WHY NOT HOME?
WHY NOT TODAY?

AGENDA

Introduction and context

Approach

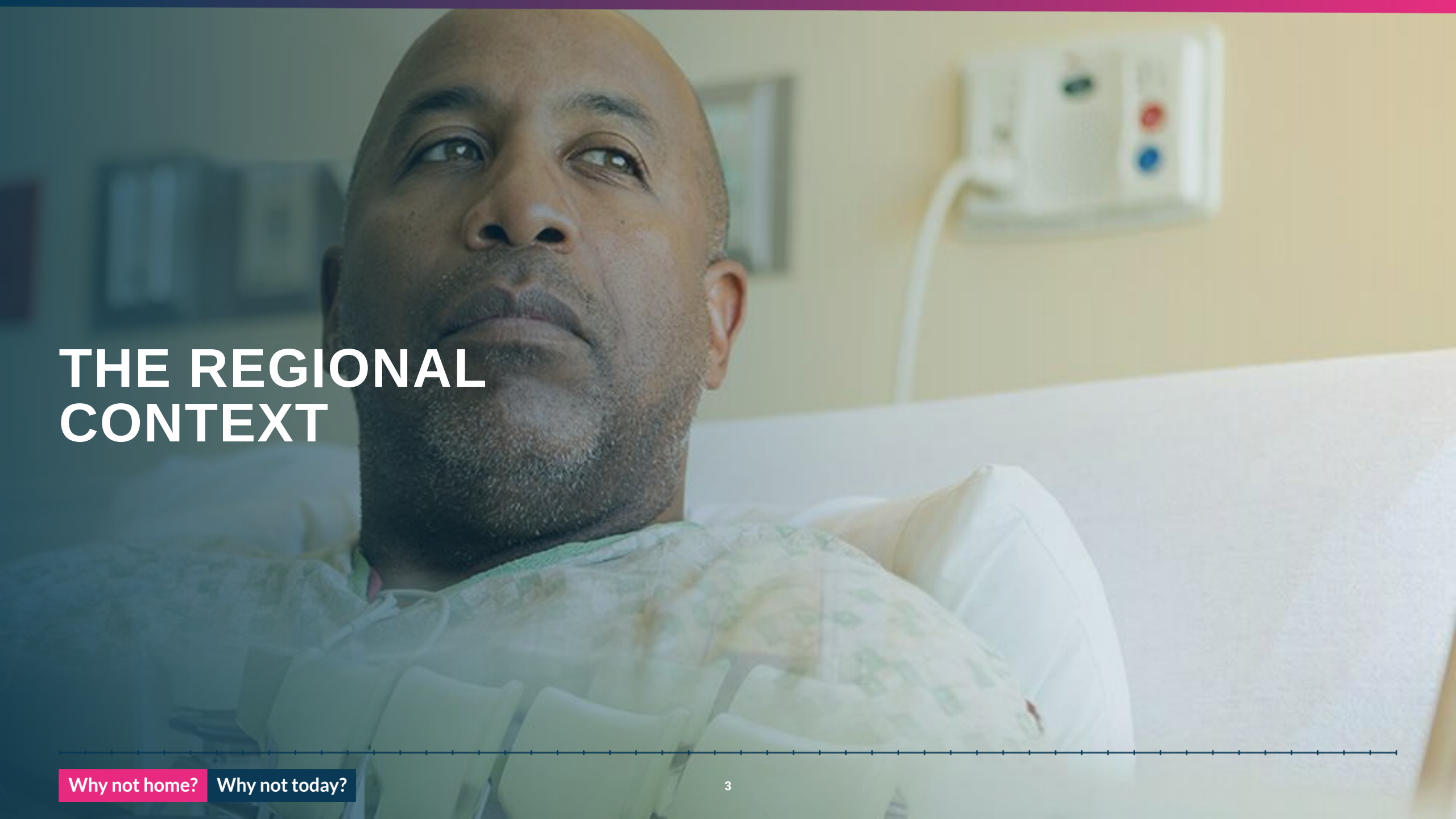
Key Findings from the North

A closer look

Solutions to consider

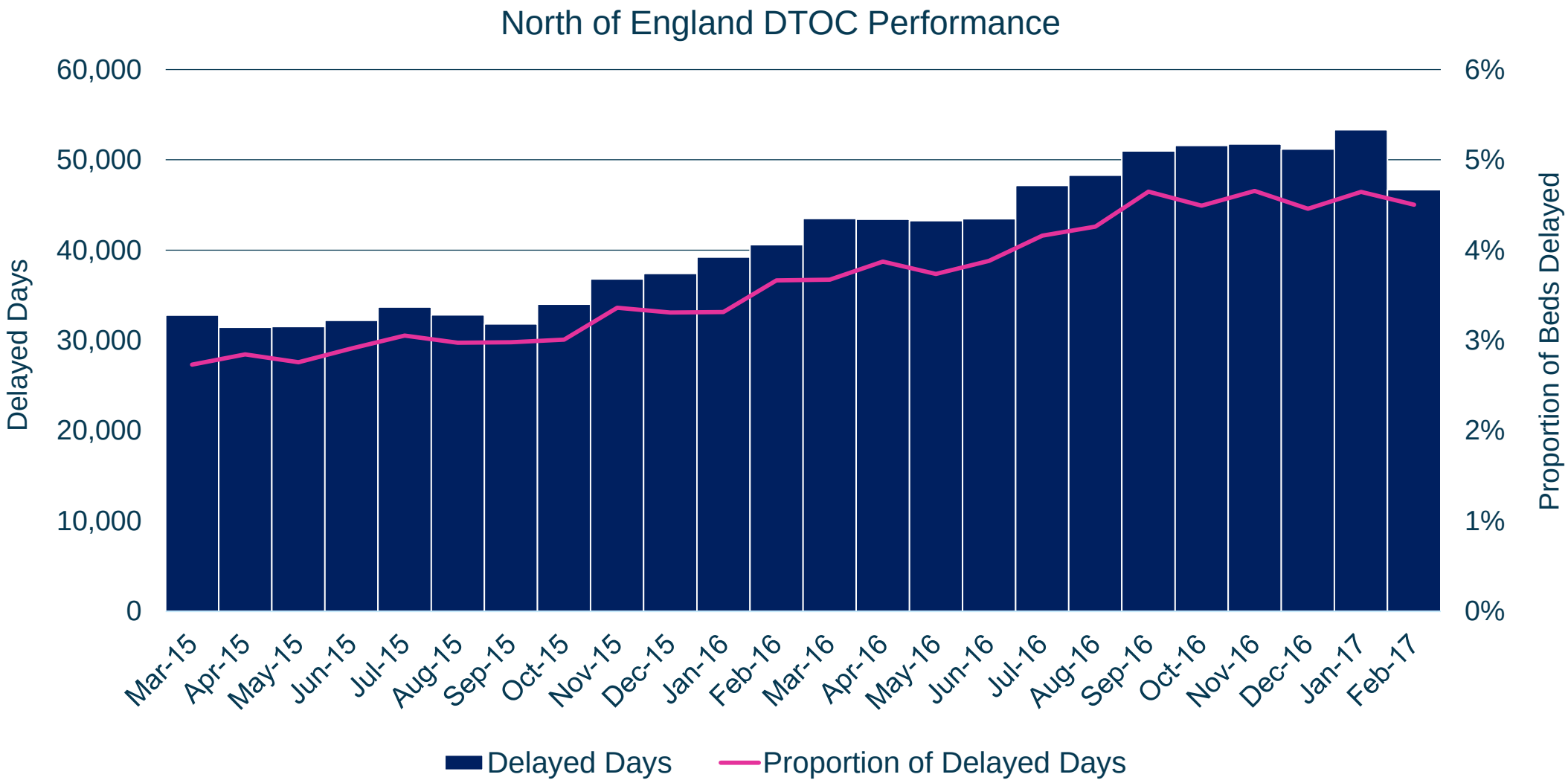
The Sheffield story

Discussion



THE REGIONAL CONTEXT

WHY DTOC?


North of England DTOC Performance
60,000
50,000
40,000
30,000
20,000
10,000
0
Delayed Days
6%
5%
4%
3%
2%
1%
0%
Proportion of Beds Delayed
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Delayed Days
Proportion of Delayed Days

WHAT WERE WE TRYING TO ACHIEVE?

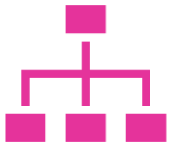
- Work with localities to diagnose DTOC system issues
- In depth analysis to identify and support change
- Ensure change is embedded and sustained
- Identify generic lessons and share more widely

THREE 2-WEEK ASSESSMENTS

- 6 patient pathway workshops with +100 staff
- +130 cases reviewed
- +2,800 beds reviewed across the North
- +80 one-to-one

Performance and Biggest Opportunities

Process Analysis

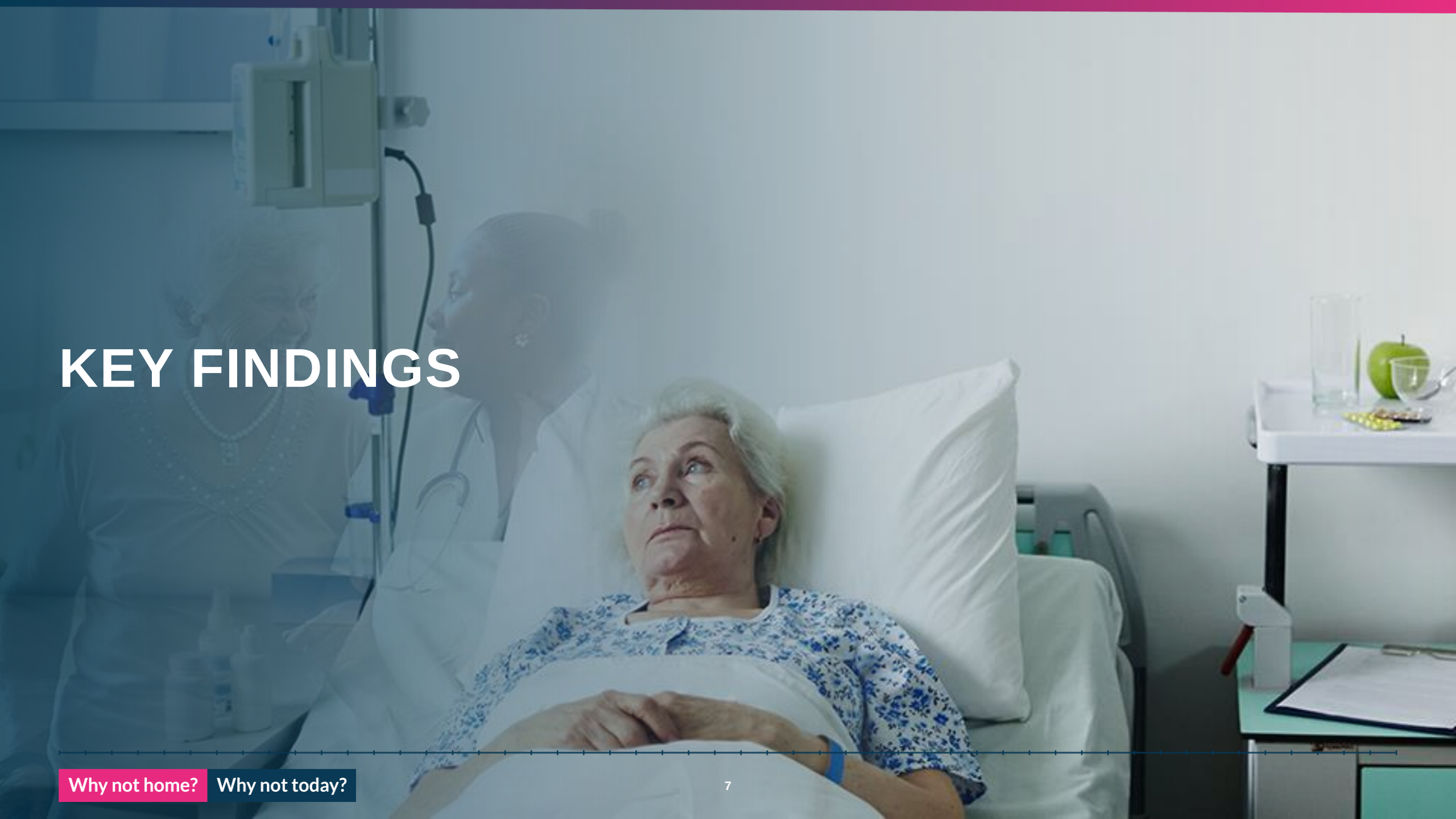


Opportunity Matrix and Delivery Plan

3 areas studied: Sheffield, North Cumbria and Fylde Coast

Working with: Councils, NHS Trusts and CCGs

KEY FINDINGS



THERE'S A LOT TO CELEBRATE

A common purpose to always put the **patient first**.

Appetite to challenge the **status quo**.

Common view of the **behaviours** needed in a good system.

Unanimously high desire to **improve**.

EVERYONE AGREES ON WHAT IS BEST FOR THE PEOPLE WE LOOK AFTER

THERE'S STILL WORK TO DO

People in Sheffield, North Cumbria and Fylde Coast have spent **182,500** more days in hospital over the last year than they needed to.

The equivalent of **500 people** unnecessarily spending the entire year in hospital.

At a net cost of around **£52 million**.

DEFINING DTOC

"During this study, DToCs reported as a percentage of total medically optimised delays varied significantly, with one system reporting 23% of medically optimised patients as DToC and another 69%."

'We spend as much time debating the numbers as we do improving the situation'.

A PATIENT-CENTRIC DEFINITION

Medically fit patients in hospital who, it is expected, will need extra support

OPERATIONAL FINDINGS

Three systems combined

36% The proportion of patients experiencing a delay leaving hospital because they are **waiting for a decision on their outcome to be made.**

33% The proportion of patients experiencing a delay leaving hospital because they are **on a pathway to either bedded intermediate, nursing and residential care.**

23% The proportion of patients experiencing a delay leaving hospital because they are **waiting to go home with some extra support.**

PEOPLE WAITING FOR A DECISION

Equivalent to **59** Beds

Could be done in **60%**
A neighbourhood setting

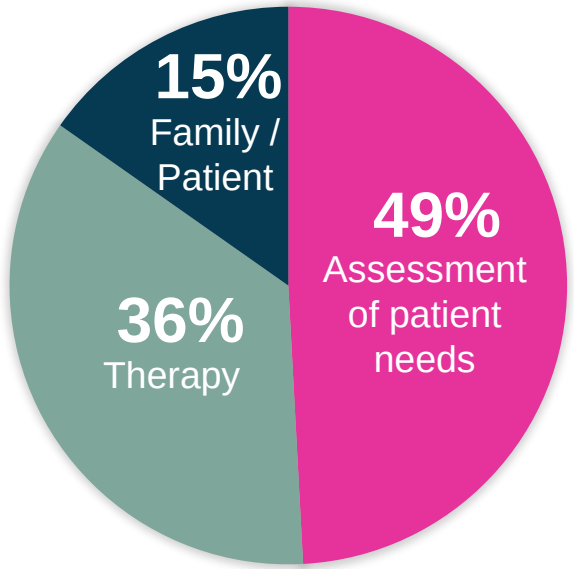
Reasons

- Consistent decision making
- Knowledge & trust of services
- Clarity of ownership
- Lack of goal setting

The remaining **40%**
Could be done in parallel

Reasons

- Matching capacity of all services to demand
- Visibility of next steps
- Ownership of decisions



Example: Fylde Coast

A consultant led review of 10 delayed patients wk. 31st July 2017

WAITING FOR AN INTERMEDIATE, NURSING OR RESIDENTIAL CARE BED

36 The number of hospital beds that would be freed up if these people went home instead.

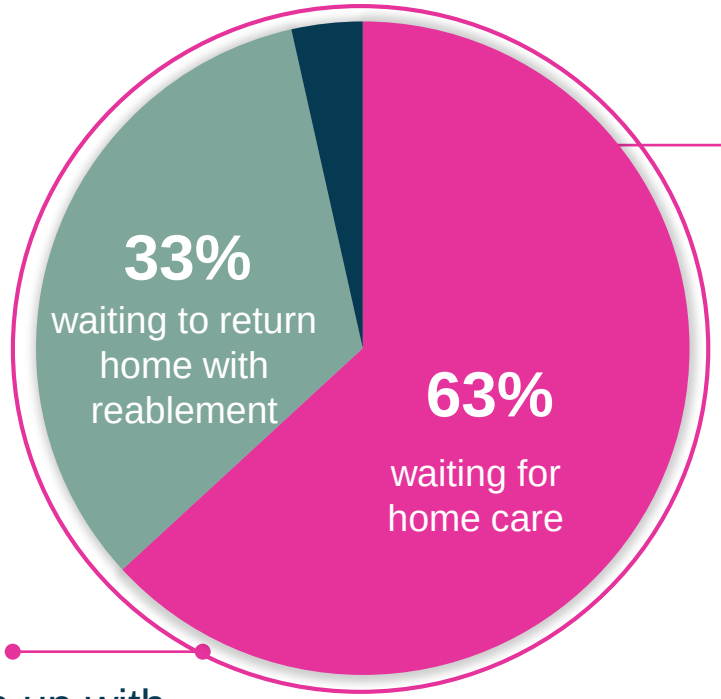
90% of the time, the best place for these people was home with some extra support.

45% Of the time, this was due to a reluctance by the decision maker to take a perceived risk with a more ‘independent’ solution.

54% of these people could have benefited from a different setting of care.

Example: Sheffield

PEOPLE WAITING TO GO HOME WITH SOME EXTRA SUPPORT



36

Beds taken up with patients waiting for home care.

50%

Of these people could have gone home with reablement, reducing their long term care needs.

However, half of the reablement capacity is being misused for providing home care.

57

Beds taken up with patients waiting for support at home.

Reducing the demand on the home care market through use of reablement and improved decision making will reduce delays.

Example: North Cumbria

BEHAVIOURAL FINDINGS

TODAY	IDEAL
Adversarial	Accountable
Firefighting	Accurate
How it's always been done	Collaborative
Lack of trust	Cost effective
No common goal	Patient centric, best outcomes
Self orientated (organisation then individual; not patient)	Predictive
Siege mentality	Responsive and effective in a crisis
System centric, not patient centric	Right people
Territorial behaviour - playing the game, operationally opposed	Risk aware
Too risk averse	Stable
	Targeted
	Timely
	Trusted

UNDERLYING ISSUES TO BE TACKLED

Lack of **trust** and feeling of fear

Transaction, rather than whole system thinking and talking

Complexity of pathways

Lack of credible, granular **evidence** to support improvement

Trying to do **too much**

Lack of appreciation of **different cultures**

Habits - the way things have always been done

SOLUTIONS TO CONSIDER

SOLUTIONS TO CONSIDER

Mindset

Every day actions, periodic events.

What we need to do:

- Get buy in to the cross system (**One Voice**) mindset.
- Call it when behaviour (**Use the Data**) slips, especially when the system is stressed.
- Create a safe environment (**Co-Location**) to share concerns.
- Time to plan (**Summits and Forums**).
- Holding each other to account (**Honest and Fair**).

SOLUTIONS TO CONSIDER

Work to do: **Data, Joint focus, Governance, Take action, Look ahead**

Examples to consider: **High Impact Change Model** (Early Discharge Planning; Monitor Patient Flow; MDT etc); **CQC Review Findings**; **Local Innovations** (Suffolk; Warwickshire) etc.

Speculation (!)**: Move all non-acute Therapy out of Hospital; Fully integrated rehabilitation, reablement and homecare provision through Accountable Care Partnerships etc.**

‘GETTING CONTROL’ PROCESS IN SHEFFIELD

THE SHEFFIELD VISION

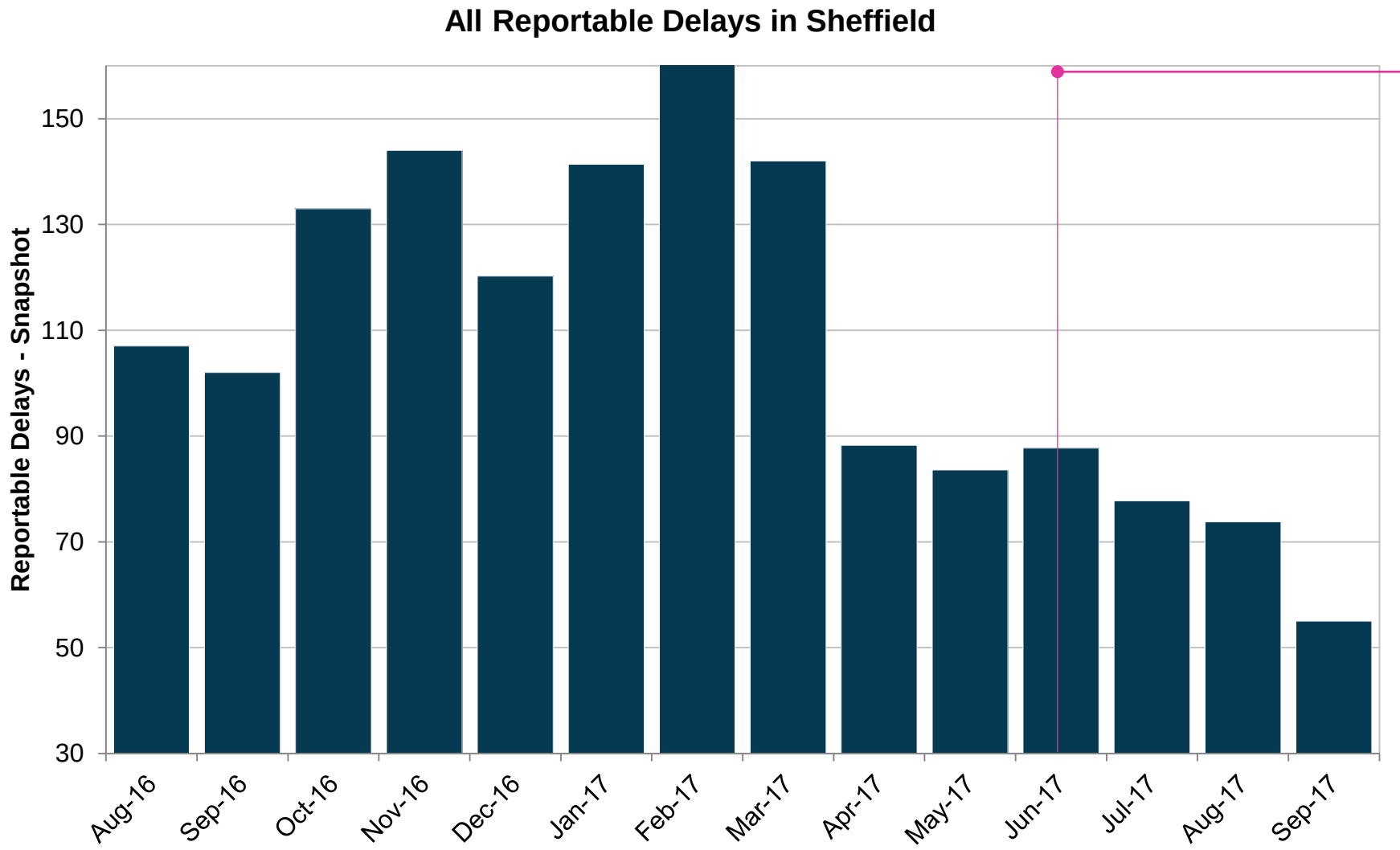
The Sheffield discharge process is built on the following principles:

1. That people come to hospital to receive acute medical treatment. When that treatment is over, we aim to get them out as quickly as possible.

2. We want people to be as independent as possible. We always aim to get people home first.

3. Assessments regarding long-term care are not made from hospital.

EARLY IMPACTS IN SHEFFIELD

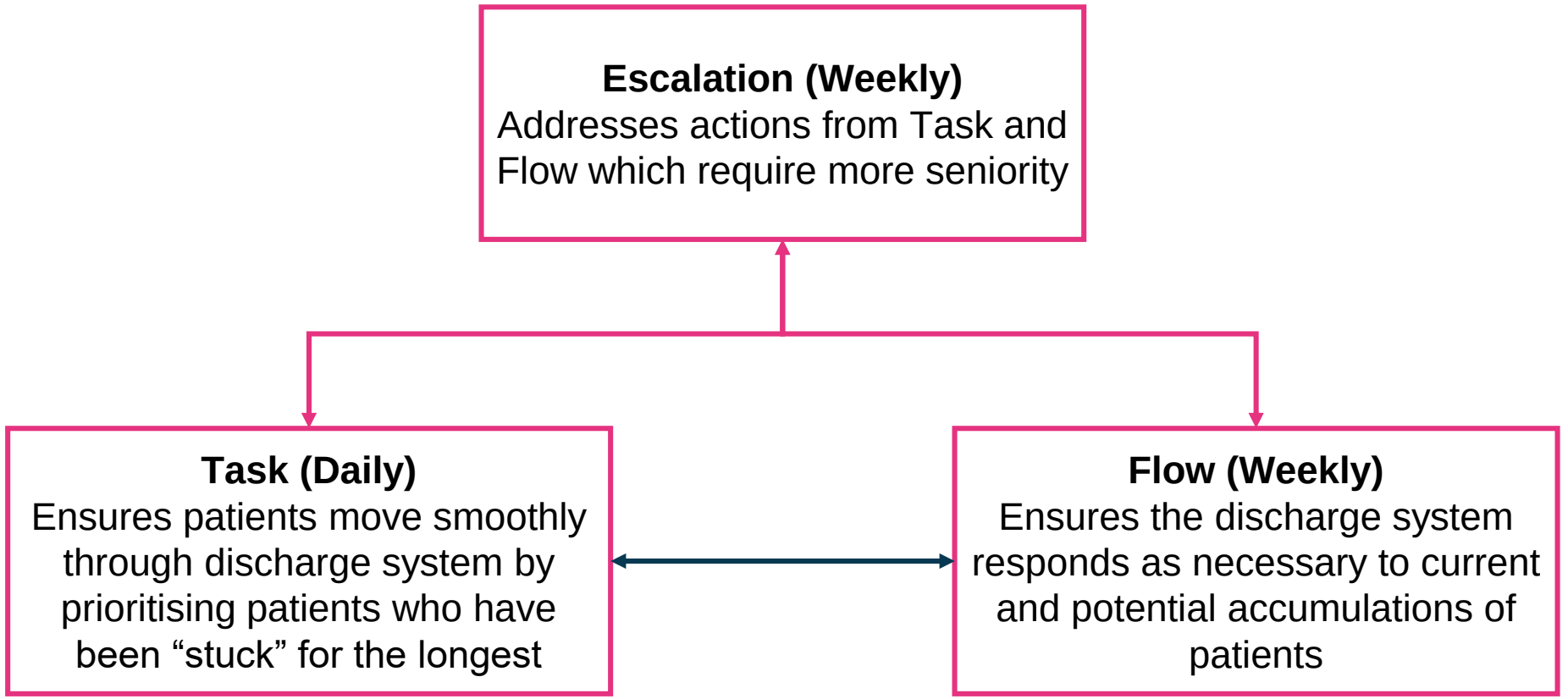


Sheffield begins 'Space for Winter' initiative

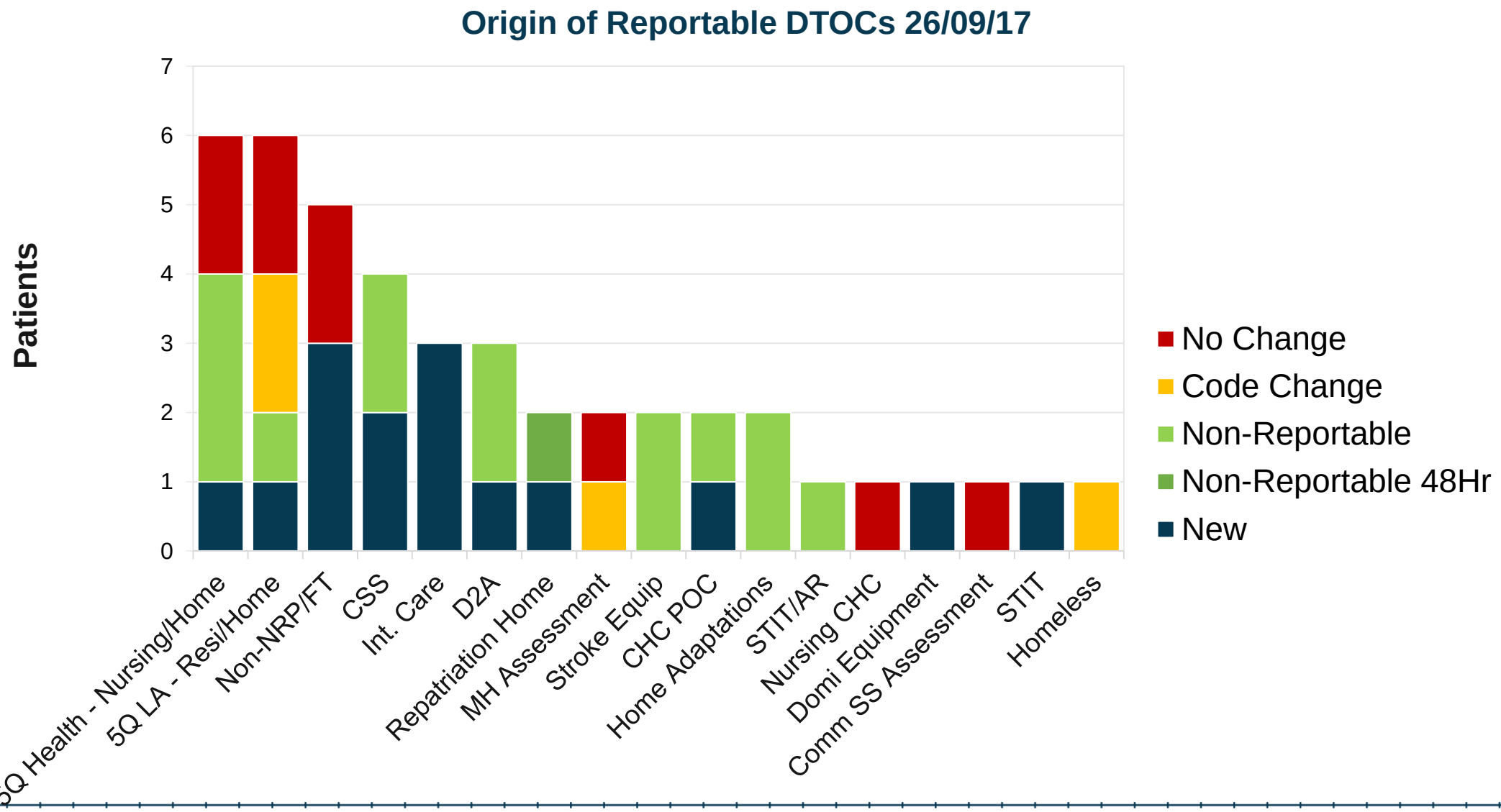
35% improvement

… work is still needed to ensure this is sustainable and built on further

OPERATIONAL GRIP



EXAMPLE OF FLOW DATA



IN CONCLUSION: FOUR KEY MESSAGES

1. The best way to help patients through discharge is to ensure the focus on their longer term recovery. DTOC is a symptom of system malfunction, not of itself a root cause. **Put the patient first and the rest will follow.**

2. Solve the biggest challenges using **fact, not opinion**. Measure the right data, prioritise effectively, collaborate with system partners to problem solve. At all levels, continuously.

3. No one part of the system is 'to blame' - all constituent parts play a part in generating DTOC – and also in achieving the solution. The onus is on system leaders to **create an environment in which frontline practitioners can do the job they want to do**, excellently and with pride

4. The local **journey** matters more than the specific solutions developed.

DISCUSSION

Please look out for the full report which will be available at **www.reducingdtoc.com**

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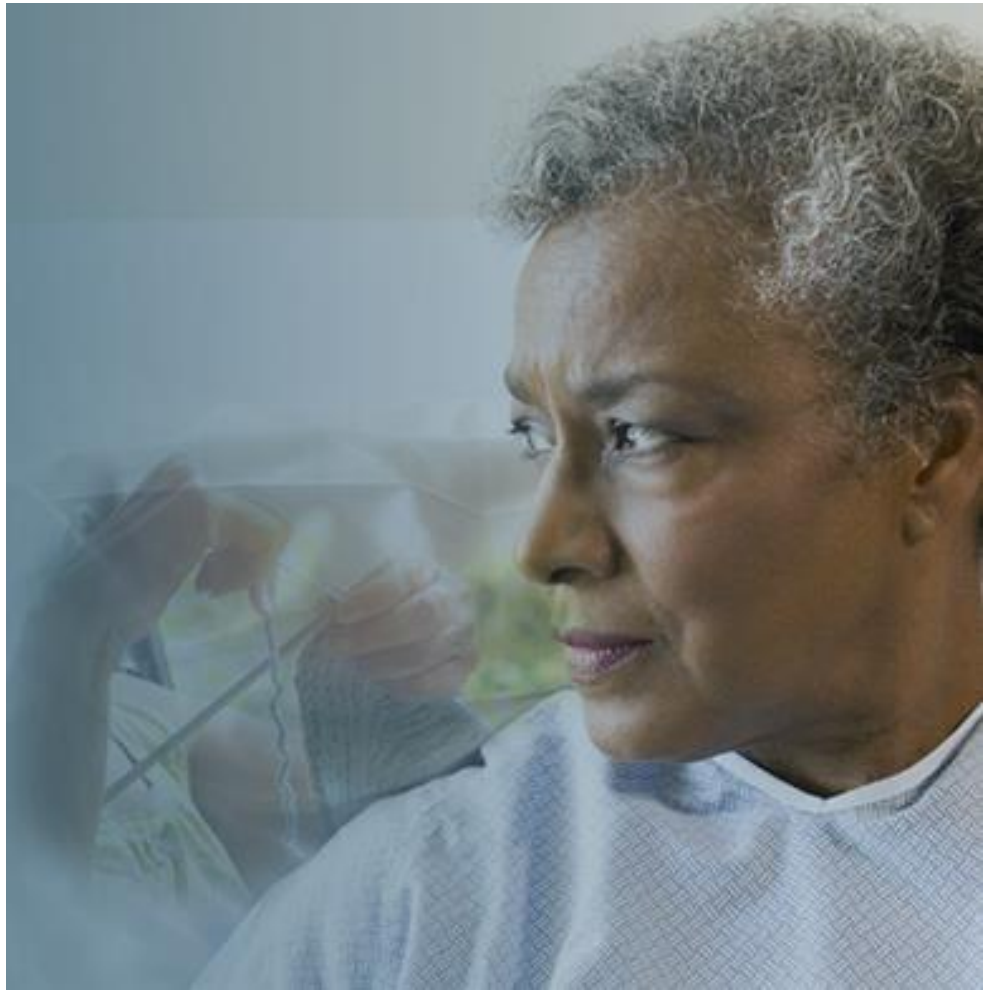
PRACTICAL STEPS THAT CAN BE TAKEN NOW

There is no easy solution to reducing delays, and making sustainable progress will take time. It is recognised that all systems will be at different points in this journey, below suggest some specifics which if aren't already happening would be expected to make a rapid impact on delays for patients:

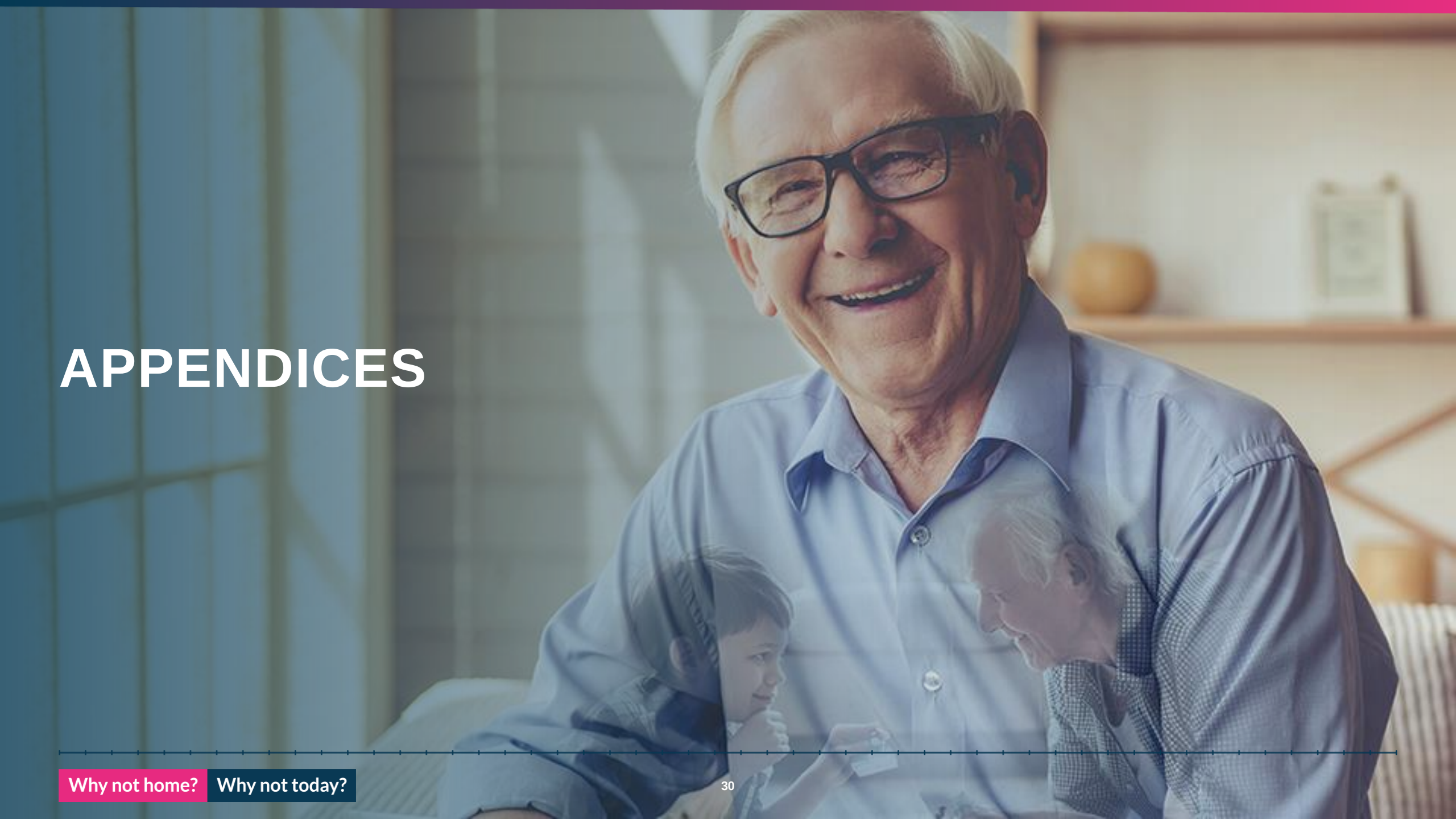
- Systems to agree and align on **one joint set of priorities** – guided by local evidence and understanding
- Frame all activities around **improving outcomes for patients** – "Why not home, why not today?"
- Every system to have cross-system access and understanding of **one (ideally live) list of delayed patients** – including the length of time each patient has been on it



PRACTICAL STEPS THAT CAN BE TAKEN NOW

- Run daily task and weekly escalation meetings with representatives from all partners to **take action** against the list of delays
- Hold **weekly face to face meetings** between a small group of leaders (executive level) from across partners to problem solve current blockages
- Ensure **reablement** is resourced to support the aim of ensuring that more patients recover in their own homes

APPENDICES



COUNTING THE COST OF DELAYS

What is the cost of delays and decisions?			
	In hospital	Out of hospital	Total
Decision point 1: Domiciliary to reablement	£ 920,000	£ 5,890,000	£ 6,810,000
Decision point 2: Residential to reablement/domiciliary	£ 280,000	£ 5,760,000	£ 6,040,000
Decision point 3: Nursing / EMI to residential/community/re-ablement	£ 480,000	£ 2,880,000	£ 3,360,000
Decision point 4: Community hospital to reablement/domiciliary	-£ 280,000	£ 2,650,000	£ 2,370,000
Cost of remaining occupied delayed beds - requiring medium / long term solutions	£ 23,980,000	£ -	£ 23,980,000
Cost of remaining occupied delayed beds - accessible through short term 'getting control'	£ 10,280,000	£ -	£ 10,280,000
All areas	£ 35,660,000	£ 17,180,000	£ 52,840,000

Source: Newton DToC assessments of the 3 systems

WHERE THE DELAYS ARE

Summary of Findings	
Number of beds reviewed across three areas	2889
Number of patients delayed (% of all beds)	501 (17%)
Number of patients that were reportable DTOC (% of all beds)	281 (10%)
Proportion of patients delayed that were reportable DTOC	56%
Number of detailed case reviews	132
Number of interviews	Over 80

Area of delay	Number of patients delayed (% of all delays)	Number of patients that were reportable DTOC (% of all delays)	What are the patients waiting for?	Number of patients delayed (% of all delays)	Top opportunities to improve	Top reasons why these aren't happening
Waiting for a decision on their outcome to be made	180 (36%)	43 (9%)	Assessment	80 (16%)	Improve communication and rate of progress Undertake in different setting Undertake pre-medically optimised and/or in parallel	Lack of clear communication and ownership for patient progress System primarily built around an acute-based assessments and therapy service
			Therapy	68 (14%)		
			Patient/Family Decisions	16 (3%)		
			Best Interest	16 (3%)		
Waiting to go to either intermediate bedded, nursing or residential care	166 (33%)	125 (25%)	Nursing/EMI	53 (11%)	Undertake assessments out of hospital after a period of Reablement Improve communication and rate of progress	Reluctance from the front-line decision maker to take a perceived risk Expectation setting earlier in the pathway System primarily built around making long term decisions in the acute setting
			CHC	37 (7%)		
			Residential	27 (5%)		
			Intermediate or community bed	24 (5%)		
			Assessment	14 (3%)		
			Other[23]	11 (2%)		
Waiting to go home with some extra support	113 (23%)	88 (18%)	Domiciliary	53 (11%)	Increase flow to and capacity of Reablement	Lack of consistent understanding of the importance of Reablement
			Reablement	47 (9%)	Improve effectiveness of Reablement	Reablement services not optimised
			Equipment	13 (3%)		
Other	42 (8%)	25 (5%)	Other[24]	42 (8%)		

Source: Newton DToC snapshots of the 3 systems

THE RIGHT PATHWAY

Are patients on the right pathway?					
Top level area of improvement	Cases reviewed	Number of cases where pathway could be improved	% of cases where pathway could be improved	Top opportunities to improve	Top reasons why these aren't happening
Waiting for a decision on their outcome to be made	11	7	64%	Assessments taken place outside hospital	Lack of clear communication and ownership for patient progress
Waiting to go to either intermediate bedded, nursing or residential care	85	36	42%	Most patients could have gone on to home care instead of resi/nursing	Reluctance from the front line decision maker to take a perceived risk Family disagreements/ expectation setting Capacity of home care
Waiting to go home with some extra support	36	9	25%	Discharge via Reablement	Capacity of reablement services
TOTAL	**132**	**52**	**39%**	-	-

Source: Practitioner led case reviews in the 3 systems

MODEL FOR CHANGE