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Integration and the Better Care Plan

Update on the 100 day challenge

The first 50 days

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Context

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- Significant commitment from all staff across the system
- A number of key schemes in place quickly
- Moving forward from the challenges faced in August
- Static level of activity in community settings
- Significant demand in all areas and challenged performance
- Care providers in the South experiencing capacity challenges
- Increasing number of health and social care delays
- A&E recovery plans in place
- System commitment to change and focused daily measurement
- Learning from the process and building for the future.

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Ambition into action

THE 100 DAY CHALLENGE

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Overview of what has gone live

Significant system development was undertaken during this period with a number of new schemes put in or about to be put in place, these are summarised below;

- Step up intermediate care in 2 locations
- 25 additional discharge to assess beds in Salisbury (although should be noted that15 of these beds only went live during week of 10TH November)
- Non bed based discharge to assess in RUH and GWH
- Access to care and one number for all health and social care referrals (non-life threatening)
- Enhanced urgent care at home with domiciliary care within the first 72 hours
- Launch of a daily operational dashboard across the system which is having significant benefit.
- DTOC recovery plans in each acute hospital
- Revised delivery plan with AWP including increased focus on delayed transfers of care in mental health
- Revised delivery plan with SWAST
- 72 hour pathway for EOL (due to go live)
- Focused risk stratification and case management at GP level which has been extended

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Missed opportunities

Missed opportunities – Avoidable admissions and Length of stay

Daily analysis through the dashboard demonstrates that further focus in a number of key areas should enable us to increase the volume of avoidable admissions still finding their way into an acute bed and the high lengths of stay in Intermediate care (which generates lost capacity)

Avoidable admissions

There are a number of diagnosis which is showing double figure growth which if addressed would enable Wiltshire to get back on track. These include – UTIs , cellutis , gastro ,respiratory , pressure ulcers and exacerbation of long term conditions. There is a need for a focused integrated approach to case management in community settings across a 7 day period

Lengths of stay in excess of 6 weeks

There continues to be an increase in the the number of patients with a length of stay in excess of 6 weeks in intermediate care , this on average results in lost capacity of circa 30-40 beds a month which if utilised appropriated would address the current levels of DTOCs in the system. Does this also mean there are a cohort of patients that are effectively long term residential /nursing still in Intermediate care. This work is critical in determining how many beds we need for the system.

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Overview of the key schemes

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"The no distinction challenge "
Key schemes – 100 day challenge

"I want the right care first time "	"No duplication and ease of access"
Integrated discharge teams – applying a range of models	**Single view of the customer** – truly integrated information approach across health & social care
Early mobilisation – integrated therapy teams across the system and	**Integrated locality working** – access to multi disciplinary teams coordinated by the GP encompassing mental health ,dementia and learning disabilities . A focus on risk stratifying patients and developing anticipatory approaches to care.
Comprehensive geriatric assessment and crisis management whatever the location	**Crisis response services** – ensuring access to shared anticipatory care plans by the ambulance service , rapid response ,enablement services and the wider range of voluntary sector **Single point of access** 7 days a week
Discharge to assess across 3 sites – once the patient is medically stable	**Self funders** – clear pathways and provision of care
Non acute bed provision – step up and step down.- transitioning towards more care at home , integrated care centers (our community campus) and assisted living	**7 day discharge and 7 day** intermediate care services

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Some practical examples

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Focus on Delayed Transfers of care

- Some good " in period " reduction but average level of delays have sustained
- Moving towards an integrated discharge approach for Wiltshire
- Existing Care packages are only kept open for 24 hours post admission , can we extend to maximise early discharge opportunities ?
- 5 day discharge focus- varied success extending to 7 days – missed opportunities
- Delays accessing packages – accessing the complex and mainstream
- When system responds – number of delays reduce significantly in a matter of days . Midweek drive needs to be sustained over a 7 day period
- There are too many accepted differences in our discharge and transfer model and a range of different definitions and processes.
- Rebase the pathway to intermediate care from each acute hospital.
- Need to apply same rigour to all areas of flow throughout the system (acute , community , intermediate care)

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Focus on Delayed Transfers of care

- Choice related delays on the increase – commitment to a Wiltshire approach to the management of choice
- Delays in accessing IC beds and packages of care have increased volumes of DTOC
- Length of stay post 6 weeks in IC/STARR =lost capacity
- Need to determine whether packages of care can be kept open for longer following a patient admission
- Need for a broader system commitment to " discharge to place of normal residence " – **ensuring right outcomes first time**
- Social care setting priority meetings with each provider at the start of the week

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Options following a 999 call

Referrer	Emergency Care Practitioner (ECP)
Time/Day of Referral	Thursday 19:50
Presenting Complaint	84 year old gentleman living at home with his wife General deterioration over previous 10-12 weeks Non-injury fall 3 weeks ago resulting in significant decrease in confidence and mobility No previous package of care but supported by his wife who was now unable to cope with the level of support required Requiring assistance of 2 for all transfers
Referral/ Assessment Process	Call received from the ambulance service and an assessment was completed over the telephone by the ATC Clinician with the ECP. At the time of referral there were no Community Hospital Step Up Beds, Intermediate Care Beds (ICT) or overnight carer availability however there was carer capacity the following morning and a the potential of step up or ICT bed availability. The clinicians jointly reviewed the options and agreed that the ECP would arrange for additional support to assist him to get the patient back into bed and the ATC team would follow up first thing the next morning to coordinate community services to prevent acute admission.
Outcome	The following day the ATC team arranged a review by the patient's own GP and an urgent therapy assessment by the Community Team with a view to providing H2L@H support and continued therapy. Following this assessment the Community Team therapist advised that the patient required 24 hours support and would benefit from a period of intensive rehab in an intermediate care bed setting. There were no Intermediate Care Beds immediately available however a bed was available the following day therefore ATC put in 24 hour support via the Urgent Care at Home Service to support the patient at home until the patient could be admitted. The patient was transferred to an Intermediate Care Bed the following day.

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Discharge to assess Patient pathway

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Patient A

- Mrs DW 84 lives alone was admitted to the hospital on the 9th September
- Initially admitted to hospital confusion linked to infection , also breast cancer
- Transferred to D2A on the 20th September to wait for large package of care which was originally assumed to be circa 4 visits a day.
- DW improved significantly in Camelot became self-caring with minimal assistance from staff , independent with toileting and managing personal hygiene
- Home visit was undertaken with OT with input from family and district nurse and GP
- On visit it was agreed with all concerned to reduce package of care to 2 visits a day and patient was discharged on the 6th October

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Some Key areas of focus

- Need to reduce delays currently experienced in accessing packages of care
- 7 day investment focusing on changing practice at the interface and driving alternatives and increased focus on 7 day provision
- Need to protect flow through our " faster access " schemes . D2A , Step up, Access to Care and urgent care at home
- Continued resource of acute DTOC planning with priority setting meetings each Monday with social care and community teams
- Focused action plan targeting all LOS in excess of 6 weeks in IC and determining the appropriate onward destination , ie determining what proportion are likely to convert to longer term residential .
- Need to enhance early identification and integrated transfer at each hospital (acute and community)
- Consistent application of the choice policy
- Roll out of the 72 hour EOL pathway
- Need to end the duplication of triage, assessment and liaison teams.
- There is an urgent need to respond to the level of avoidable admissions still resulting in a hospital stay, integrated action is required now

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Some Key areas of focus

- Early review of lessons learned to inform system wide winter planning
- Ensuring all core services are enabled to keep pace with the transformation agenda
- Implementation of the "Right care 2 "pathway with SWAST
- Need to activate community pull rather than acute push in relation to discharge planning . **Community = whole system**
- Increase options to admissions for all practionners whatever the location
- Consistency of approach in managing risk across the pathway

Next steps

- The 100 day period ends on the 9th December – determining what we continue to deliver
- Formal report and system review week of the 16th December with organisation specific recommendations
- Ensuring key outcomes inform our commissioning and service development priorities moving forward this is crucial in translating the learning and experience into real delivery.