Department of Health & Social Care

Ministry of Housing, Communities & Local Government

NHS

Integration and Better Care Fund

Local Government Association

directors of adass adult social services

National Delayed Discharge Reduction Network Workshop

england.dtoc@nhs.net

#DTOCworkshop

Wednesday 24 October

Overview of the day

- Introduce the Delayed Discharge Reduction Network and the work we are doing
- Look into our key priorities outlined in the DTOC Reduction Plan
- Allow greater in-depth discussion on specific aspects of hospital discharge to identify barriers to change, share good practice and identify key system challenges
- Agree potential future national activity to support system improvements
- Forge new relationships and networks for the purpose of improvement

Introductions

- What is your name?
- Where do you work?
- What do you want to take away from today?

National Delayed Discharge Reduction Programme

Victoria Bennett

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

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Welcome, introduction to the Network and what we are trying to achieve

Victoria Bennett

The Delayed Discharge Reduction Network

Joined-up working across all sectors was one of the key recommendations from the CQC's Beyond Barriers report (2018):

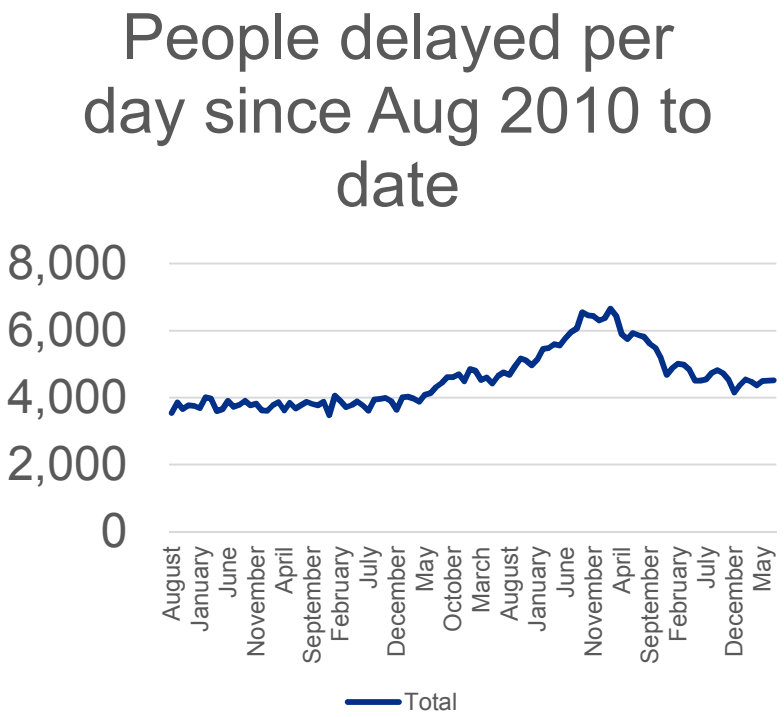
"*to prevent delayed transfers of care…involves all professionals working towards **a culture** that:*

- *focuses on getting the person home as soon as they are ready;*
- *where it is unacceptable for people to be in beds longer than they need to be."*

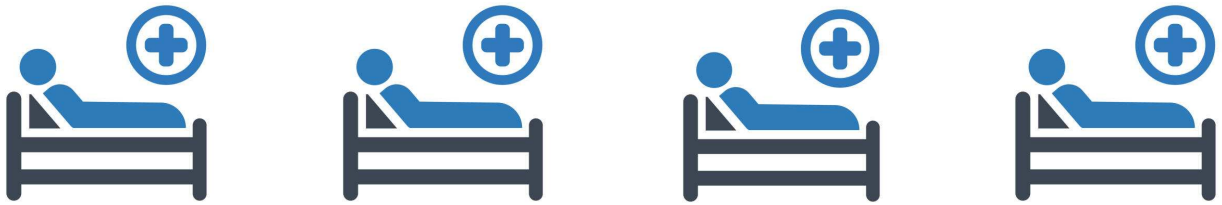
The NHS Long Term Plan summarises why this is so important:

"…reducing risk of harm to patients from physical and cognitive deconditioning complications."

- February 2017 – on average, 6660 people every day were in a hospital bed who did not need to be there because their discharge was delayed.
- New ambition created – reduce to 4,000 people delayed per day



How to we measure delays?



We measure the delayed days. This is the number of days a person is delayed for in a month.

There may be days when a person is no longer a delay e.g. is no longer medically fit for discharge

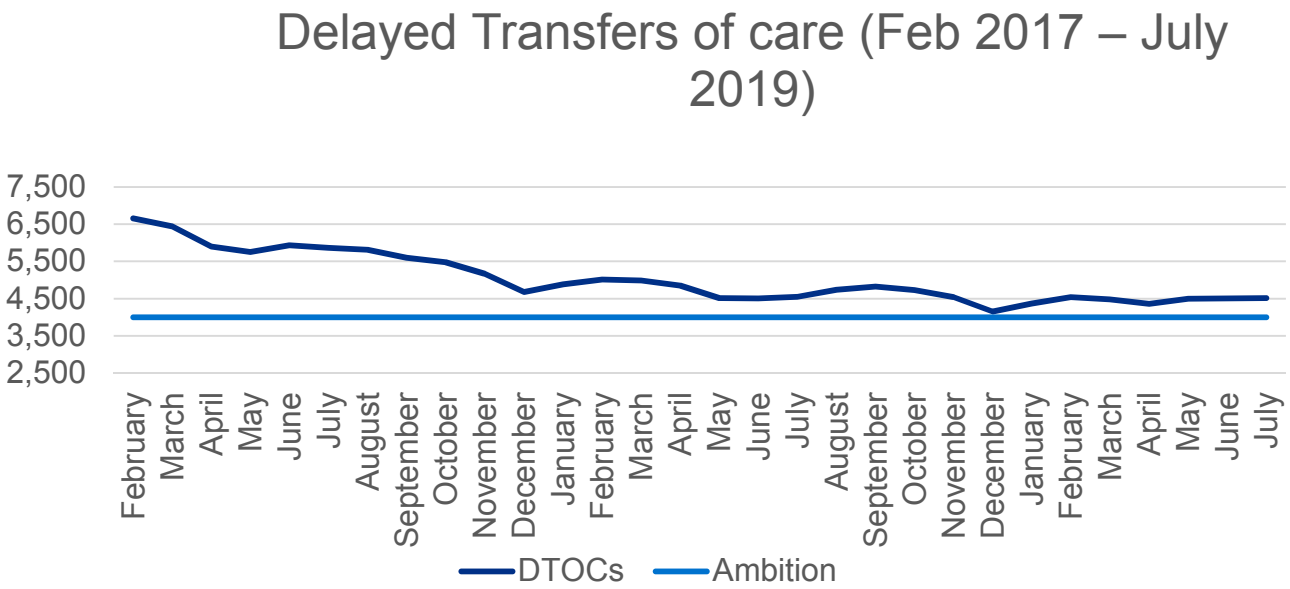
We measure the reason for delay – there are 10 reason codes. e.g. awaiting package of care at home

We measure the average number of people delayed per day by:

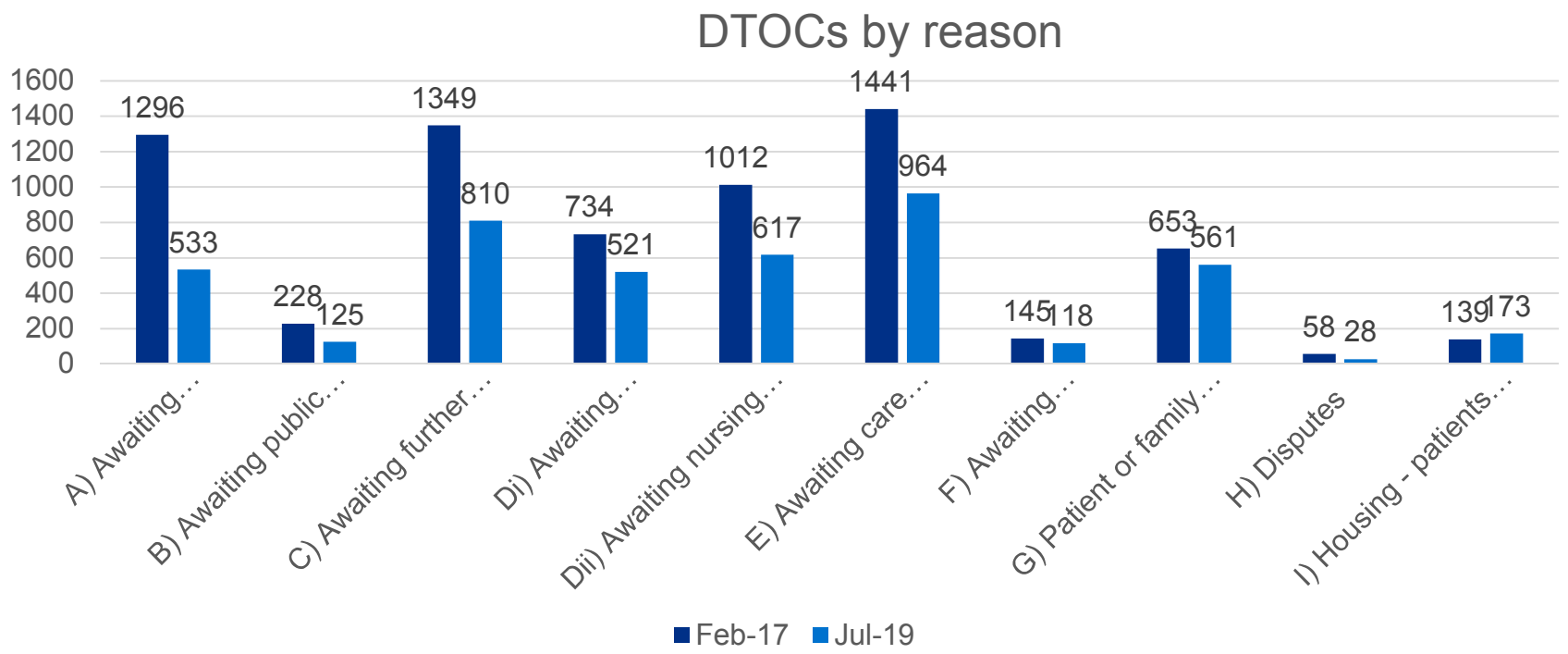
$$\frac{\text{No. delayed days}}{\text{Calendar days}}$$

The data can also be split by type (acute or non-acute), sector responsible (NHS, Social Care, Joint), Trust, Local Authority, Health & Wellbeing Board.

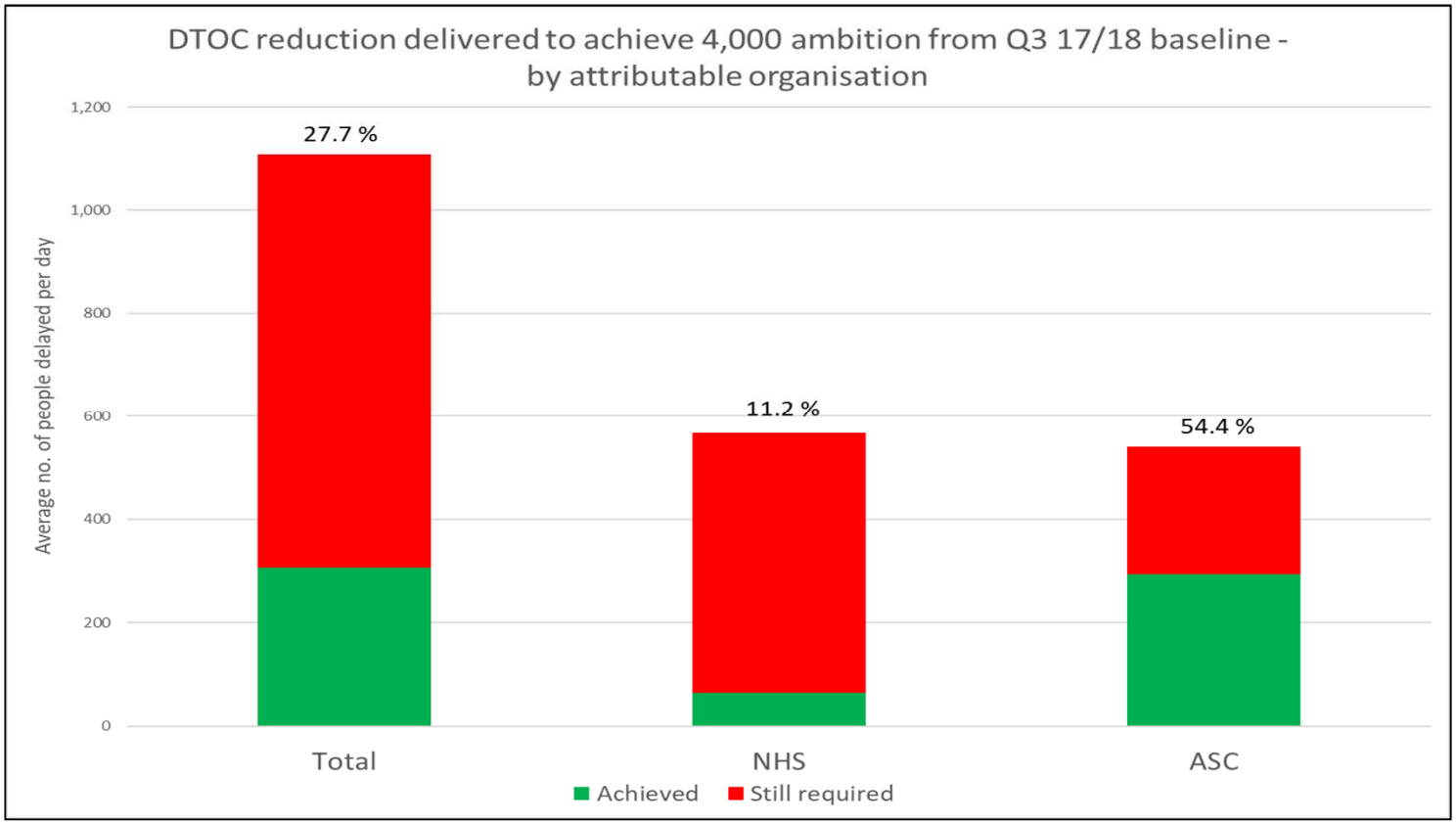
Progress to date

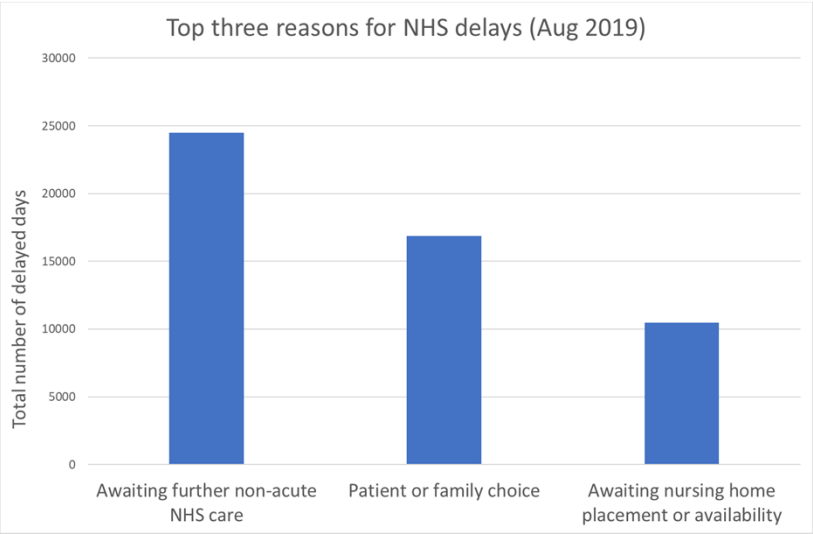


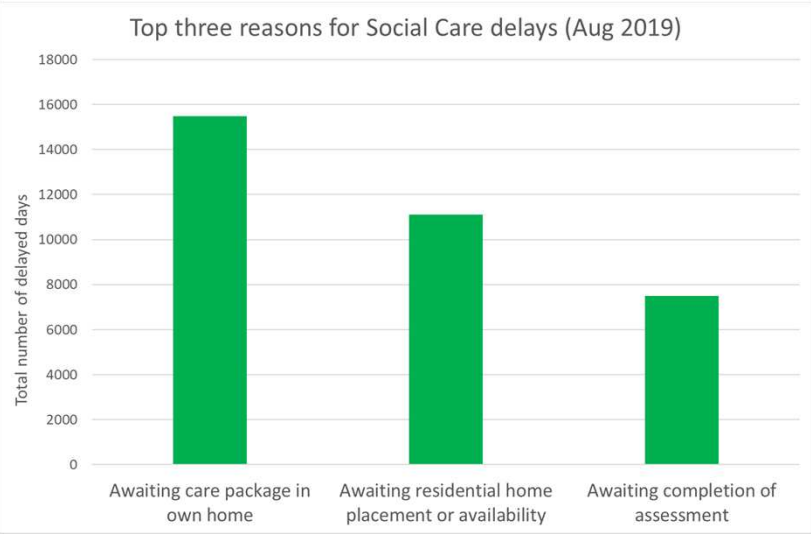
Improvement in delays by reason



Current Delays (August 2019)







Current Delays (Aug 2019) by reason

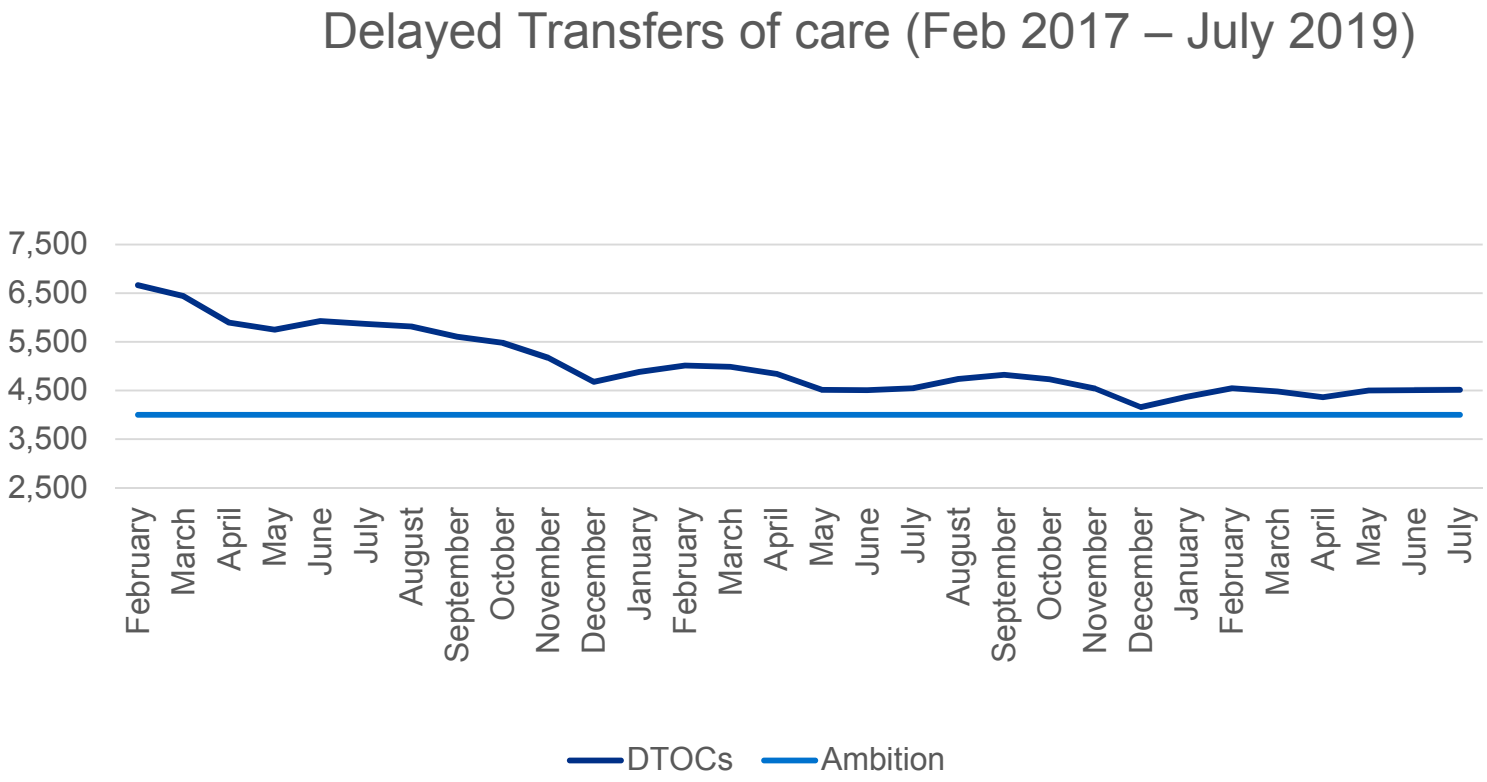
Current ambition - NHS Long Term Plan

The NHS and social care will continue to improve performance at getting people home without unnecessary delay when they are ready to leave hospital…The goal over the next two years is to achieve and maintain an average Delayed Transfer of Care (DTOC) figure of 4,000 or fewer delays, and over the next five years to reduce them further.

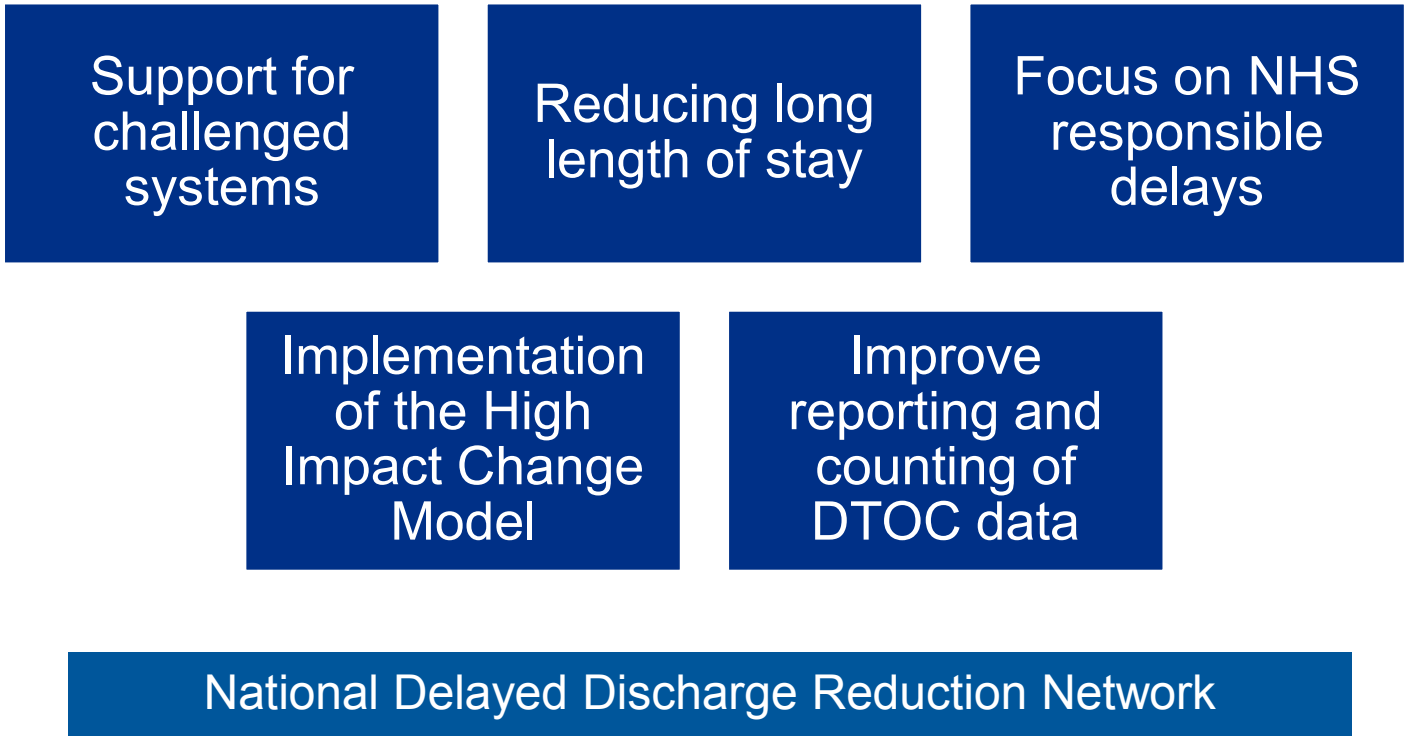
Achieve 4,000 people delayed per day by March 2020

Maintain throughout 2020/21

Decrease in delays from Feb 2017



National Discharge Reduction Plan



Support for challenged systems

Peer reviews

- 4 day, 1 day and ½ day peer reviews
- Funded through Better Care Fund – LGA commissioned to lead this work;
- 4 areas supported with 4 day reviews so far in 19/20;
- Further bespoke support being worked up now that BCF funding confirmed.

Better Care Fund

- Webinar and 2 events on Newton Europe work on discharge, working with the British Red Cross;
- EXPO event on delayed discharge;
- New case studies on Better Care Exchange to share learning.

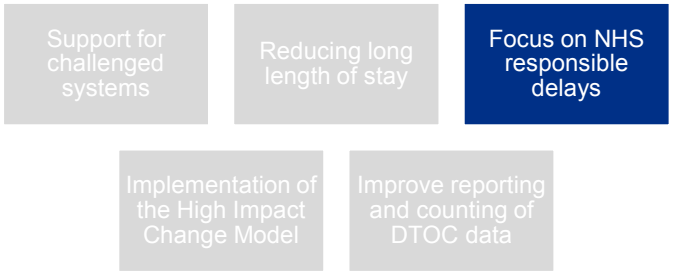
Long Length of Stay Programme

- Circa 60 areas are receiving consultancy or intensive support each month from ECIST;
- Multi-Agency Discharge Events (MADE) also delivered.

More information available at 11:45 - Fiona Russell (LGA)

Reducing long length of stay

Long Length of Stay Programme	**Work to date**
• NHS LTP ambition – reduce by 40% the number of people in hospital with LoS 21 days or more; • Focussed on internal delays.	• ECIST support to challenged Trusts; • Implementation of the Discharge Patient Tracking List (DPTL); • Comms package for staff
Work in progress • A virtual learning network being established; • Regional LOS workshops being delivered; • High impact changes tool pilot; • Work so far has shown that where LLOS has decreased a corresponding decrease in DTOC has also been seen.	
More information available at 12:00 – Liz Sargeant (ECIST, NHSE/I)	



Focus on NHS responsible delays

Ageing Well Programme

- NHS LTP ambition of 2 day average for referral to receipt of reablement / intermediate care services;
- Delivered through expansion of community MDTs within Primary Care Networks (PCNs).

Quick Guide updates / relaunches

- Led by the Network;
- Revision of the Quick Guide: Supporting patient choices to avoid long hospital stays.
- Project group to be established.

Community Capacity Framework

- Led by the Network;
- Today's event begins the work;
- Project group to be established;
- Outputs piloted with one STP before further roll-out

More information available at 13:30 – Sarah Ramjeet

Support for challenged systems | Reducing long length of stay | Focus on NHS responsible delays

Implementation of the High Impact Change Model | Improve reporting and counting of DTOC data

Implementation of the High Impact Change Model

Better Care Fund • HWBs report level of maturity against the 8 high impact changes; • Recovery plan and support for any element 'not yet established'.	**Quick Guide updates / relaunches** • Led by the Network; • Revision of the Quick Guide: Discharge to Assess • Project group to be established.
High Impact Change Model (HICM) refresh • High Impact Change Model (HICM) has been revised following extensive cross-sector consultation; • Soft launch due November 2019; • BCF reporting from April 2020.	
More information available at 11:45 – Fiona Russell (LGA)	

Support for challenged systems | Reducing long length of stay | Focus on NHS responsible delays | Implementation of the High Impact Change Model | **Improve reporting and counting of DTOC data**

Improve reporting and counting of DTOC data

Revised technical (counting) guidance	**Masterclasses**
• 'Why not home, why not today?' published in Nov 2018; • Further update currently being drafted – learning from masterclasses	• Series of masterclasses delivered (in 8 of 9 areas – BCF funded) and over 650 delegates attended, uncovering both under- and over-counting in certain areas. Not significant at a national level.

Further work

- Aim is to train 'Counting Experts' in every STP area as a minimum, but aiming for one per HWB area;
- Policy guidance to be developed for mental health and learning disability delays (aligning with revised reason codes reported through MHSDS).

More information available at 12:00 – Liz Sargeant (ECIST, NHSE/I)

Agenda for today

Agenda

Time	Item	Lead
1000	Registration, refreshments and Networking	All
1030	Housekeeping	Tom Luckraft
1035	Table introductions	All
1045	Background/context of the network and what we are trying to achieve	Victoria Bennett
1100	Lived experience	Jane Lord
1115	Tea break	
1130	Right care, right time, right place – learning from Newton system support	Stuart Macleod
1145	Support offer for DTOC improvement	Fiona Russell
1200	Reducing Long Length of Stay	Liz Sargeant
1215	Panel Q&A	All
1245	Lunch and Networking	
1330	Ageing Well – enhancing primary and community care capacity	Sarah Ramjeet
1345	Breakout session 1	All
1430	Tea break	
1445	Breakout session 2	All
1530	Plenary discussion / next steps	All
1600	Workshop Close	

Email: England.dtoc@nhs.net

Right Care, Right Time, Right Place – Learning from Newton System Support

Stuart Macleod

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

Local Government Association

NHS England

RIGHT PLACE, RIGHT TIME, RIGHT CARE FOR PEOPLE

October 2019

Integration and Better Care Fund

WELCOME AND INTRODUCTIONS

Stuart Macleod

Senior Support Lead

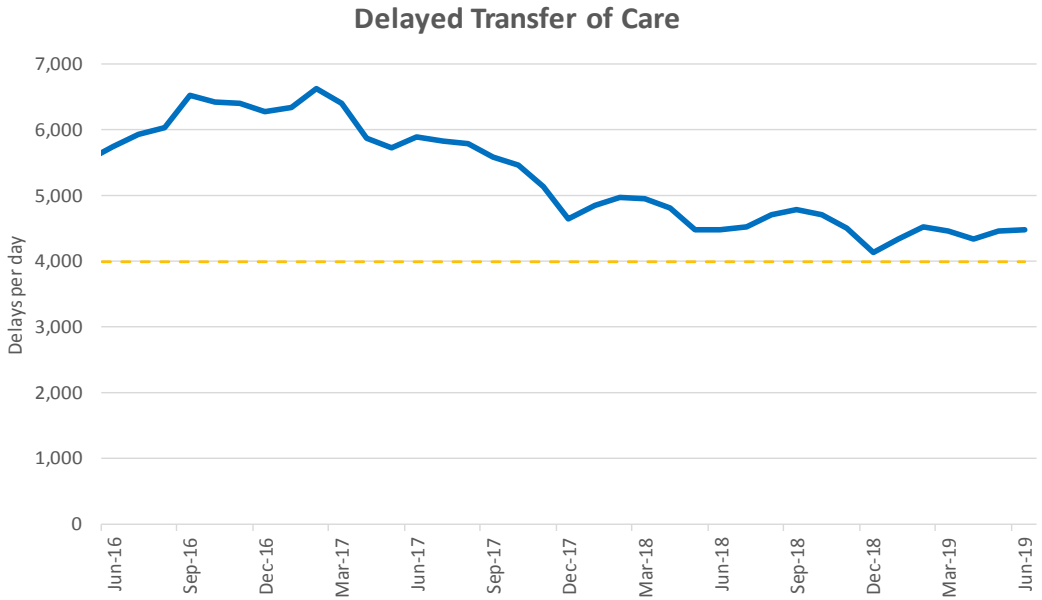
Better Care Support Team

Integration and Better Care Fund

WHAT IS COVERED IN THIS SESSION

1. Why did we commission this support
2. What the support looked like.
3. Key findings
4. What else this support tells us

IMPACT ON DELAYED TRANSFERS OF CARE



Following an increase nationally in delayed transfers of care, centrally set local expectations were introduced as part of BCF plans in 2017-19. Delayed transfers of care across England have reduced steadily by **33%** in the period between February 2017 - June 2019.

The National Audit Office's report highlights the BCF in terms of having **'considerable success' in tackling the issue of 'treating older patients who no longer need to be in acute hospital'**

PEOPLE FIRST, MANAGE WHAT MATTERS: SCOPE AND SCALE

A national programme of support was undertaken in 2018 to work with 14 local systems to focus on discharges from hospital.

Local improvement teams and leaders from both health and social care worked with Newton to look closely at:

- the scale of the challenge in each system
- the processes behind the biggest challenges
- how discharge decisions were being made
- whether people were being discharged to the best possible place
- whether the flow through the hospital was efficient and person centred
- the role that leaders in the system perform.

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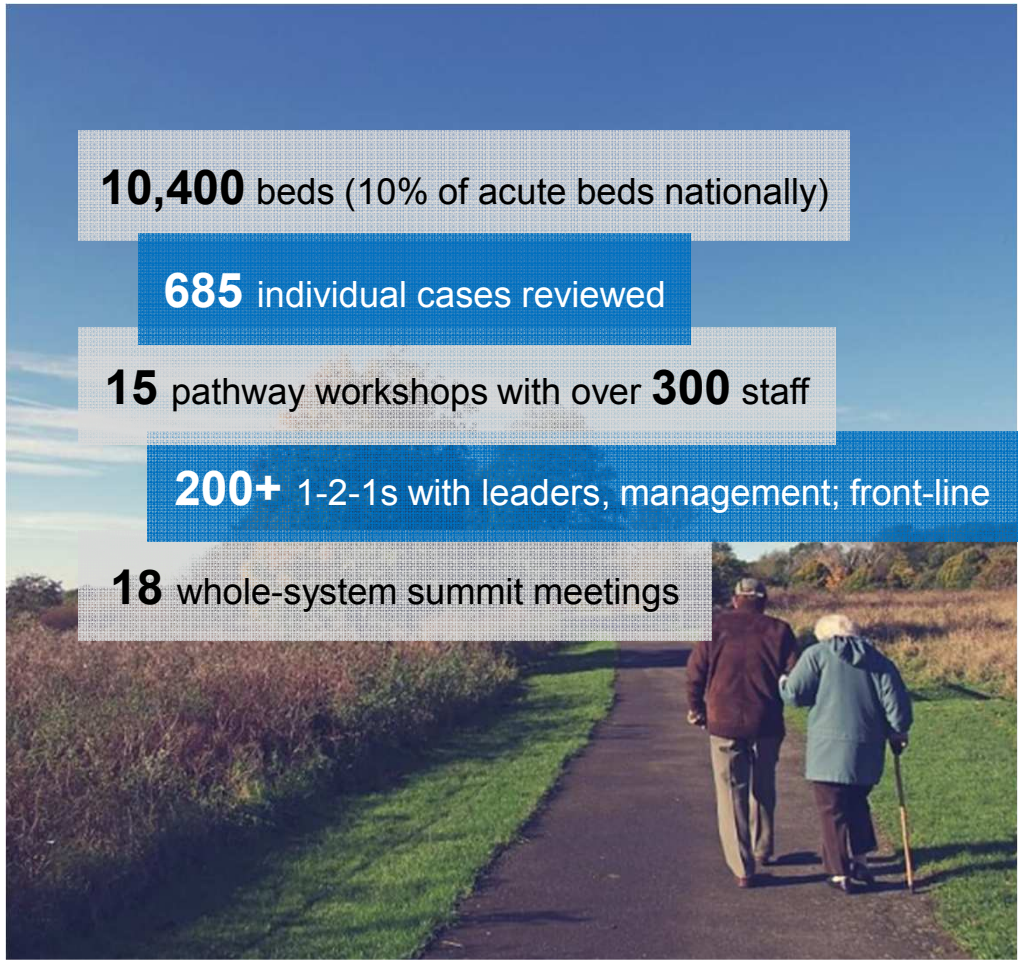

SUPPORT OFFER

This programme of support consisted of a four stage approach:

1. Engagement
2. Diagnosis
3. Implementation setup
4. Design of implementation, transition and plan for sustainability

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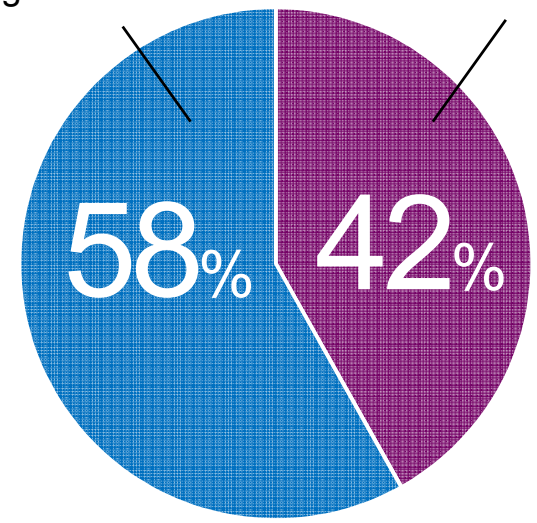
ARE PEOPLE DISCHARGED TO THE MOST APPROPRIATE PLACES?

Multi-disciplinary teams retrospectively reviewed their own cases.

People **discharged to the best possible place** given their needs.

People **not discharged to the best possible place**, given their needs.



92% of the 42% were discharged with a **level of care in excess of their needs.**

What **top three reasons** were given for this happening?

24%

Real, or perceived, lack of capacity in service

17%

Risk averse decision

12 %

Family disagreement

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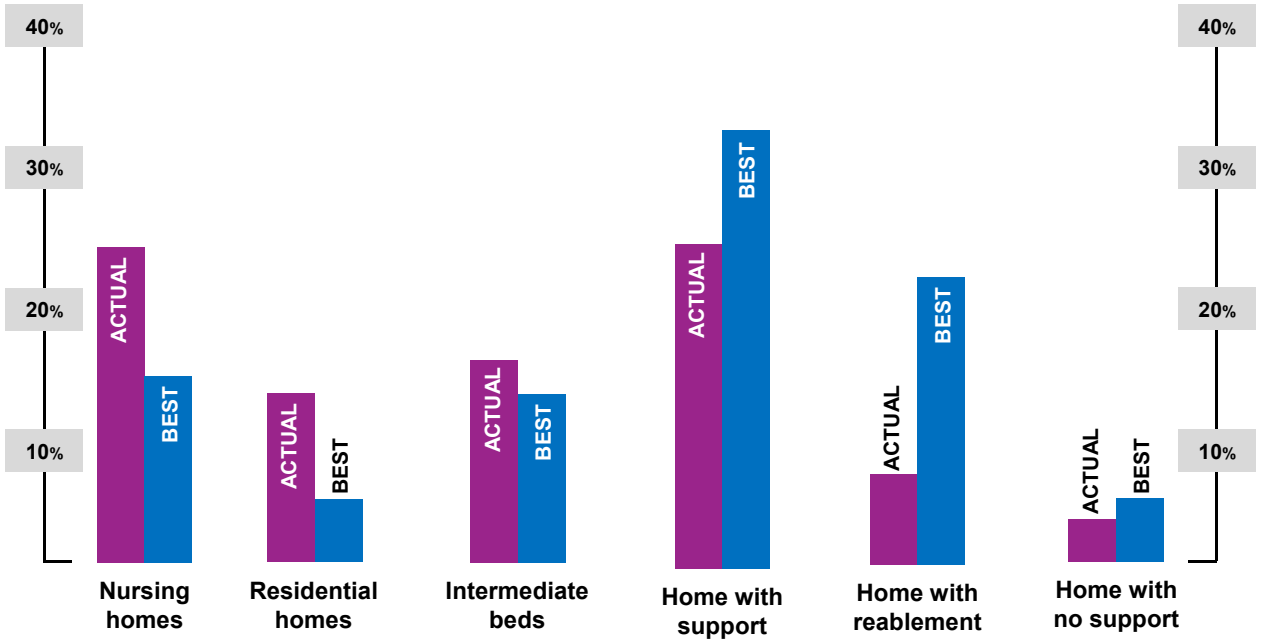
SOURCE: Newton 685 cases reviewed in 15 workshops with 300 multi-disciplinary staff in 14 acute trusts and 9 local authorities; April-July 2018.

WHERE ARE PEOPLE BEING DISCHARGED TO VERSUS WHERE'S BEST FOR THEM?

1. Nursing and residential home placements could reduce by almost half.
2. Going straight home with some support could increase by almost a third.
3. Going home with reablement could increase almost threefold.



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SOURCE: Newton 685 cases reviewed in 15 workshops with 300 multi-disciplinary staff in 14 acute trusts and 9 local authorities; April-July 2018.
The three summary points are based on the sample reviewed in this work.

REASONS FOR DELAYS

Across the 14 systems, on average, **27%** of patients had been declared medically fit for discharge, but were still in hospital. Of these:

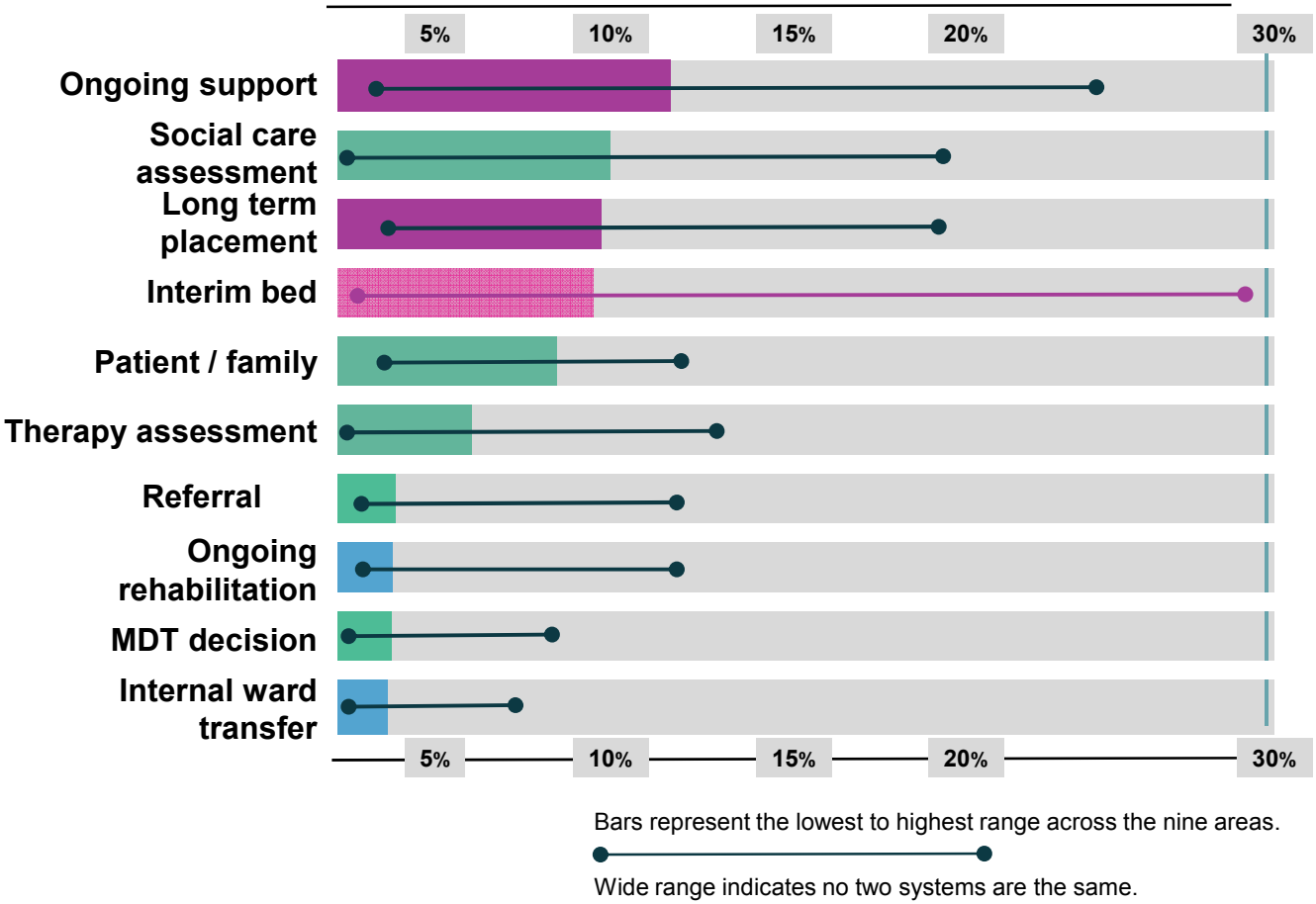
37% were waiting for an ongoing service

37% were waiting for a decision about their ongoing care

Reasons:

- 37% ongoing service
- 37% decision about ongoing care
- 26% other

Across all 14 systems areas, what were people waiting for?



Bars represent the lowest to highest range across the nine areas.

Wide range indicates no two systems are the same.

WHAT CAN YOU TAKE FROM THIS WORK?

1 NOT ACHIEVING THE BEST OUTCOMES FOR PEOPLE INCREASES DELAYS AND SPEND

1. Measure the quality of discharge decisions, not just delays.
2. Work on changing decision making practice in hospital, at the same time as improving the effectiveness and capacity of home based reablement services.

2 WHAT GETS MEASURED GETS MANAGED

1. Achieve clarity on the operational issues behind delays, as this is crucial to managing them.
2. Agree with all partners on what to measure and how, so the whole system can get behind the same issues.

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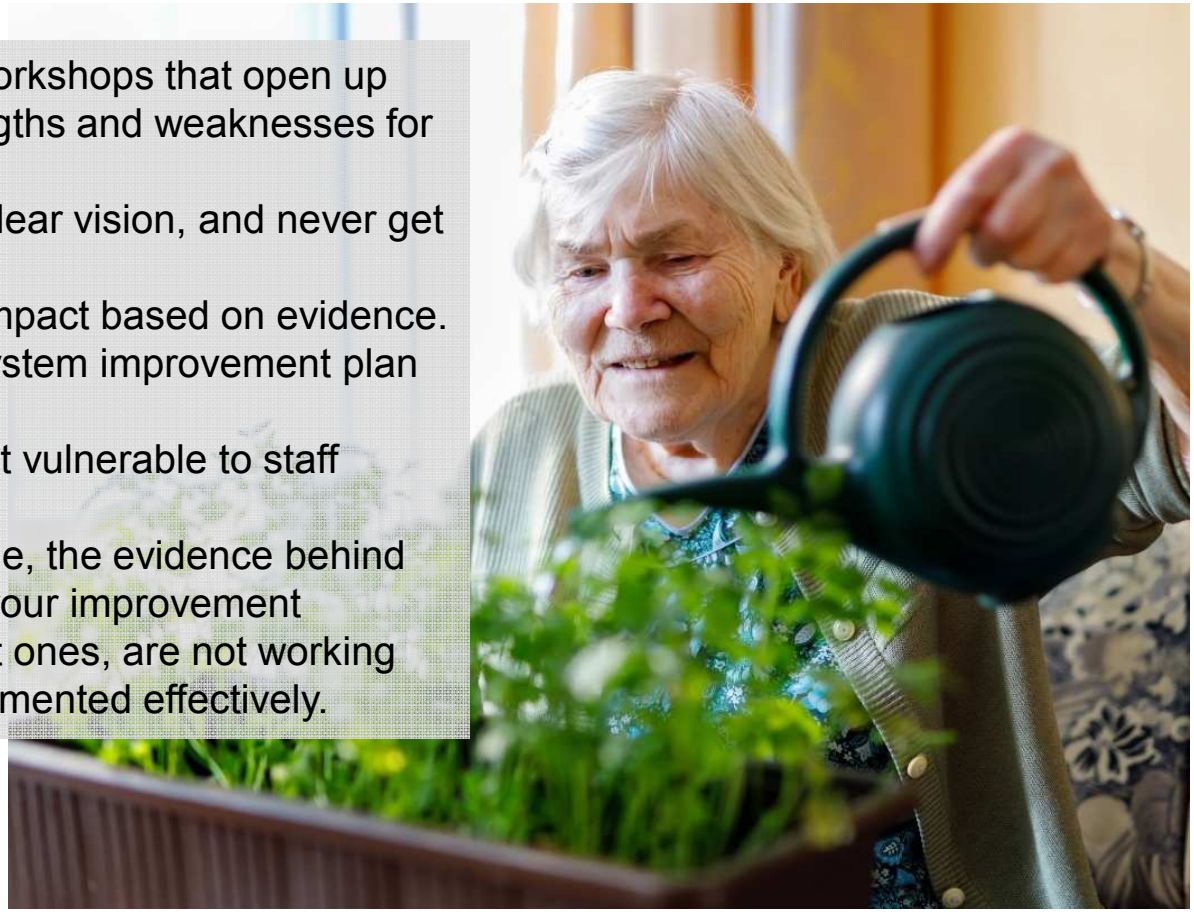
WHAT ELSE DID THE WORK TELL US?

During the work, a number of practical actions were identified. It will be important to consider these in the context of your system.

- Set-up cross-system leadership workshops that open up honest dialogue and identify strengths and weaknesses for your group.
- No matter how obvious, define a clear vision, and never get tired of sharing it.
- Prioritise issues with the biggest impact based on evidence.
- Work towards agreeing a whole system improvement plan and be prepared to stick to it.
- Ensure your strategic plans are not vulnerable to staff changes.
- Acknowledge that if after some time, the evidence behind your delays remains unchanged, your improvement programmes might not be the right ones, are not working fast enough or are not being implemented effectively.



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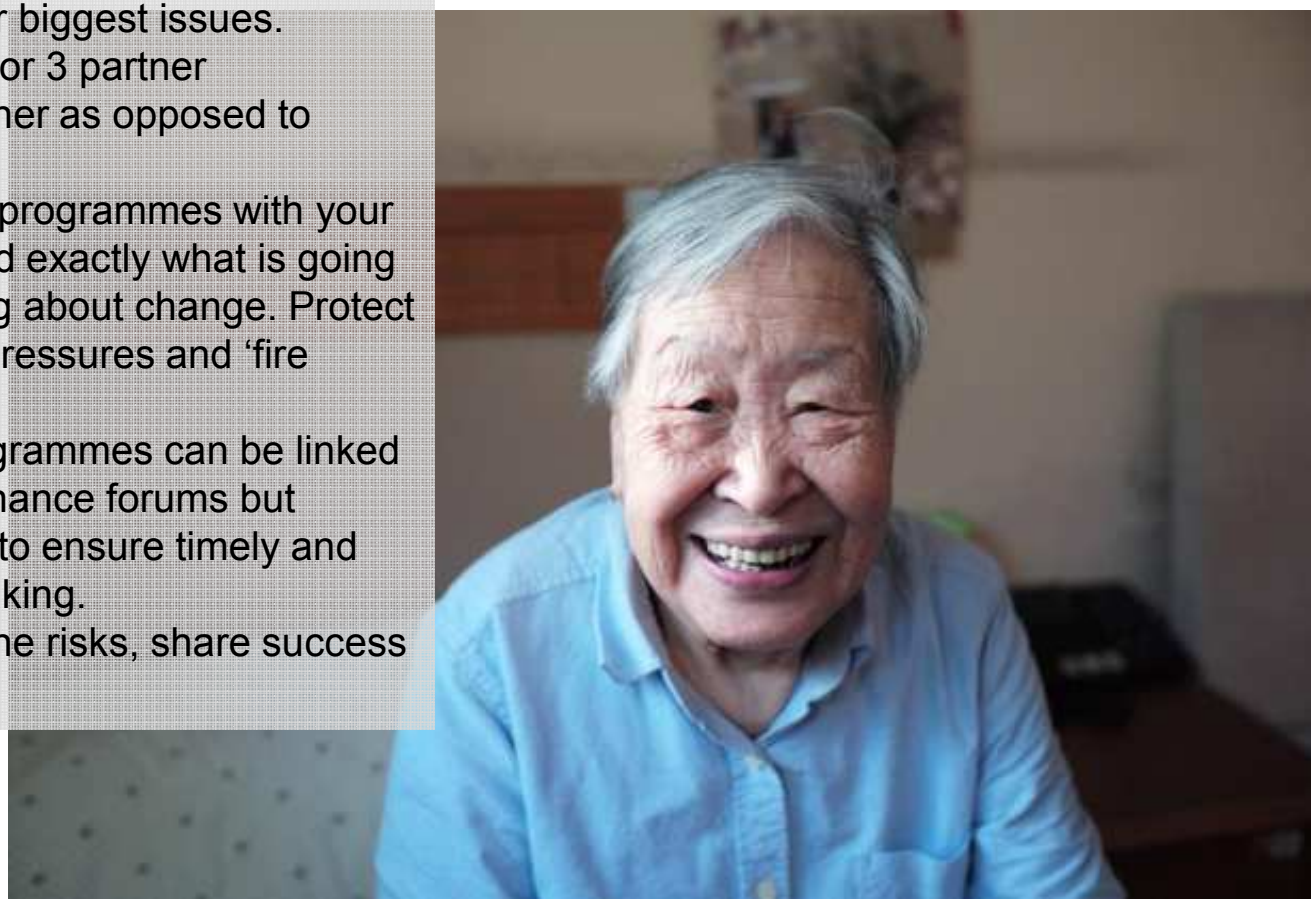
WHAT ELSE DID THE WORK TELL US?

- Stop initiatives that are not making a significant difference or aligned to your biggest issues.
- Look for opportunities for 2 or 3 partner organisations to work together as opposed to everyone all the time.
- Resource complex change programmes with your best people who understand exactly what is going on and what it takes to bring about change. Protect their time from day-to-day pressures and ‘fire fighting’.
- Governance of change programmes can be linked to business as usual governance forums but should also have their own to ensure timely and tightly qualified decision making.
- Move beyond just sharing the risks, share success too.



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PEOPLE FIRST: MANAGE WHAT MATTERS

DOWNLOAD THE FULL REPORT:
www.reducingdtoc.com

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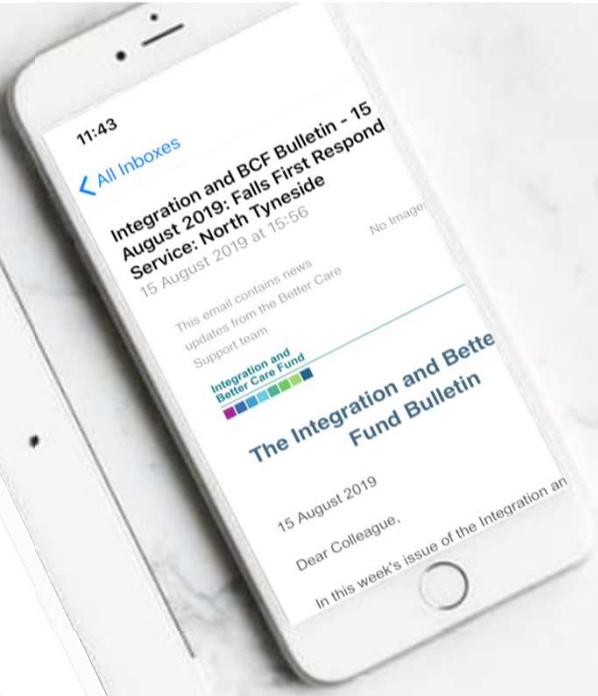
THANK YOU

For more information and regular updates, sign up to the Bulletin and the Better Care Exchange



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England.Bettercaresupport@nhs.net

England.bettercareexchange@nhs.net

Support Offer for DTOC Improvement

Fiona Russell

Supporting improvement

Fiona Russell

Local Government Association

fiona.russell@local.gov.uk; 07799 466328

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What support is on offer?

- Available via Better Care Support Programme or LGA's Care and Health Improvement Programme
- Peer reviews:
  - Collaborative, peer-led reviews to assess strengths, challenges and progress, and identify next steps
  - Half, one or four-day reviews, depending on nature of issues faced
- Bespoke support:
  - Address challenges around the interface with hospitals including delayed transfers of care
  - Facilitated sessions to progress integration ambitions
  - Guidance and support to progress BCF and/or integration ambitions

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Also: national tools and resources

- High Impact Change Models:
  - Managing transfers of care
  - Avoiding unnecessary admissions to hospital or care
  - Supporting community wellbeing through integration
- Briefings, case studies and good practice tools:
  - 15 good practice actions to achieving integrated care
- Events:
  - DTOC counting masterclasses
  - Learning from support and national programmes

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Refreshed high impact change model for supporting discharges

- Consultation over past year found model generally positively received by systems
- Perceived as a useful tool to support improvement and for bringing systems together, as well as sharing good practice
- But also call for greater clarity, a strengthening of focus on the person, and greater emphasis on the key Home First policy
- We have added:
  - I and We statements
  - More case studies and supporting materials
  - A new change on housing and related services

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High Impact Change Model for managing transfers of care

Early discharge planning	Monitor and respond to system flow	Multi-disciplinary working
Home First	Flexible working patterns	Trusted assessment
Engagement and choice	Improved discharge to care homes	Housing and related services

https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model

Ageing Well – Enhancing Primary & Community care capacity

Sarah Ramjeet

Ageing Well and Community Services
NHS Long Term Plan

Sarah Ramjeet, Senior Planning Delivery Officer

October 2019

NHS England and NHS Improvement

What is policy seeking to achieve?

Key outcomes:

1. Care that makes sense to people (and their carers and families)

2. People get what they need, when they need it.

Three national priorities for older people

1. Change in approach to health & social care nationally

2. Preventing poor outcomes through active ageing

3. Quality improvement in existing acute & community services

Delivering a new service model for the 21st century

Transformed 'out-of-hospital care' and fully integrated community-based care

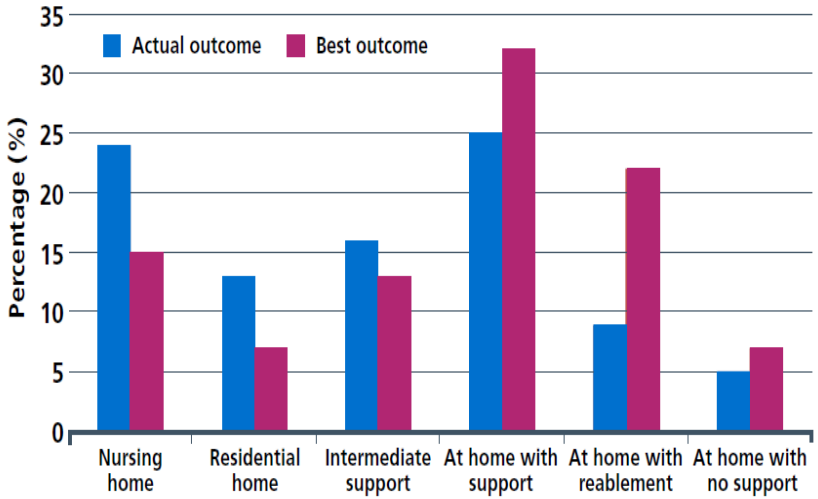
- Our ambitions are to develop models of integrated care across providers of Community Health, Primary Care Networks, the broader voluntary and social care sectors to improve the outcomes for their local populations.

- Implementation of the Ageing Well Programme, provides a once in a lifetime opportunity to breakdown the historic barriers between community and primary care and move to a proactive care model rather than responding to ill heath in local residents.

- The programme enables the opportunity for broader innovative approaches to rethink and redesign systems (with partners, people and communities) to support our people to age well in mutually supportive communities.

Background to the programme

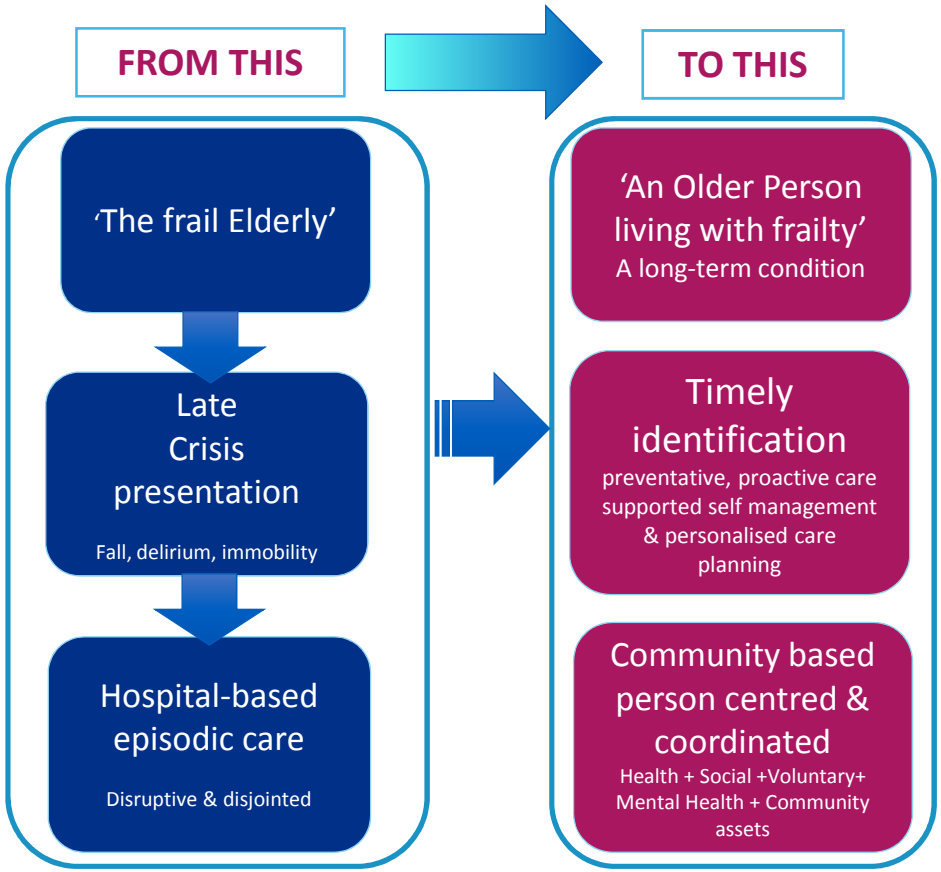
Figure 5: Differences in where people are discharged compared to where would be best for them.



Source: Newton Europe.

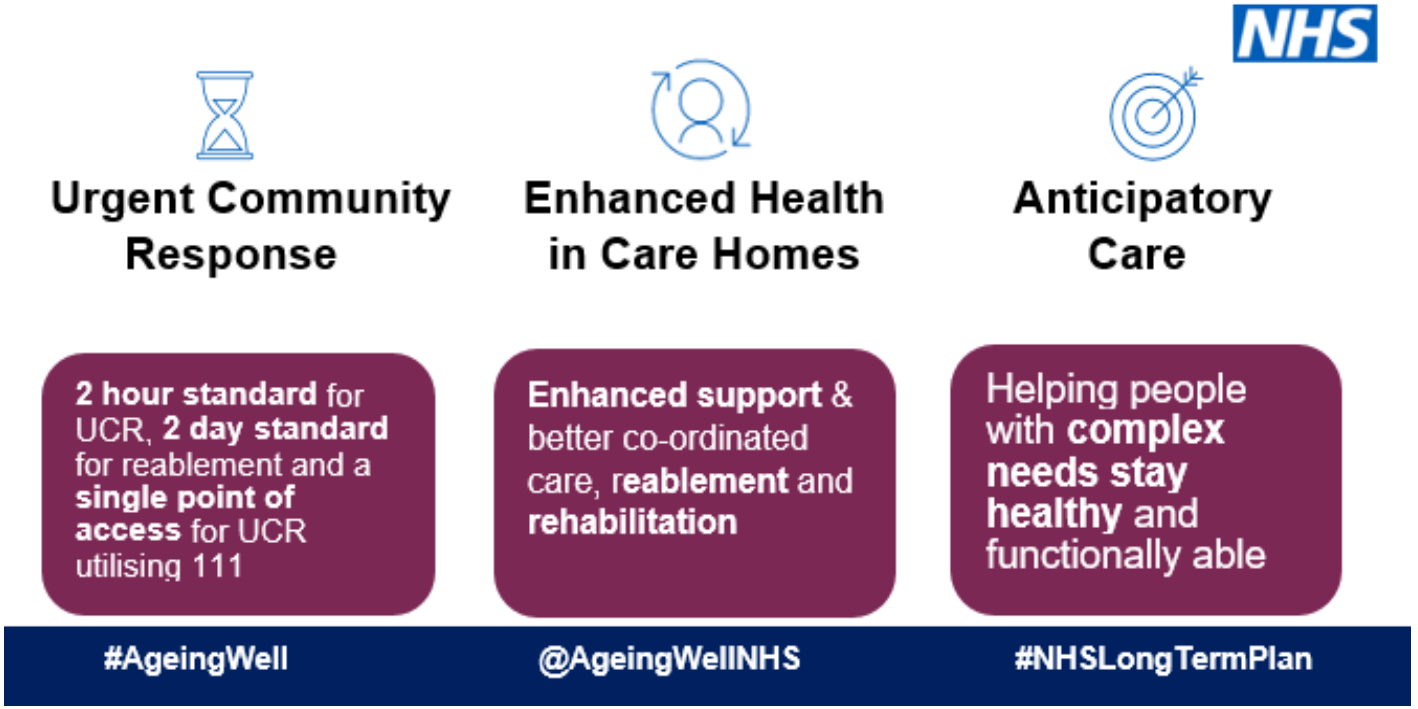
People first, manage what matters, March 2019

What's the national approach?



Programme Workstreams

An overview: Ageing Well Programme



Urgent Community Response

- Improve responsiveness of community health crisis services by 2023/24 within two hours of referral in line with NICE NG74 guidelines.
- Reablement / Intermediate care within two days of referral
- Capacity and demand for these services to be visible and responsive across the country
- Services should be inclusive and "no wrong door" including meeting the needs of people at the end of their life and with dementia
- By 2023, 111 (clinical assessment service) will typically act as the single point of access for patients, carers and health professionals for integrated urgent care and discharge from hospital care
- Helping to reduce unnecessary admissions to hospitals and residential care, as well as ensuring a timely transfer from hospital to community through Urgent Community Response

Anticipatory Care

- Proactive care focused on people living with complex health and care needs to help them stay as healthy and functionally able as possible for as long as possible.
- Delivered by primary and community health services working in multidisciplinary teams in partnership with social care, mental health teams, the voluntary sectors and other partners.
- Recurrent and proactive population segmentation.
- Support greater recognition and support for carers
- Developing the PCN “Service Specification” with an Expert Working Group
- We will be seeking one accelerator site per NHS region in the New Year
- Putting together an “Anticipatory Care” Framework by the December 2019. Would like your help!

Enhanced Health in Care Homes

- Upgrade NHS support to all care home residents with the EHCH model rolled out across the country beginning with the ‘clinical elements’ from next year (subject to negotiation)
- Ensure stronger links between primary care networks and their local care homes, with all care homes supported by a consistent team of healthcare professionals
- Refreshing the EHCH Framework by December 2020 and strengthening aspects to improve quality care including oral health, good mental health, falls prevention, nutrition and hydration
- Developing the PCN “Service Specification” with an Expert Working Group
- Building on the existing vibrant EHCH community of practice and existing body of knowledge
- Roll out of NHSMail to allow easier, secure, sharing of information between care homes and NHS staff.

Single Point of Access - Urgent Community Response

Pre-Hospital Urgent Care:

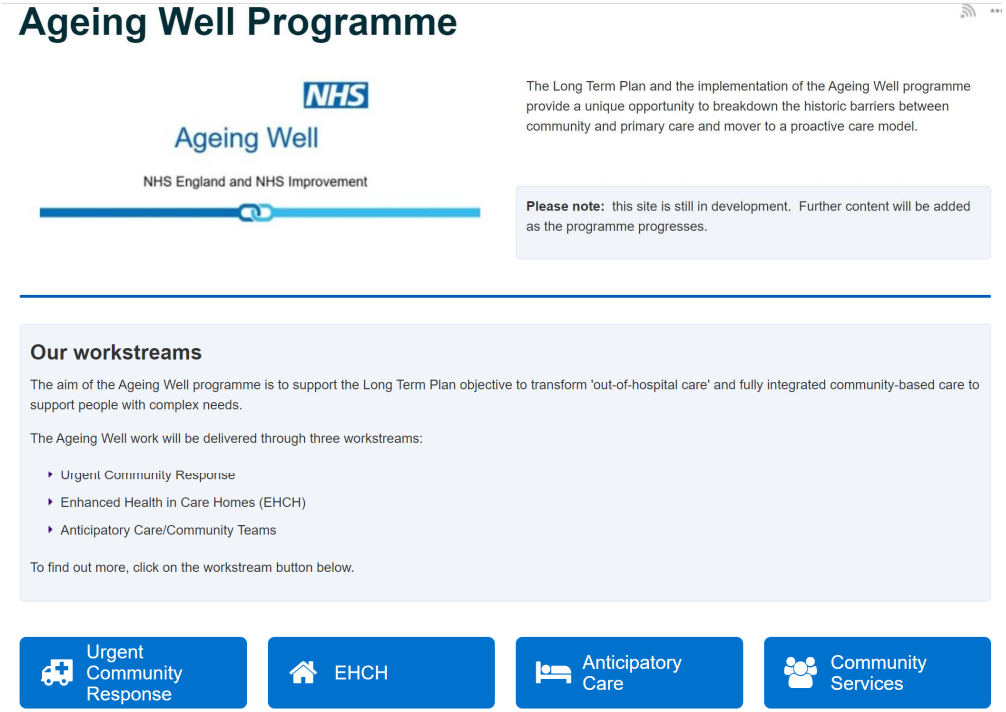
By 2023, Clinical Assessment Service (CAS) will typically act as the single point of access for patients

- This includes using the CAS to simplify the process for GPs, ambulance services, community teams and social care to make referrals via a single point of access for an urgent response from community health services using the new model.
- The new model, Urgent Community Response's aim is to improve the responsiveness of community health crisis services (2hrs/2days)
- During initial scoping it was identified currently there are multiple models in place for having a Single Point of Access (SPA) for Urgent Community Response but none had NHS111 IUC as the front-end access point within the system currently
- We aim to work with the IUC team to perform a pilot over the next 6 month to explore with a couple of sites to test this model, gain learning and develop guidance or a framework for wider system learning

Next Steps

- Engage with regions to identify systems who can work with us on the programme, helping to drive the delivery and lay foundations for others
- Develop visibility of the capacity in Community Services
- Communications and engagement to develop insight into the capacity and capability of Community Services to effectively manage patients in an out of hospital setting
- Confirm the accelerator sites that will be the forerunners
- Finalise arrangements for measuring progress

The Community Platform



Community ACTION:

Post in the chat box:

"I have a case study ready to share"

"I have information to share, but it's all in my head/not a "shareable" format yet"

"I might someone who does who has a fantastic case study to share"

"I'm not yet sure"

NHS England and NHS Improvement

Contact us

Ageing Well on : @AgeingWellNHS

Email: england.ageingwell@nhs.net

Improvement Community access also email
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NHS England and NHS Improvement

Break out session topics for community capacity:

- **Table 1:** Residential and nursing home provision, including extra care housing and supported housing
- **Table 2:** Care at home, (homecare, intermediate care and reablement services)
- **Table 3:** Voluntary and community service provision (voluntary or community bodies and volunteers)
- **Table 4:** Housing services (including home adaptations / care and repair services, home improvement agencies, and housing associations)
- **Table 5:** Developing a community capacity framework

Break Out Session Questions

- Within the context of the topic you have chosen, how could services and organisations provide further support to improve the quantity and quality of community-based support to deliver better outcomes for people?

- What good practice examples of specific services or interventions for your chosen table topic are you aware of and what are the key components of that service or system that made it effective?

- If you could wave a magic wand, what are the three things that you would like to change that could increase the effectiveness or capacity of the community provision being discussed in your group?

Workshop Closure

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

NHS

Integration and Better Care Fund

Local Government Association

directors of adass adult social services

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#DTOCworkshop