RAP) for Urgent Care and link to the objectives of the new A&E delivery board of which numbers 4 & 5 are discharge related:

1.Streaming at the front door - to ambulatory and primary care
2.NHS 111 - Increasing the number of calls transferred for clinical

advice
3.Ambulances - DoD and code review pilots; HEE increasing workforce
4.Improved flow - 'must dos' that each Trust should implement to enhance patient flow
5. Discharge - mandating 'Discharge to Assess' and 'trusted assessor' type models.

Conclusion

16. The discharge steering group continues to drive forwards the system wide changes required to reduce delayed transfers of care and it provides a governance structure to support, escalate and challenge performance against the workplan. The group also oversees the implementation of the work remaining to embed the 5 new discharge pathways and identifies and resolves where needed any strategic and operational barriers to delivery?

17. The 8 national high impact interventions for reducing delayed transfers of care will be analysed for further improvements across the health and social care system

18. The new discharge pathways, along with the focused actions from the LLR discharge summit will provide a new way of working across LLR which should see a reduction in delayed transfers of care.

19. While the 5 new pathways are being implemented, and their impact fully realised further specific actions are needed to analyse and address the deterioration in delayed transfers of care performance experienced in Q1 of 2016/17

20. The new A&E delivery board will continue the focus on all parts of urgent and emergency care (including discharge).

Officer to Contact

Name and Job Title: Claire O’Donohue, Service Improvement Manager
Telephone: 01509 567756
Email: claire.o’donohue@westleicestershireccg.nhs.uk

List of Appendices

- Quarter 1 DTOC data
- 8 high impact interventions – DRAFT as due for further discussion 6th September at the Discharge Steering Group

Relevant Impact Assessments

Equality and Human Rights Implications

21. Discharge planning is a person centred approach which considers the specific needs and preferences of the patient/service user, and involves working closely with their advocates, carers, or family members. Due regard is paid to protected characteristics in assessing an individual's needs and preferences and health and care staff receive specific equality duty training. As part of discharge planning person centred information is transferred securely between agencies within the health and care system which is essential to ensure continuity in care between hospital and community settings.

Partnership Working and associated issues

22. The delivery of sustained improvements in delayed transfers of care (DTOC) remain a high priority for all partners in LLR and a joint approach is taken to delivering system improvements, reporting our position and sharing accountability for our performance as a system.

23. As highlighted in the report, joint working is currently taking place to review the metrics and measurement of DTOC across LLR and embed the 5 new system 5 discharge pathways fully within the health and care system – this work is being actively supported by all partners and will lead to stronger relationships and an improved ability to describe areas for improvement.

Risk Assessment

24. The impact of reduced DTOC performance presents risks to patient/service user experience, quality of care and places the effectiveness of the he entire system of urgent care at risk

25. The deterioration of performance on delayed transfers of care may be the subject of further escalation within NHS and LA systems, locally, regionally and nationally (linked to achievement for example of Better Care Fund metrics which are reported quarterly to NHS England)

26. Pathway 3 is subject to a successful re-procurement process based upon improved engagement of the market prior to the procurement going live. If the procurement is not successful, a review of the approach will be undertaken, including the possibility of 'assessment only' beds and 'rehab beds'.