DToC Roadshow – 18th October 2016

Summary notes

DToC position and A&E improvement plans (Simon Weldon)

- August 2016 was highest DToC on record (28% rise in no. of patients delayed in Aug compared with Aug 2015)
- For every 1 day you don't discharge the same amount as you admit, you create 1 week worth of work
- Consistent rise in delays across the country, but London seems to be one of the better areas
- Most common reasons for delays include:
    1. Awaiting further NHS non-acute care
    2. Awaiting completion of assessment
    3. Patient/family choice
    4. Social care awaiting nursing home placement
    5. Social care awaiting residential home

- Simon suggested 3 key metrics that A&E improvement plans should include:
    1. What you thought was going to happen with demand, compared to what is actually happening
    2. Hospital measure - what is your local threshold for occupancy/what is the threshold for when performance is compromised?
    3. Metrics of standards - continuing healthcare standards and how to improve them

ECIP Lessons Learnt

- Internal hospital issues and arduous processes are still very much present
- Risk aversion across system
- Discharge to assess should be at patient's residence
- Over-prescription is common

CHC Assessments

- Included a talk by CHS Healthcare, which provides a range of discharge services across 40 hospitals
- Majority of care homes beds are being taken by self-funders, making it hard for public sector to acquire beds
- Reluctance from care homes to take complex patients/pay for 1-to-1 support until patient is settled
- Care homes have workforce problems and cost cutting issues
- Care homes are cherry-picking patients/taking a prolonged period of time to assess and causing delays in the system

Other

- Delayed transfer of care plan should be included in A&E improvement plan as well as future trajectory
- Roll-out of Trusted Assessor model- Jan 2017

Breakout session feedback

Region	Comments
BHR	• Waiting assessment for CHC, no agreed solution but agreed it needs to be a priority • Patient choice • Internal trust processes • There is system buy-in but now needs to be about implementation
TH, WF (WEL)	• Need for a consistent pathway across the whole footprint • Want to strengthen the MH input into discharge planning • Be more proactive around care home thinking – interactive approach • Joined up approach to managing discharges for homeless people and those without access to public funding • Fast-tracking discharge pathway • Use community hospital in a more flexible way • Consistency in terminology
City & Hackney	• Patient choice – care homes • Assessments taking place in the wrong place (hospital) • Solutions – previously agreed as a system to come together but not really happened • Discharge to assess – need to look at step down beds • Devolution pilot area so new model in place by April
Haringey	• Health vs social care delay – health issues are specialists places and long waits for neuro-rehab • ECIP in local trust and therefore a number of groups e.g. OOH group – meets weekly, matrix working • PDSAs for CHC • CCG has funded CHC nurses to work across the hospital and community
Camden and Islington	• Patients going into long term care which is premature and not really best place • D2A – Islington has a plan and Camden is just about to start thinking about it. Ditto for Trusted Assessor • STP – issues around consistency • Barriers – different systems can be a huge barrier • Support will always be welcomed but not sure what is needed right now
Brent, Harrow & Hillingdon	• Challenging behaviour is an issue • Hillingdon already has a plan, Brent also with integrated beds for step-down • Specialist care provision to meet high level of patients they struggle to place • Solutions – discharge and choice policy (pivotal to family delays), trusted assessor, step down beds – working towards a pilot for D2A • Need to have a cultural shift away from bedded area • STP level – Enfield – is there something about units being developed? Workforce and market management of care homes – how do we get the workforce to be vibrant? There is a BCF scheme around market management, need to get this to scale • There is some support required but still not totally sure – struggling to push work over the line (they have consensus but need some technical support)

Ealing	• Locating care homes is an issue and the fees they charge • CHC assessments in hospitals and then funding • Family disputes with the choice policy • Packages of care – double up calls • Unrealistic discharge destinations • Solutions – having conversations with CCG, social workers going to A&E to prevent admissions, also looking at D2A model, extra care & beds where available
Tri-borough	• Key issue is overnight care and commissioning a dedicated night service • Some work to be done on re-working capacity to support a D2A approach • Long term care – specialist nurse • Solutions – look at commissioning night provision to complement step-up/ down bed work; D2A model – dedicated support for social worker • Having a workshop on Thursday to operationalise plan, all part of STP • Support – leadership support to ensure they have right incentives in the systems to change and transform and develop and drive the right behaviours
Hounslow	• How existing schemes have changed the case mix of patients coming into hospital – patients with challenging behaviour and complex needs • Don't have a formalised D2A model at the moment but a plan is being developed
Bexley, **Greenwich & Lewisham**	• Issues around accuracy of information which can lead to miscommunication and unnecessary escalation • Playing the blame game – hospital quick to blame others • Care Act? What Care Act? • Issues around capacity • Solutions – plans for D2A schemes • Not a wide understanding of the STP and what's in it – more communication needed at ground level • More alliance commissioning needed and joint market development • Managed market requires long-term solutions • Services not in place in the community for dementia and falls • Seem to be moving away from outcome measures • Staff need to feel more valued • Support – some already working with leadership team from Local A&E DB, but need a long term solution for workforce • High vacancy rates in Trusts mean messages are not getting through to staff • Would appreciate support re long-term workforce strategy for health and social care, focusing on development and sustainability - apprenticeships/local colleges
Bromley, Lambeth, Southwark	• Have got some neuro-navigators in the hospital and a patient choice policy • Management of nursing care market limits what can be done/ level of influence • Using "Best Practice in Discharge Protocol" by acute trusts
Sutton	• Lack of capacity • No choice policy • Massive gap in managing challenging behaviour • Various discharges schemes in place but could do something better together around D2A model

Croydon	• Financial special measures across CCG and Trust is an issue • Mental health is an issue • Croydon going through a project • New urgent care solution coming in just after winter • Looking at integrated care models • D2A is an aspiration • Awaiting ECIP report • SWL has done a bit on beds and OOH – more needs to be done
Wandsworth & Merton	• Patients of no fixed abode are a problem • Choice – leads to duplication – reablement will turn up to find they are an EoL patient • Looking at the possibility of joint commissioning community care beds • Co-locating some health services with LA community services to support them working better together – hospital referrals can be looked at in an integrated way • Communication could be better – NHSE should communicate the need to do this better • Always grateful for support but not sure yet how it could be utilised
Kingston & Richmond	• Lack of specialist provision • Systems and too many hand-offs • Need to think about better IT systems • What are we doing London-wide to support better IT on a STP footprint? – HLP?

Question to DB Chairs

Where are the plans and what are they doing to increase communications across Local A&E Delivery Boards?