Better Care Southampton
working together to make a difference

Reducing Length of Stay and Delayed Transfers of Care in Southampton City

Our Overarching Strategy for Reducing Length of Stay and Delayed Transfers of Care

Our shared vision

"We want people in Southampton to live safe, healthy, independent lives and will ensure that, when people have to go into hospital, they are only there for as long as they medically need to and are enabled through well coordinated, person centred support to return home and regain their independence as soon as possible."

Our ambition

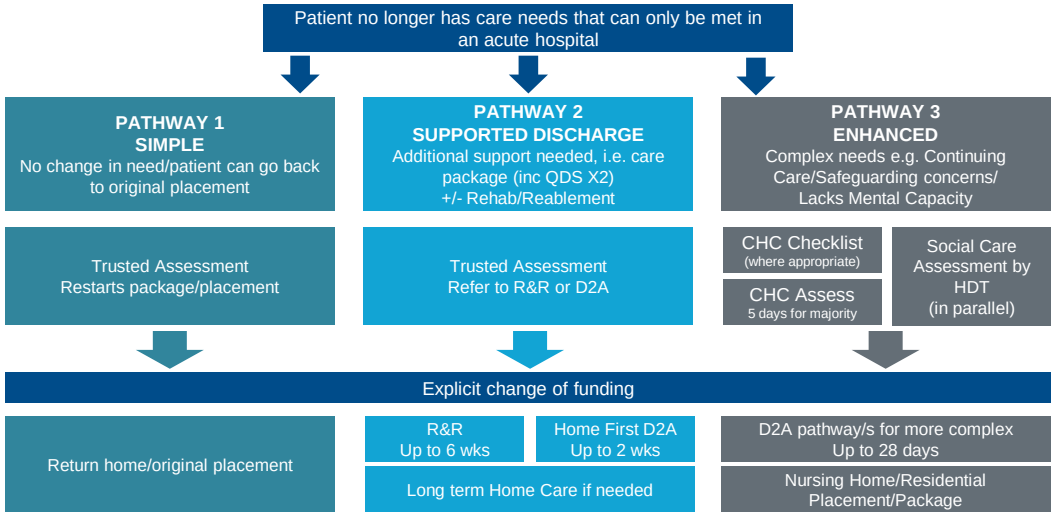
That nobody stays in hospital longer than they need to.

Key Principles:

- **Discharge is everyone's business.** Ensuring that patients are discharged in a timely way is everyone's responsibility and is a key part of the job for both staff working in the community and on the wards.
- **Planning for discharge will begin before or as soon as possible after admission.** This will be carried out in the main by ward staff and all patients will know their expected discharge date and discharge plan within 24 hours of admission.
- **Why not home, Why not Today?** Wherever safe to do so, people will be discharged as soon as they no longer need to be in hospital to their home or usual place of residence.
- **No decision about me without me.** Open and honest conversations about discharge arrangements and future care options will take place with patients and their family/carers as soon as possible.
- **No assessment for long term care in hospital.** People's long term needs are best assessed in their own home or similar setting and so every effort will be made to discharge people as soon as possible for this assessment to take place.

Our model

All discharges will go down one of only three pathways



Our six areas of focus

1. **Continue to mainstream discharge to assess** which for the majority of patients will be in their own home.
2. **Improve planning at the hospital front door** to assess needs, direct people to the most appropriate setting, avoid admission where possible, commence early discharge planning and early conversations about discharge.
3. **Strengthen community services** to provide person centred, proactive, coordinated care and support, 7 days a week capable of managing greater levels of acuity outside of hospital.
4. **Increase the supply of home care** to meet greater levels of complexity and address gaps e.g. people with low level health needs.
5. **Improve hospital processes for organising discharge** – timely and reliable transport and provision of medication and equipment, timely transfer of patient notes and consistent application of Complex Discharge policy, particularly in relation to early discharge planning.
6. **Work towards 7 day discharge.**

Our commitments for the next 12 months

Commissioners (CCG and SCC)

- Commission a pathway for people with low level health needs to leave hospital in a timely way and be supported at home.
- Continuously review demand and capacity to target additional resource in the right place and work with Care Homes and Home Care providers towards making 7 day discharge a reality.

UHS

- Improve the quality of discharge processes with a particular focus on timely provision of transport, medications, equipment, patient records and 7 day working.
- Ensure that all staff receive regular updates on the Complex Discharge Policy and that this is evidenced through practice, with a particular focus on having early conversations with patients about their discharge arrangements.

Solent

- Continue to develop the Urgent Response Service to respond to need by supporting people with increased levels of acuity in the community.
- Strengthen the palliative care support worker offer to enable more people to die at home as opposed to in hospital or a care home.

Southampton City Council

- To ensure robust provision to prevent delay for pathway 3 and ensure statutory responsibility under safeguarding and mental capacity are adhered to.
- Continue to support 7 day working across the system to help maintain timely patient flow.
- To support community hospitals and Urgent response to prevent delays and maintain flow.

Our Current Performance

There has been a steady reduction in DTOC over past 2 years influenced by a number of initiatives:

- Integrated Rehabilitation and Reablement Service.
- Integrated Joint Equipment Store with performance standards related to hospital discharge.
- Increase in "Home First" care Capacity
- 3 Reablement Beds.
- Integrated Discharge Bureau (IDB).
- IDB System Manager.
- UHS Discharge Officers to support the wards.
- "Assess at Home" model introduced.
- Complex care "Discharge to Assess" pilot planned to "roll out" by April 2019.
- Enhanced Health in Care Homes pilot planned to "roll out" by April 2019.
- Increased investment in End of Life care in the community.

Since May 2018, the DTOC rate has risen, although the numbers of patients actually discharged has remained relatively high.

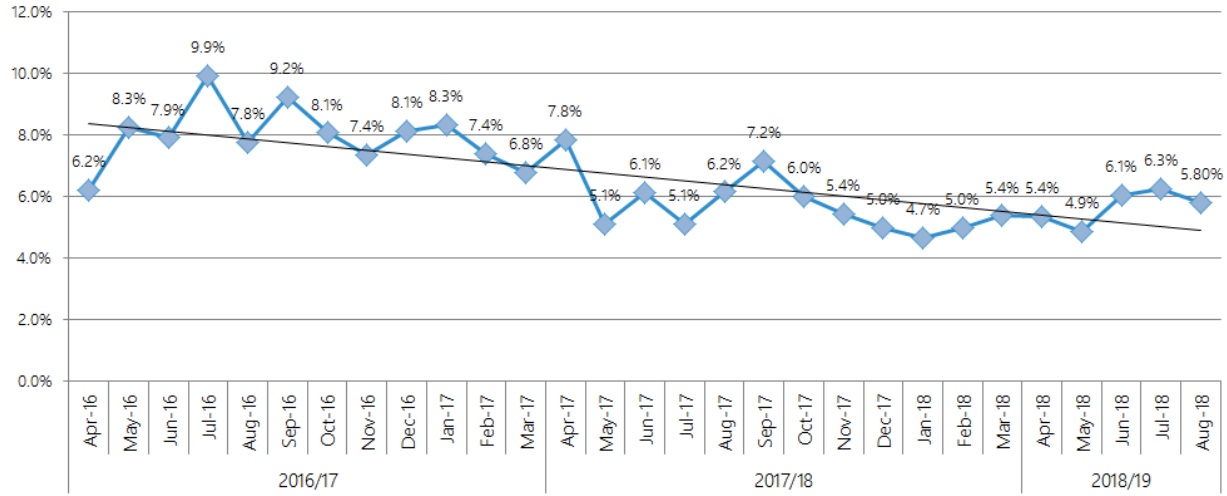
The main challenges are:

- Sourcing complex "double up" care packages.
- Sourcing care for patients with low level health needs.
- Increasing levels of complexity amongst patients being discharged.

Similar to Hampshire we are commissioning a new framework for Home Care provision which aims to address these challenges.

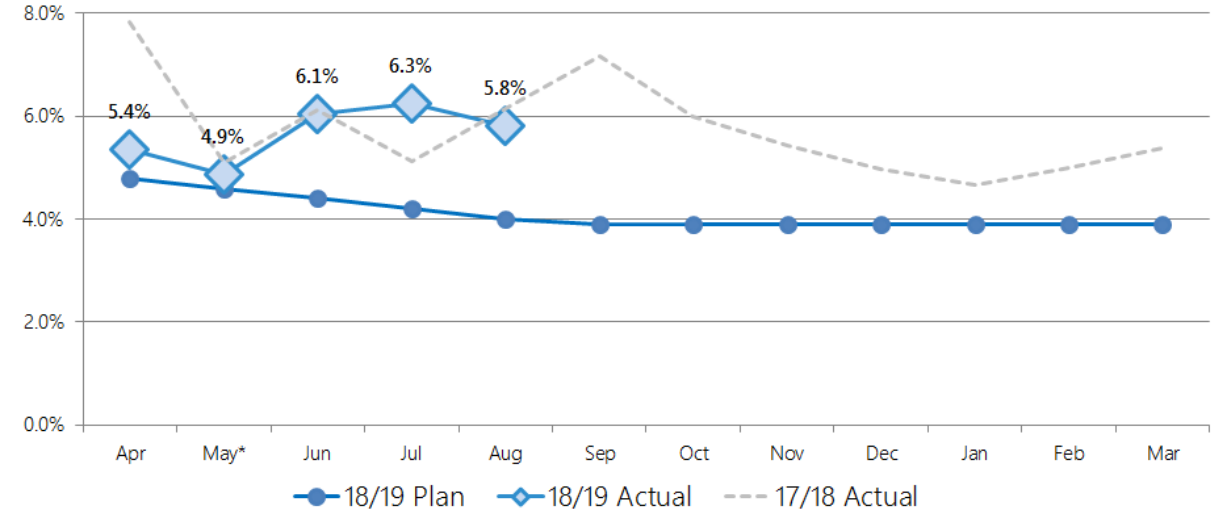
Our DTOC performance over the past few years

The graph shows Southampton City's DTOC rate from April 2016 to the most recently available data, August 2018.



Our DTOC performance in 2018/19

The graph shows Southampton City's DTOC rate performance for 2018/19 versus plan, and a comparison to the previous year.



Our Main Pressures and Our Response: High Level Version

Main Pressures

Community Resource Pre-Admission

- Whilst there are pockets working well, early help, self management and preventative activity is not consistently coordinated across the city in order to prevent unnecessary admission.

Hospital Processes

- There are a number of initiatives and processes in place that support hospital discharge, such as SAFER, "Home for Lunch" , trusted assessment, identifying D2A patients and basic requirements, such as the arrangement of transport and TTO's.
- None of these appear to be consistently undertaken across all wards.

Discharge Process and Community Provision

- The 3 discharge pathways still need to be fully operationalised and embedded.
- Homecare capacity for complex care (including two carer packages) is challenging in terms of sourcing.

Overall Increased Complexity of Patients

- We are seeing an increase in the level of comorbidity, age and complexity of need amongst patients being discharged.
- Many hospital discharge schemes involve earlier discharge, thus increasing the likely complexity at discharge. This means that sourcing the required care becomes challenging.

Southampton City's DTOC Performance

Our Response

- Commissioners are working with providers to become more preventative, anticipatory and coordinated with a view to implementing service change by April 2019.
- Community clusters are working with the voluntary sector to develop "Social Prescribing" to support people preventatively.
- Review of the end of life pathway.

- UHS is developing an action plan to create greater consistency across the hospital.
- The CCG quality team is working with UHS to develop performance reporting that would encourage greater transparency related to hospital processes.

- Trusted assessors undergoing training to support Pathway 1.
- More investment in pathway 2 to increase reablement capacity and support for lower health needs.
- Following the pilot, our intention is to implement Pathway 3 from April 2019.
- We have invested in more home care over the summer and are gearing up now to bring more hours on line over the Winter.

- Bespoke work to support complexity, such as mini-competitions, to secure complex care.
- Spot purchasing provision to support Pathway 3 D2A.
- Community OT in-reach into the hospital to jointly assess patients and their needs post discharge.
- Greater Consideration of how equipment and care technology might support people in the community and reduce levels of dependency.

Our Main Pressures and Our Response: Detailed Version

Main Pressures

Community Resource Pre-Admission

Early help, self-management, and preventative activity is not robustly coordinated across the city
- People are not able/encouraged to take responsibility for their own health and wellbeing.
- Early Intervention/prevention doesn't take place.

Case Management and Risk stratification are not fully operational
- Proactive and anticipatory care isn't consistent taking therefore there is an increased risk of NEL admission.

Reduced access to a range of functions in the community e.g. community nursing, CHC, EOL, social care assessment, reablement.
- Reduction in anticipatory planning increasing the risk of admission.
- Processes unnecessarily started in a hospital setting that increase the risk of delay

High levels of hospital conveyance. Falls RAG criteria not consistently applied
- People conveyed to hospital unnecessarily.

Hospital Processes

There are a number of schemes underway however it is unclear how embedded these are e.g. SAFER, "Home for Lunch", Estimated Discharge Dates, use of "Choice Policy", "Red and Green" days, Red Bags
- There is a risk with the high number of schemes in operation that activity is missed or staff members become confused by the processes.
- It is also unclear how embedded these schemes are across the hospital settings.

Risk aversion at UHS together with maintaining knowledge and information in a system that has high levels of staff change including temporary staff and rotation systems.
- Patients are increasingly likely to remain in a hospital bed for longer which reduces the impact of discharge to assess schemes.
- Difficult to source double up care is more likely to be prescribed in a hospital setting increasing the likelihood of delays related to care packages.

Coordination issues related to TTO's, transport arrangements, belongings
- Discharges are cancelled, delayed or of poor quality.

Lack of trust between the wards and residential and nursing home and home care providers often based on communication issues.
- Care/Nursing Homes won't accept discharges in the evenings or at weekends because they don't trust the support will be there if something goes wrong.
- Trusted assessment approaches can't be introduced which would reduce the delays associated with assessment of eligibility by the homes.

Discharge process & Community Provision

3 Discharge Pathways not fully developed
- General confusion regarding the appropriate Pathways.
- Minimal Trusted Assessment on the wards means unnecessary expectation on social care to fill the gap.
- Discharges related to low level health needs are challenging and lead to lengthy delays and avoidable XSBD's.
- Assess@Home (Pathway 2 D2A) activity is reliant on therapists identifying suitable patients early in the process if they are not confident in the process then these impacts on the pathway.
- Pathway 3 D2A has just completed its pilot stage therefore this needs further work for a "mainstream roll out" which impacts on the system.

Capacity in community provision particularly Homecare related to complex double up care, PCSW Service,
- Delays associated with lack of provision
- Patients don't die where they wish to or patients that are well enough to leave the hospital become unwell.
- Capacity issues in homecare increase the likelihood that move on issues from URS is impeded thus effecting overall patient flow.

The Community Nursing offer is relatively narrow.
- Patients are delayed because alternative health care not offered by the community nursing teams needs to be sought from elsewhere.

Need a more consistent approach to the use of telehealth/care
- Missed opportunities to support people at home that may avoid hospitalisation
- Missed opportunities to support timely discharge and reduce readmission.

Overall increased complexity of patients

- **Rapidly increasing levels of complexity brought on by increased population age, multiple comorbidities and subsequent** complexity of the interventions required to meet those needs.
- Increase in double up and time specific care
- More bespoke residential options required
- Increased likelihood of providers turning down patients at assessment.
- Increase in equipment spends.

Meeting the expectations of a number of schemes designed to discharge as early as possible may mean patients more complex at the point of discharge or less resilient.
- Increased risk of a more complex home care package on discharge which being more difficult to source could lead to higher levels of DToC
- Increased risk of readmission rates if patients are only just medically fit for discharge.

Southampton City's DTOC Performance

Our Response

- Timely access to GP appointments
- AVS developed to provide timely GP home visiting
- Social Prescribing being introduced in 4 clusters.
- Shift to a strength based approach – generating capacity
- Community wellbeing Team now in place
- Care Navigation is in place in the clusters
- Community Development proposals to increase capacity in the community and voluntary sector

- Plan to integrate CIS, Community Nursing, strength based social work teams and locality mental health teams
- System reviewing the use of risk stratification as an enabler
- EHCH has been piloted with 15 homes and will roll out across the city by April 2019.

- Revisit current specifications and contracts with a view to identify gaps, areas of non-compliance or renegotiation.

- Clinical Demand Manager in place to support crews in their decision making
- URS working closely with SCAS to ensure that there that rapid response approaches is utilised where appropriate.
- URS and CIS are working with SCAS to make the Falls RAG system more robust.

- UHS are developing a plan to focus on these areas – project group initiated.
- Quality team to add these schemes to the reporting template to increase transparency
- Welcome home programme being developed between acute and community partner (Communicare)

- Building in shadowing work between community and hospital therapists, we are planning to have community therapist in-reach into hospital to work alongside UHS therapy teams to establish acceptable levels of risk and promote alternative intervention e.g. Molifts to reduce the need for "double up" care.

- UHS are developing a plan to focus on these areas – project group initiated.

- UHS have developed an engagement strategy with the homes supported by the EHCH work undertaken by the CCG (based on the EHCH NHSE Framework (2016).
- Possible MOU across the system in relation to activity (to be agreed by System Chiefs).
- Following the EHCH Pilot there are opportunities to work with some of the homes to introduce federated working which could support improved relationships with the acute sector.
- The EHCH pilot has also introduced increased primary care support to the homes that it is hoped will increase weekend confidence.
- Following the procurement of a new Home Care framework there is an opportunity to work with lead providers on trusted assessment process.

- Pathways are being simplified and aligned with Hampshire to reduce overall confusion.
- The trusted assessment training programme is being revitalised with newly recruited Discharge officers.
- Commissioners are working with Solent URS to look at undertaking the low level health needs activity from April 2019. (scoping current home care providers to support this work ahead of April 2019)
- URS have an ongoing training programme to ensure that new therapists receive an appropriate timely induction.
- Pathway 3 is due to roll out by April 2019
- Possible Peer Review programme (to discuss with System Chiefs)

- Homecare framework being developed for April 2019
- Mini competition to increase the level of homecare available for complex packages.
- EHCH Programme to support greater care home coproduction.

- Specification is being revisited alongside other nursing activity with a view to closing the current gaps in service.

- Develop City wide telehealth/care strategy

- Mini competitions to do more bespoke work around complex pathways
- Increased investment in extra care housing options

- Mini competitions to do more bespoke work around complex pathways
- Retendering of Homecare framework – start date April 2019