‘Discharge to Assess’
Warwickshire Model

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Warwickshire Context

• 548,000 population
• 1 County Council
• 3 Clinical Commissioning Groups
• 3 Acute Hospital Trusts: 1 tertiary; 1 vertically integrated provider

Key Challenges:
• Frailty
• Financial
• Patient flow
How did we get here without a map?

Winter pressures plans were first aid not a cure.
Years of collaborative planning

Organic programme: strong shared purpose
building on successes

Learnt as we went: testing and tweaking

Lots of communication
An Integrated Health and Social Care Response: Our Shared Purpose

- No decision about long term care needs in an acute setting
- Discharge Home where possible

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

- Maximise ambulatory care
- Value added days vs non-value added days flow management
- Complex support needs – but how much is hospital-based decompensation?

Source: Dr Foster Intelligence
The Warwickshire pathways: Discharge to Assess model

**Pathway 1**
- Medical Episode Complete - Able to return home

**Pathway 2**
- Unable to return home
- Med - high complexity of dependency
- Up to 2-6 weeks RH/NH placement for assessment

**Pathway 3**
- Unable to return home
- Very high complexity of dependency
- Up to 4-6 weeks NH placement for assessment

- Nursing home care
- Other

Note – excludes fast track Continuing Healthcare (CHC)
Phase 1: Building Pathway 1

Create resources

Closure of community hospital (41 beds)
Invest in Community Emergency Response Team (CERT)

5 a Day North Warwickshire

Community and social care in-reach to George Eliot Hospital
Community input to Accident and Emergency 7 day service
8.30am – midnight
Community navigator in hospital 7 days
Daily multi-agency discharge meeting (5 days)
Friday senior review meeting: weekend planning and performance review

Roll out to South Warwickshire

Closure of 31 community beds
Reinvestment in CERT
Capacity increase: 25 to 71 patients per week
Vertically integrated model
Trusted assessment
Care package restarts within 10 days by discharge team
Direct referral to Reablement without hospital
Social work team involvement
Electronic common assessment tool (eCAT – in-house solution)
Phase 2: All good work but....

Community based changes 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 about their long term care needs made in hospital

Bedded model needed for patients not able to return home

<table>
<thead>
<tr>
<th>Moving on beds</th>
<th>Community Hospital beds</th>
<th>Nursing home beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 beds, re-ablement &amp; rehab focussed</td>
<td>Residential home setting</td>
<td>Flow managed by acute hospital discharge team</td>
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<tr>
<td></td>
<td>Flow managed by OTs</td>
<td>Length of stay: 18 days community hospital (CH), 37 days in Nursing Home beds</td>
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<tr>
<td></td>
<td>Length of stay 5.5 weeks</td>
<td>Dedicated weekly GP led MDT for discharge planning &amp; enhanced GP input to care</td>
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<tr>
<td></td>
<td></td>
<td>PT and OT available for active therapy in CH and maintenance therapy in Nursing Home</td>
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## Outcomes

### System Metrics 2011 - 2015

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline 2011</th>
<th>Jan 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E 4 hour performance</td>
<td>93.5%</td>
<td>96.3% Avg ytd</td>
</tr>
<tr>
<td>SHMI</td>
<td>1.11</td>
<td>1.04</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>21 days</td>
</tr>
<tr>
<td>Community capacity (IMC + community Hospital admissions per week)</td>
<td>25</td>
<td>83</td>
</tr>
<tr>
<td>Average medical outliers</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>Patient over 3 hospital ward moves</td>
<td>14%</td>
<td>2%</td>
</tr>
<tr>
<td>Patient falls in hospital per 1000 bed days</td>
<td>Acute 2</td>
<td>Combined 1.3</td>
</tr>
<tr>
<td></td>
<td>Community 2.4</td>
<td></td>
</tr>
</tbody>
</table>
Key challenges & how we dealt with them

- How to fund it?
- Lack of faith in delivery

- Benefits don’t always accrue where cost is incurred
- Behaviour change needed
- Pressure to deliver performance today whilst transforming the system
- Ensuring the nursing home market could respond without damaging flow or market prices

- Left shifting resource
- Phasing: deliver flow upfront tied to agreement to close acute capacity
- Risk/gain share approach to investment
- Coaching support, signposting
- MoU crucial in terms of managing risk, roles and responsibilities.
- WCC relationship with the nursing home market determined the beds commissioned and price
Key Lessons Learnt

- Multi-agency governance structure vital for engagement
- Managing expectations of clients/families needs good communication
- Pathway 3: Having the right champions for the model leading delivery is key
- Support to Nursing Homes for a culture change is essential: Rehabilitation ethos, planning for discharge
- ‘Flow’ management across Acute and Community supports shared ownership
- ‘Left shift’ investment up front in Intermediate Care/ Reablement Services supports affordability
- Managing team, professional and organisational culture is continuous
Where next…

Warwickshire Cares - **Better Together**: Plan on a Page

**Vision for Residents:** “I can plan my care with people who work together to understand me and my carers, allow me control, and bring together services to achieve the outcomes important to me.”

**Vision for Services**
- People are helped to remain healthy and independent
- People are empowered to take an active role in managing their own care and the care they receive
- People get the right service at the right time and in the right place

**Key themes:**
- **Care at Home**
  - Transforming the delivery of care at home
  - Home adaptation and rehabilitation services
- **Long Term Care**
  - Supporting people to manage long term conditions
  - Dementia friendly services
- **Community Resilience**
  - Helping people to help themselves
  - Connecting people with their communities
- **Accommodation with Care**
  - Reshaping the accommodation with care market
  - Supporting people to live independently
- **Integrated Care**
  - Integrated health and social care teams working closely with GPs
  - Urgent Care services as an alternative to hospital admission

**To work collaboratively across Warwickshire’s health and social care systems to:**
- Help people to manage their own care.
- Deliver better care closer to home.
- Reduce inappropriate admission to hospital and/or long term residential care.

**Who is Involved:** Warwickshire Cares - *Better Together* is an overarching initiative between commissioners and providers of health and care services and importantly the people of Warwickshire.
Interdisciplinary Health Hubs

HOME OF CARE FOR FRAIL AND VULNERABLE PEOPLE

- I feel more in control
- I have information and support I need
- I have care and support that is decided by me
- Reduced avoidable admissions

Outcomes

- Co-ordinated care for frail and vulnerable people
- Care and Support / Self-Management
- Community assets, Social prescribing opportunities
- 4 – 6 Weekly MDT Meetings
- Shared care management plan

Outputs

- Assessment and MDT Shared Care Planning
- Frailty Assessment
- Falls screening tool
- Dementia Screening
- EOL / DNAR Assessment
- Weight Management
- Smoking Cessation
- Increase opportunities for exercise
- Social Isolation

Care Navigation Social Prescribing

Mission

Community Matrons will work within interdisciplinary hub teams with GP practices to case find frail and vulnerable people using local intelligence and / or risk stratification opportunities.

To support Frail and Vulnerable people through a systematic care coordination approach in primary and community care as to improve patient outcomes and experiences.