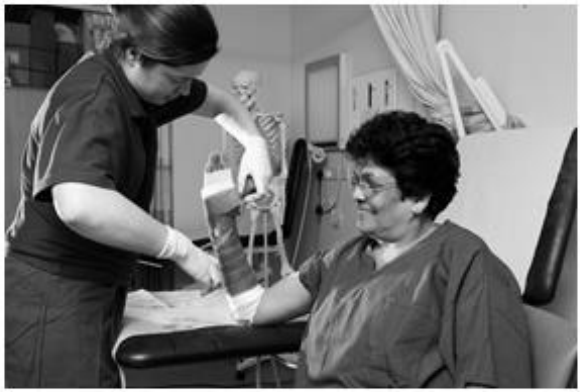
Emergency Care Improvement Programme

Safer, faster, better care for patients

NHS Improvement

Discharge 2 Assess



What is D2A?

D2A is primarily about patients having their needs assessed in their usual place of residence, or own home, as soon as they are medically optimised and safe to leave hospital. It's about not making a patient wait unnecessarily for assessment and support that should be able to be provided out of hospital.

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Drivers for Change…

- A&E Plan 16/17
- 5 Year Forward View
- Safer, Faster, Better

It is essential that everyone across the system recognise that poor patient flow leads to a reduction in high-quality care and a way to improve flow is to ensure effective and timely discharge facilitation. Poor patient flow (resulting in crowded Emergency Departments (ED) and high bed occupancy) adversely impacts patient outcomes

- For patients who are seen and discharged from ED, the longer they have waited to be seen, the higher the chance they will die during the following 7 days
- 10 days in hospital leads to the equivalent of 10 years ageing in the muscles for people over the age of 80
- Once a hospital is over 90% bed occupancy it reaches a tipping point in its resilience
- Lowering levels of bed occupancy is associated with a reduction in hospital mortality and improved performance on the 4-hour target.

What a D2A model should look like?

•Assessment within an environment familiar to the patient. The patient's immediate and longer term needs can be more appropriately evaluated in their own home

•Assessment of the issues which may have precipitated the acute admission and anticipatory plans put in place while the patient was still able to be at home

•Removal of steps, processes and delays in the discharge process which consume valuable resources and do not add value for the patient

It should deliver:

•A reduction in length of stay

•A reduction in the risk associated with vulnerable patients remaining in a hospital environment and deconditioning

•Increased discharge rates on the wards

•Freeing up of hospital beds reducing medical outliers

•Increased patient flow through the hospital

•Impact upon other national performance metrics

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Quotes that have made an impact

Understand and successfully operate the existing business – Alignment (Ian Sturgess)

Home First Principle (Ian Sturgess)

No patient should ever enter hospital and never return to see their home ever again (Liz Sergeant)

Need to remove barriers and perverse incentives created by contracts and organisational boundaries via planning and working collaboratively (Ian Sturgess)

Medway's

Home First

Setting the Scene

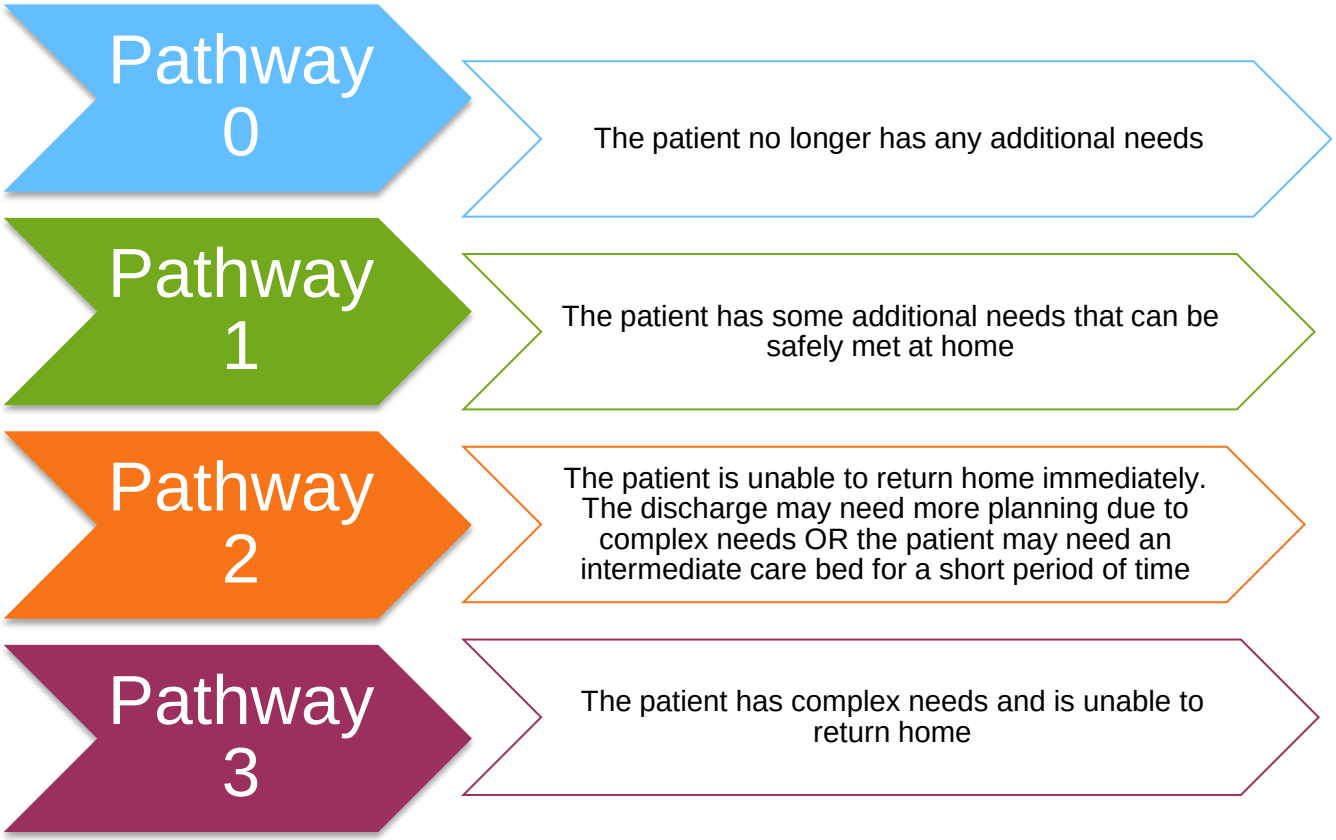
- Acute trust in special measures
- Focus on three areas of improvement
- Discharge to Assess pilot - September 2015
- Other models explored
- Procrastination…and then

8 WEEKS

- Designated Lead
- Pathways

Practicalities

- Pathways – The Medway model designed four pathways to get people out of the hospital quicker:



Pathways

Who has responsibility for which pathway?

Pathway 0	Pathway 1	Pathway 2	Pathway 3
• Ward coordinates discharge	• Ward calls SPA • Community responds	• Ward contacts IDT • IDT coordinate	• Ward contacts IDT • IDT coordinate

- Designated Lead
- Pathways
- Single Point of Access (SPA)
- Staffing
- Enablement agency support
- Board rounds
- Equipment provision
- Transport
- Wrap around support
- Contingency and escalation plans
- Comms
- Branding

A Phased Approach

- Existing teams already providing multiple elements of intermediate care services – not joined up - confusing
- Home First implementation April 2016
- Intermediate care tender awarded July 2016
- Mobilisation in October 2016 – care agency utilisation
- December 2016 - double running
- February 2017 in-house reablement provision up scaled

- Future plans – admission avoidance pathways to mirror Home First
- Reduce the community bed base and transfer more resource in to the community

Medway Stats

- 8 weeks to design and implement D2A – across the whole hospital
- Over 1000 discharges onto pathway 1 from April to November
- DTOC's reduced by ¾ from over 120 patients to 40 by July
- Wards and community hospital/ intermediate care units in the system reporting empty beds because of improved flow and more people leaving under pathway 1 – this was at the same time the community hospital was relocated and a subsequent reduction in beds across the whole system
- Nearly half of the patients on pathway 1 did not need a care package/ reablement programme
- 76% of those that did receive reablement did not go on to need long term social care

Recap of Key Points

- Sign up to a whole system pledge and promise
- Keep it simple! Especially for the wards
- What does the community have to offer?
- Agree pathways
- Stop labelling patients and trying to fit them into neat little boxes
- Have an escalation/ back up plan for all parts of the process
- Expect and plan to constantly tweak and review various parts of the process – PDSA….but always keep the core pathways the same – remember what happens behind the scenes the wards do not need to know
- Recognise and accept that it wont be perfect but it will be' good enough' whilst you work together to get there!