Our Journey to Discharge to Assess (D2A)

Jane Ives
Director of Operations
South Warwickshire NHS Foundation Trust

Wendy Lane
Senior Partner Transformation & Innovation
Arden Commissioning Support

Zoe Bogg
Strategic Commissioning Service Manager, Integration Older People, Warwickshire County Council
Warwickshire Context

• 1 County Council
• 3 Clinical Commissioning Groups
• 548,000 population
• 3 Acute Hospital providers
• 1 vertically integrated provider following Transforming Community Services (TCS)
• South Warwickshire frailty challenge
• Financial challenges
The Case for Change

- **Ageing population:**
  - Elderly people biggest group of hospital bed users
  - 80% of emergency admissions who stay for more than 2 weeks are over 65
  - Emergency admissions staying more than 2 weeks are 55% total bed days
  - Increasing demand for healthcare and traditional beds

- **Financial challenge:** flat health and decreasing social care funding

- **Duplication and inefficiency**

- **Hospital pressures:**
  - Major incidents called to manage bed crises
  - Sub-optimal outcomes
  - High length of stay for emergency admissions
  - High levels of Delayed Transfers of Care (DToC)
  - Staff stress (A&E)
  - National targets pressure
System Transformation Plan

- PATHWAY 1: Community Integrated Health and Social care Team
- PATHWAY 2
- PATHWAY 3
- Trusted Assessment
- Todays work Today Ambulatory Care
- Frailty Specialist Service
Health and Social Care Initial Response: 2011-13

PATHWAY 1

- Development of Community Enablement and Recovery Teams (CERT) and Reablement
- Trusted Assessment: starting to change culture
- Traditional use of Winter Pressures funding e.g. spot purchase
**Development of Warwickshire Re-ablement**

**Aim:** Decrease the requirement for long term, high cost packages of care and maintain a person's independence in their own home.

**Impact:** 1,747 referrals received by 2013:
- 38% from Acute, 39% CERT, 22% Community Teams

**Impact of Reablement on home care hours by 2013:**

<table>
<thead>
<tr>
<th>Pre-reablement</th>
<th>Reablement</th>
<th>End of reablement</th>
<th>Home care</th>
</tr>
</thead>
</table>

51% of customers had no home care requirement 1 year after Reablement.
Development of CERT North Warwickshire

• Closure of Bramcote community hospital
• Investment in community capacity to build Community Emergency Response Team (CERT)
• In-reach to George Eliot Hospital wards from community and Social Care teams (CERT and Reablement)
• Community input to Accident and Emergency (A&E)
• “5 a day”
• Pull through model for hospital discharge
• 7 day service, 8.30am – midnight
Development of CERT South Warwickshire

- Based on learning from North Warwickshire model
- Closure of some community hospital beds (27 beds or 36%)
- Reinvestment in community team capacity and creation of CERT
- Capacity increase per week from 25 patients to 71.
• Restarts of packages of care within 10 days by discharge co-ordination team
• Direct referral to Reablement without hospital social work team involvement
• eCAT – in-house technology solution
All good work but....

Remaining Health and Social Care System Challenges: 2013

• The community based changes were not enough for the system to manage demand for emergency care
• A&E pressure improved but still there
• Excess hospital stay still for those unable to go home
• Unfulfilled desire to ensure that no patients had decisions made about their long term care needs made in hospital
An Integrated Health and Social Care Response: Our Shared Purpose

- Support timely discharge from hospital
- Maintain independence where possible
- Reduce the level of long term care packages
- Net neutral impact on Social Care spend

No decision about long term care needs in an acute setting. Minimise hospital stay and maximise independence, with care at home wherever possible.
Shared Understanding of Risk to be Managed

- Benefits don’t always accrue to where the cost is incurred
- Commissioner cost is not the same as provider cost
- Risk share and gain share needs to be fully explored
Pathway 1
Medical Episode Complete
- Able to return home

CERT/Re-ablement for up to 6 weeks

- Self care/ fund
- POC WCC fund (If delayed then fund IMC to provide service)

Pathway 2
Medical Episode Complete
- Unable to return home
  - Medium to high complexity of dependency

Up to 2 -6 week RH/NH placement for assessment

- Self fund
- WCC fund

Pathway 3
Medical Episode Complete
- Unable to return home
  - Very high complexity of dependency

Up to 4 -6 weeks NH placement for assessment

- Self fund
- WCC fund
- CHC fund

Key:

- Yellow = Health and Social care joint funding (Risk share)
- Green = Social care funding
- Purple = Health funding

Red arrow denotes explicit change of funding of care pathway.

Note – excludes fast track Continuing Healthcare (CHC)
Sizing the D2A Pathways: South Warwickshire

• **Pathway 1**
  – CERT 35 Early Supported Discharge (ESD) per week
  – CERT 20 Admission prevention
  – Reablement 5 Supported Discharge (SD)

• **Pathway 2**
  – Community Hospitals – 56 beds Length of Stay (LoS): 18 days (18 per week)
  – Moving on Beds – 10 beds LoS: 5.5 weeks

• **Pathway 3**
  – 30 commissioned NH beds – LoS: 34 days (3) and 19 (2)
Commissioning the pilot

- Word Class Commissioning (WCC) relationship with the nursing home market determined the beds that were commissioned.
- Price could be negotiated due to relationship between WCC and the nursing homes short listed.
- Memorandum of Understanding (MoU) between Clinical Commissioning Group (CCG), South Warwickshire NHS Foundation Trust (SWFT) and WCC was crucial in terms of managing risk, roles and responsibilities.
- Assessing the nursing home market: quality and readiness of providers to engage versus not wishing to destabilise the market or stifle CHC flow
- Procuring the model of medical support
- Managing additional capacity in the system (for Social Care and Community investment...)
Emerging D2A Outcomes

Early days to assess full impact

Three areas of measures:
• Cost and Flow
• Quality
• Culture
Eligible patients = 31
Accepted = 25
Accepted = 21 days
Care home = 19.7 days
Est. average EBDs = 2.6
Total Length of stay = 40.7 days
Deceased = 1
Own home = 15  71%
Not known = 4  19%
Care home = 1  5%
Readmitted = 1  5%
Deceased = 1
Own home = 3  60%
Not known = 2  40%
Care home = 0  0%
Refused = 6
Acute = 56.4 days
Care home = 19.7 days
Est. average EBDs = 36.8
Total Length of stay = 56.4 days
Eligible patients = 31
Accepted = 25
Refused = 6

Avg total cost = £7,179
Avg acute spell = £4,420
Avg cost of EBDs = £138
Avg D2A spell = £2,759

Est avg EBD saving = £2,106

Social Care cost:
Pre acute = 5 pts, avg £109 / week
Post D2A = 4 pts, avg £226 / wk

CHC/FNC: 1 pts
Avg cost £885

Social Care cost:
Pre acute = 0 pts
On discharge = 1 pt, £442 / wk

CHC/FNC: 0 pts

PATHWAY 2 Tracking cost in Pathway 2
Eligible patients = 124

Accepted = 83

Refused = 41

Total Length of stay = 64.2 days
- Acute = 32.2 days
- Care home = 32 days
- Est. average EBDs = 6.2

Total Length of stay = 63.3 days
- Acute = 63.3 days
- Est. average EBDs = 25.3

Deceased = 15
- Own home = 9 18%
- Not known = 1 2%
- Care home = 35 71%
- Readmitted = 4 8%

Deceased = 6
- Own home = 16 46%
- Not known = 12 34%
- Care home = 7 20%
Eligible patients = 124

Accepted = 83

Refused = 41

Avg total cost = £8,212
Avg acute spell = £4,312
Avg cost of EBDs = £1,017
Avg D2A spell = £3,900

Est avg EBD saving = £5,830

Social Care cost:
Pre acute = 32 pts, avg £257 / wk
Post D2A = 20 pts, avg £433 / wk

CHC/FNC:
Pre acute = 2 pts
Post D2A = 26 pts

Social Care cost:
Pre acute = 14 pts, avg £302 / wk
On discharge = 11 pts, £356 / wk

CHC/FNC:
Pre acute = 0 pts
On discharge = 22 pts

PATHWAY 3 Tracking cost in Pathway 3
Emerging Cost and Flow 2014

• CHC – early days but the increase in CHC spend on new CHC patient has been halted (but not yet reversed)

• WCC – Admission to residential care has decreased slightly over the past 12 months (P1 & 2 and early discharge will give real benefit here)

• Total length of stay is not increased by the Discharge to Assess (D2A) pathway
Emerging Quality Outcomes 2014

• System
  – Quality metrics for Hospital mortality and harm have improved
  – Urgent care system has functioned all Winter

• Patient Experience
  – Less patient ward moves
  – Positive patient stories

• Staff Experience
  – Staff survey results amongst the best in the country
  – Positive staff stories
• The close working relationships between WCC commissioners, providers and the CCG have helped make D2A a success. Constructive challenge!

• This will be a long journey: early indications are less blame of other sectors for system pressure, more proactive working together.

• The nursing home market is keen to engage with new initiatives such as D2A – and this is not just based on cost!

• GPs involved have reported being excited about the potential to make a real impact on pathway 2 patients
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline 2011</th>
<th>March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E 4 hour performance</td>
<td>93.5%</td>
<td>97.9%</td>
</tr>
<tr>
<td>SHMI</td>
<td>1.11</td>
<td>1.05</td>
</tr>
<tr>
<td>Acute Hospital length of Stay</td>
<td>7.7 days</td>
<td>6.6 days</td>
</tr>
<tr>
<td>Community Hospital length of stay</td>
<td>35 days</td>
<td>18 days</td>
</tr>
<tr>
<td>Community capacity (IMC + community Hospital admissions per week)</td>
<td>10 + 15 = 25 / week</td>
<td>53+18=71/week</td>
</tr>
<tr>
<td>Emergency readmissions</td>
<td>12%</td>
<td>12.8%</td>
</tr>
<tr>
<td>Excess bed days cost</td>
<td>£3.234m</td>
<td>£2.707m</td>
</tr>
<tr>
<td>Excess bed days % of emergency income</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>Patients treated on ambulatory pathway</td>
<td>0</td>
<td>120</td>
</tr>
<tr>
<td>Average medical outliers</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>Patient over 3 hospital ward moves</td>
<td>14%</td>
<td>3%</td>
</tr>
<tr>
<td>Patient falls in hospital per 1000 bed days</td>
<td>Acute 2 Community 2.4</td>
<td>Combined 1.7</td>
</tr>
<tr>
<td>Patients home for lunch</td>
<td>23%</td>
<td>35%</td>
</tr>
</tbody>
</table>