NHS England
Delayed Transfer of Care
Pan London Review
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Executive summary

This report has been prepared by the NHS England Delayed Transfer of Care Programme and provides an overview of the causes of delayed transfers of care across London, and the characteristics of a good model for reducing these. This piece of work forms part of the Accident & Emergency (A&E) Taskforce project which as part of the winter resilience planning, has focused on London Ambulance Service, Delays in Transfer of Care (DTOC) and Emergency Care Improvement Programme. There is a lot of emphasis and focus placed on A&E performance; however as this report demonstrates, there is a significant system wide problem which hinders the ability for even the most efficient of Trusts in getting patients discharged from hospital to their next stage of their pathway in a timely manner.

The impact of delayed transfer of care on both patients and the overall health economy is very significant. As part of the review the DTOC Team undertook a one day snapshot to get a view of the total of medically optimised (MO)/DTOC across London. The estimated daily cost of delays was calculated to be in excess of £287,000. Over a year this cost equates to over £104,000,000, however, this could be higher as several trusts were excluded as they did not submit the required data and others may be under recording their MO figures.

To get an overview of the key issues in each health system, the DTOC team met with all System Resilience Group (SRG) leads across the five areas of London plus visited the top tier 1 trusts/sites who consistently perform above the national target of 2.5%. What is clear is that the DTOC indicator is only the tip of the iceberg as our snapshots showed the number of MO/DTOC patients is a far greater issue and less visible, reaching 18% of occupied beds in some Trusts.

The DTOC team identified areas of good practice across all the five SRG’s which provides a good foundation for shared learning and creating a more joined up approach to pulling the system together. Based on our findings in London, a well performing system with a good discharge model would combine the following characteristics as seen in our review.

Characteristics of a well performing system:

1. An agreed discharge policy which can be adapted to suit local need with clear escalation in place.
2. An agreed workable definition of medically optimised and patients and DTOC including when and where it is recorded. This needs to be recorded and visible to the whole system so it can be managed and drive pathway improvement.
3. A streamlined health care assessment and decision making panel process.
4. Agreed mechanisms for out of panel decisions including authorisation on behalf of out of area boroughs.
5. Greater focus on ‘care at home’ and ‘intermediate care’ models including ‘discharge to assess’ using resilience monies/Better Care funds to support the discharge process.
6. Ownership - seeing delayed transfers of care as everyone’s responsibility by improving system relationships and flow to NHS and non NHS care providers.
7. Good communications and timely decisions making through joint working between Health and Social care.
This report pulls out the key issues and challenges in each system across London focusing on both the provider issues as well as how the local health system is supporting and working with them to help manage patient flow. There are a number of common recurring themes which are reflected in the discussions of this report and whilst good practice is demonstrated, each system works in silos.

**SRG focus for 2016/17 winter planning**

- **Process:** We know care home capacity, rehabilitation, stepdown beds and housing are all limiting factors and there will never be enough beds in the system to cope. SRG’s do have an opportunity however to focus on developing their relationships across the sector as seen in the NWL tri-borough model and forming joint action plans and streamlined processes. It will be crucial to ensure there is good oversight of community bed length of stay as well capacity to ensure that flow is maintained in other parts of the system as well.

- **Policy:** Applying a standard and agreed discharge policy. There is an opportunity to roll the South East London Discharge policy across all areas sharing best practice but also optimising buy in from Trusts to apply this policy with more rigour, particularly around family choice.

- **People:** Getting the right people in place to provide expertise, ownership and leadership to the patient pathway is critical. The Princess Royal University Hospital have experienced case managers who manage the discharge process. We found other Trusts struggled internally as they either had too few experts to complete health assessment paperwork, or did not have quite the level of engagement they required at ward level to focus on discharges. There are many opportunities to provide nursing home training as Guys and St Thomas NHS Foundation Trust does to help stepdown from hospital; or greater community based rehabilitation to alleviate the gaps in level 2 and 3 beds. There is also opportunity to tap into the primary care sector and maximise services offered there.

**NHS England 2016/17 winter planning**

- **System leadership:** NHS England together with NHS Improvement needs to ensure systems report MO/DTDc in a consistent way and monitor performance on a regional basis to encourage systems to take responsibility for reducing them.

- **Agreeing a workable London definition for medically optimised patients:** which is jointly developed with key stakeholders and consistently recorded.

This report also provides a set of recommendations based on the good practice seen and researched; plus provides some discussion on how the system can work more collaboratively together to drive improvements around the discharge process.
Introduction

The DToC and MO programme forms part of the A&E Taskforce which was set up as part of the NHS England winter resilience team. The taskforce focused on four work-streams which linked in all aspects of the patient’s pathway from pre-admission to discharge into the community. Each work-stream focused on the tier 1 Trusts whose A&E performance had deteriorated over the winter period and a deeper dive into the key issues and challenges was deemed as necessary.

The DToC/MO review followed a set of key objectives to achieve plus required a more qualitative approach to gather soft intelligence behind the performance data and understand the system wide issues which ultimately impact on A&E performance.

The A&E Taskforce 4 distinct work-streams:

- System Resilience
- Emergency Care Improvement Programme (ECIP)
- London Ambulance Service (LAS) handovers
- DToC/MO

The DToC Team Objectives

1. Gain an understanding of the key DToC and medically optimised reasons for the top tier 1 trusts/sites who consistently perform above the national target of 2.5%.

2. Engage/work with commissioners and stakeholders to identify key enablers and blocks to delayed discharges both internally and externally.

3. Establish how Trusts externally report DToC and MO for acute hospitals.

4. What does ‘good’ look like? Identify best practice for those Trusts and areas that perform well.

5. Make recommendations based on best practice across the system for SRGs and Trusts to work collaboratively on for winter 2016/17 and future planning.
**Table 1:** The table below is a summary RAG rating as of March 2016 of the progress made against the original DTOC/MO project objectives and core deliverables.

### DTOC / Medically Optimised

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Core Deliverables</th>
<th>Operating Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Targeted intervention in five systems with most DTOC/MO challenges</td>
<td>- Agreed rectification trajectories, supported by action plans and resources.</td>
<td>- London Region good practice guidance for data reporting and DTOC management</td>
</tr>
<tr>
<td>- Agreed rectification trajectories, supported by action plans and resources.</td>
<td>- On-going monitoring and reporting of improvement</td>
<td>- Assurance on adoption of best practice by each SRG through WarRoom</td>
</tr>
<tr>
<td>- Ensure all SRGs are following best practice for DTOCs/MOS</td>
<td>- London Region good practice guidance for data reporting and DTOC management</td>
<td></td>
</tr>
</tbody>
</table>
Limitations of DToC Project Review

- The DToC Team formed in mid-January 2016 and had a timescale to deliver a full system review by the end of March 2016. The team consisted of an interim project lead (full time from February) and other members from NHS England who were ‘volunteering’ from their normal roles. Time constraints was a key factor for several members of the substantive members as they still had their other work commitments to fulfil.
- Organising site and SRG visits early in January was delayed as this required a formal approach, resulting in a number of outstanding visits until mid-March. We embraced the support of the NHS Trust Development Authority (TDA) who helpfully facilitated a number of visits.
- Access to data for MO was highly inconsistent. NHS England collects Sitrep DToC data against the London 2.5% trajectory, however, granular data was required for the purposes of this report and was collected manually.
- The winter pressures work continues annually and for future projects, the resilience team may wish to consider how they bring this work together for future teams to access at the beginning of the process.
1. Delayed Transfers of Care

DTOC have been a constant concern within the care economy for a number of years; London is not unique in this situation as the national picture is similar where an ageing population with complex needs and multiple health and social care dependencies is stretching an already tight resource base.

A delayed transfer of care is where a formal decision has been reached that a patient is ready to leave hospital care, however, a delay may occur due to external delays and the patient continues to occupy a hospital bed. Unreported delays are attributed to patients who are termed as ‘medically optimised’ or ‘medically fit’ for discharge. This second group is less visible as they are not routinely monitored on a local or regional basis.

Delayed transfers of care reached record levels in January 2016 (The Public Sector Executive in March 2016). Of the total 159,000 delays (including those who are medically fit); 103,000 were in acute care which was an increase of 6% from the previous year. Broken down, 61% were attributable to waits for further non acute NHS care and 32% were delays for social care packages for care at home. The Kings Fund (March 2016) cite the pressure of cuts in the social care budget in recent years has overall contributed to funding and placement pressures.

Compounding the pressure within the acute hospital system, the Kings Fund (March 2016) published its findings on the A&E performance reporting that of all attendances, 13% of patients were discharged home without treatment and a further 35% received guidance or advice only. This is not to say that the attenders did not require medical attention, however the feedback from patients cited a lack of GP access and confusion around availability of access to acute care. From this data it does suggest A&E departments are coping well in triaging patients.

Hospitals rely on efficient patient flows to ensure they have adequate beds to admit newly presenting patients and supporting A&E flow. Where this flow is blocked for any reason, the provision of bed capacity becomes challenged. As a general rule, hospitals work to the basis that where bed occupancy rates are kept below a level of 95% they will have enough capacity to manage the daily flow.

When patients are delayed in their discharge, this flow stops, and the impact results in a back log culminating in delays for patients within the A&E Department. The main causes of DTOC vary across London’s Trusts; however the DTOC/ MO Taskforce observed recurrent trends relating to high numbers of patients waiting for:

- Nursing home placement or availability of a residential home
- Patients awaiting the completion of an assessment
- Awaiting care packages in own home
- Patient and family choice
- Patients awaiting ‘other NHS’ based care

The Kings Fund (2016) reported that high bed occupancy levels has been driven up by delayed transfers of care which prevents beds being freed up to allow smooth flow from A&E for new admissions. They report that delayed days have increased by 33% since the start of 2014/15 with a particularly steady increase by 12% from April to December 2015.
Figure 1: Delayed Transfers of Care: Total number of days delays each month

Source: Kings Fund March 2016. What’s going on in A&E?

Notwithstanding the supporting evidence that demonstrates a system under pressure, the hospital visits and discussions undertaken as part of this review by the DTOC Team with relevant agencies also reflect Trusts need to more streamlined around their internal discharging processes and be closely aligned to social care and other care providers to offer patients the right care in the right setting.
2. Patient Experience

The following examples are detailed in the body of this report; however, they demonstrate the reasons for delays and how long patients remain in hospital. Many patients become medically unfit again and the process starts again. This evidence was gathered during patient review meetings:
3. Data Analysis

- **Tier 1**: Trusts which consistently measured over the London 2.5% DTOC target
- **Tier 2**: Trusts performing under 2.5% were contacted for best practice

Table 2: This table lists the Trusts that were identified for visiting due to their DTOC Performance.

<table>
<thead>
<tr>
<th>Tier</th>
<th>Trust</th>
<th>Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>Barts Health NHS Trust</td>
<td>Whipps Cross Hospital</td>
</tr>
<tr>
<td></td>
<td>London North West Hospital</td>
<td>Northwick Park Hospital</td>
</tr>
<tr>
<td></td>
<td>Royal Free London</td>
<td>Barnet Hospital</td>
</tr>
<tr>
<td></td>
<td>Kingston Hospital NHS Foundation Trust</td>
<td>Kingston Hospital</td>
</tr>
<tr>
<td></td>
<td>University of London College Hospitals NHS Foundation Trust</td>
<td>Princess Royal University Hospital</td>
</tr>
<tr>
<td>Tier 2</td>
<td>St Georges Hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kings College Hospital</td>
<td>Princes Royal Hospital</td>
</tr>
<tr>
<td></td>
<td>Lewisham and Greenwich</td>
<td>Lewisham Hospital</td>
</tr>
<tr>
<td></td>
<td>Barking, Havering, Redbridge University Hospitals NHS Trust</td>
<td>Queens Hospital</td>
</tr>
</tbody>
</table>

Table 3: This table shows a breakdown by London Trusts of DTOC performance against the London 2.5% DTOC target. Those shown in red are the worst performing Trusts with higher rates of DTOCs.

<table>
<thead>
<tr>
<th>Trust</th>
<th>Bed Day Delays caused by DTOC</th>
<th>DTOC rates (bed days delays per occupied bed) National recommend&lt;2.5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barts Health</td>
<td>2093</td>
<td>2238</td>
</tr>
<tr>
<td>London North West</td>
<td>1464</td>
<td>1458</td>
</tr>
<tr>
<td>Univ College London</td>
<td>568</td>
<td>762</td>
</tr>
<tr>
<td>Royal Free</td>
<td>955</td>
<td>906</td>
</tr>
<tr>
<td>Kingston</td>
<td>429</td>
<td>771</td>
</tr>
<tr>
<td>St Georges</td>
<td>385</td>
<td>580</td>
</tr>
<tr>
<td>Barking</td>
<td>333</td>
<td>403</td>
</tr>
<tr>
<td>Guys &amp; St Thomas</td>
<td>522</td>
<td>455</td>
</tr>
<tr>
<td>Epsom &amp; St Helier</td>
<td>564</td>
<td>533</td>
</tr>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>494</td>
<td>575</td>
</tr>
<tr>
<td>Imperial College</td>
<td>364</td>
<td>461</td>
</tr>
<tr>
<td>Lewisham</td>
<td>346</td>
<td>304</td>
</tr>
<tr>
<td>Homerton Univ</td>
<td>267</td>
<td>373</td>
</tr>
<tr>
<td>Kings College</td>
<td>396</td>
<td>340</td>
</tr>
<tr>
<td>N Middlesex</td>
<td>213</td>
<td>428</td>
</tr>
<tr>
<td>Croydon</td>
<td>391</td>
<td>260</td>
</tr>
<tr>
<td>The Whittington</td>
<td>177</td>
<td>204</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>3</td>
<td>42</td>
</tr>
</tbody>
</table>

The graph below was taken during a one day snapshot on the 11th February 2016 as surge directors proposed this would be a useful exercise to see the overall average for London. All SRG leads were asked to report their MO totals as well as DTOCs to show a total. This was then mapped against the Trusts acute medical bed base to show a % of bed occupancy across London and checked with each surge hub. The bedbase was also confirmed with the relevant surge team. Lewisham and Greenwich are omitted as the bed data was not available. The Homerton and Newham Hospital do not record MO so are also not included.
Whilst the data could be viewed as crude, it does provide a good indication of the level of total beds occupied by MO/DTOC patients and can be viewed alongside the data provided in this chapter.

**Graph 1:** The graph below shows the percentage of acute and general medical beds occupied by delayed discharges for all London Trusts (MO/DTOC).

Collecting data for MO across all London Trusts is not routine, therefore as part of the review, a one day snapshot was taken to calculate performance. North Central CSU confirmed that the bed occupancy figures shown above are realistic for those Trusts known to have a high number of delayed discharges (i.e. North Middlesex and Whipps Cross Hospital).

For Whipps Cross Hospital this equates to approximately 2.5 – 3 wards.

<table>
<thead>
<tr>
<th>DTOC/MO cost per day</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost bedday (based on Northwick Park bed day cost)</td>
<td>£280</td>
</tr>
<tr>
<td>total beddays of Mo/DTOC combined</td>
<td>1025</td>
</tr>
<tr>
<td><strong>total cost per day</strong></td>
<td><strong>£287,000</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DTOC/MO cost per year</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cost per day</td>
<td></td>
</tr>
<tr>
<td>Days per year</td>
<td>365</td>
</tr>
<tr>
<td><strong>total cost per year</strong></td>
<td><strong>£104,755,000</strong></td>
</tr>
</tbody>
</table>

For a breakdown of the activity against all London Trusts see Appendix 1.
The following section provides a 2 week snap-shot for each of the five Tier 1 Trusts whose DToC reported data is consistently > 2.5%. The aim is to show the overall operational activity on a day to day basis which has a direct impact on A&E performance.

This data was collected manually from Sitrep reports and surge performance submissions. Weekends are excluded due to an inconsistency in reporting data. Also to note is the lack of split between social and health care as again there is inconsistency in recording the data so these are included together.

The aim is to show how flow in and out from the hospital will impact on MO/DToCs. By looking at the admission and discharges together with the beds occupied by MO/DToCs patients, this can also be linked to the overall A&E performance and how this impacts on each other. Although the admissions and discharges is total number and is not broken down by speciality, it provides an overall flavour of the pressures.

**Graph 2 & 3:** The graphs below show Whipps Cross activity for DToCs and MO as well as number of admissions and discharges and how these relate to each other.

**Barts Health - Whipps Cross Hospital**

- Whipps Cross site shows a consistently higher level of admissions to discharges. An overall deficit during this period of -154.
- This is reflected in the high level of DToC/MO data which runs at an average of 59 patients during this period.
- The DToC/MO snapshot demonstrated the total acute general bed-base was occupied with 18% delayed.
Graph 4: The graph below shows the delay reasons for beddays lost at Whipps Cross Hospital for September 2015

[Graph showing delay reasons for beddays lost]

Graph 5 & 6: These two graphs below highlight reasons for beddays lost in Nov 2015 and Jan 2016

[Graphs showing delay reasons for beddays lost]

Graphs 4 and 5 above demonstrate a major shift and reduction in delays resulting from completion of assessments between September to November 2015. It would be interesting to understand what actions were taken to reduce this reduction by 50% over 2 months and how this could be reduced again by 50% from 538 beddays lost as this would significantly help the Whipps Cross site flow.

At the time of the Trust visit, there were > 60 delayed patients. The patient review meetings and feedback from the Trust visit reflects assessments are a major barrier to hospital discharge with delays including getting paperwork to panels, decision making and agreeing funding. This is also impacted by where patients are from although is not reflected in the above graphs. The Trust also indicated out of area assessments can take weeks to agree and transfer patients out. Backlogs of assessments at panels were reported for Redbridge CCG and West Essex CCG.
Northwick Park Hospital (NWP)

Graph 7 & 8: The graphs below show Northwick Park Hospital activity for DTOCs and MF as well as their number of admissions and discharges

- NWP shows a consistently higher level of admissions to discharges. Deficit during this period was **-444**
- This is reflected in the high level of DTOC/MO data which for Quarter 3 is > 3%
- The combined average of MO and DTOCs is **44 patients** over this period
- Across all North West London Hospitals NHS Trust (NWLHT) sites this is much higher with a daily combined average of MO.DTOCs of > **85 patients**

Graph 9 & 10: The graphs below show the Beddays lost at Northwick Park Hospital in Nov 2015 and Jan 2016

NWP Nov 15 delay reasons for beddays lost

NWP Jan 16 delay reasons for beddays lost
The majority of bed days lost are for **nursing home placements**. The soft intelligence gathered from surge calls and visits reflect the closure of 9 nursing homes following CQC inspections has had a huge negative impact and it is not clear when these will re-open. There is also an acute shortage of housing in the Barnet, Ealing and Hillingdon area making placements from hospital very challenging. The CCG gave an example of one patient waiting in a community bed for one year. Total bed days lost in November **1029 and 1016** in January 2016 reflect the capacity constraints in the community.

**University College Hospital (UCLH)**

**Graph 11 & 12:** The graphs below show UCLH’s activity for DTOCs and MF as well as number of admissions and discharges.

- UCLH has an average of **23 DTOCs/MO** at any one time. It was not clear that all MO is recorded so could higher
- UCLH shows there is an overall balance of admissions and discharges with 21 more discharges than admissions in this period.
- This is marginal however this increases the risk of additional surges in activity.
- Whilst only a snapshot, Graph 12 suggests more patients are discharged in the middle of the week than towards the end.
- DTOcs performance for Quarter 3 has been consistently **>2.5%**.

**Graphs 13 & 14:** The graphs below show the Beddays lost by category at UCLH in Nov 2015 and Jan 2016.
Graph 13 & 14 reflects the trust feedback that waits for **further non acute care** is the major cause of delays and intermediate care provision is limited. Also 45% of patients are Islington residents and without on-site Islington social workers, this is also a key block to discharges.

**Kingston Hospital**

**Graphs 15 & 16:** The graphs below show Kingston Hospital’s activity for DToCs and MF as well as number of admissions and discharges.

- Kingston hospital has one of the highest level of DToC of all London Trusts with performance in Quarter 3 running over 5%
- The combined average of MO and DToCS is **39 patients** over this period
- Trust data was not available for the 16th – 18th February for admissions and discharges

**Graphs 17 & 18:** The graphs below show Beddays lost by category at Kingston Hospital in Nov 15 & Jan 16

At Kingston the majority of delays are due to waits for further non acute care.
Barnet Hospital (Royal Free)

The graph below was extracted from 4 weeks of daily admission and discharge data for Barnet hospital which has continued to show real constraints on a daily basis.

Graph 19: The graph below shows admissions verses discharges for Barnet Hospital for January 2016

- Admissions exceeded discharges during this period by 96 patients
- Discharges were highest on Fridays
- The DTOC team noted that Barnet’s DTOC performance is significantly influenced by four complex cases (>50 days each)

North East London Surge feedback regarding Barnet Hospital:

- Out of area repatriations from Hertfordshire is a key block
- Chase Farm is a ‘cold site’ and Barnet is a ‘hot site’. There is little movement between sites to help pull patients and aid flow
- Limited access to community beds in the Barnet area is an issue
Graphs 20 & 21: The two graphs below show Barnet Hospital’s number of admissions and discharges as well as DToCs and MO:

- Discharges exceeded admissions by 8 during the 2 week snapshot.
- Barnet site has an average of 28 MO patients at any one time. This number is consistent with the CCG calls where majority of patients are waiting for further non acute placements.

Graph 22 & 23: Graphs below show the Beddays lost by category at Barnet (Royal Free) in Nov 2015 & Jan 2016.
4. Map of London Health Economy
5. South East London Area (SEL)

Hospitals visited by the NHS England DToC team in SEL:

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Meeting held with</th>
<th>Area/Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>HealthWatch Lambeth</td>
<td>Chief Executive</td>
<td>Lambeth</td>
</tr>
<tr>
<td>Kings College Hospital</td>
<td>Director of Flow and transfer of Bureau team</td>
<td>Visit to Princess Royal University Hospital</td>
</tr>
<tr>
<td>NHS Southwark Clinical Commissioning Group</td>
<td>SEL- Head of System Resilience</td>
<td>NHS Southwark CCG/SEL CSU</td>
</tr>
<tr>
<td>NHS SEL CSU</td>
<td>Repatriation Manager</td>
<td>SEL CSU</td>
</tr>
<tr>
<td>Lambeth and Southwark Local Authority</td>
<td>Integrated Social care team</td>
<td>Covers Lambeth and Southwark local authority</td>
</tr>
<tr>
<td>Lambeth Clinical Commissioning Group and London Borough of Lambeth</td>
<td>Assistant Director Integrated Commissioning - Older Adults</td>
<td>Lambeth CCG</td>
</tr>
<tr>
<td>Lewisham CCG</td>
<td>Interim Director of Delivery</td>
<td>Lewisham CCG</td>
</tr>
</tbody>
</table>
SEL SRG has developed a very robust model to review long stay patients and DToCs. In 2014 Southwark CCG set up a task and finish group to review patient pathways and a key outcome was to develop patient sector meetings to address DToCs. The CCG also recruited a Repatriation Co-ordinator to address repatriations. The SRG are also continually focusing on the blocks across the community, in homes, out of area acute Trusts and supporting the system to reduce delays. Therefore DToCs are minimised and this is reflected in Table 3 for Kings College Hospital (KCH) and Guys & St Thomas NHS Foundation Trust (GSTFT). This model is not replicated across London and probably needs to be. SEL is run by the CCG which they consider enables them to have much better access to the community than other sectors do.

What works well:

- SEL is **run by the CCG** so they get greater traction from the system
- There is a **real focus on MO patients** with the whole system organised to focus on flow. This is reflected in their low DToC/MO data
- The **repatriation manager** based at the CCG and focuses on patient level repatriations, liaises directly with trusts and has made significant impact particularly out of area i.e. Kent

**SEL Repatriation Manager**

The **Repatriation Project** began in October 2014 and was initially intended as a 6 month South London (South East London & South West London) pilot funded by the CCGs in SE and SW London to assist with adult specialist tertiary care delays. The key function of the role involves: South East GSTT and Kings (stroke at Princess Royal Hospital and Denmark Hill)

- Gathers full patient identifiable details and repatriation data from each tertiary unit so manager is able to chase up repatriating patients back to their own District General Hospital closer to home.
- Since June 2015 South East and South West London were divided with the manager continuing to cover SEL’s patch and associated 6 CCGs in SEL. This left South West London uncovered.

**Graph 24**: The annual reduction in repatriations by hospital site between 2014 and 2015
All 3 of the above graphs demonstrate the significant impact the repatriation role has had on patients waiting to be transferred back to their local DGH.

Lambeth and Southwark Integrated Social Care Team

The Lambeth and Southwark (L&S) social services team comprise of 16 social workers on both the GSTFT and Kings sites. They operate a 7 days service which commenced in the last 12 months. This initiative has had a positive impact on flow.

The team provide ward based named social worker support who attend the multi-disciplinary team (MDT) meetings which are clinically led. They provide cross cover during lead and there is a duty social worker out of hours.

They have commissioning authority and can purchase care packages at weekends thereby facilitating smooth discharge out of hospital in a timely manner. Nominated social workers are authorised to make out of panel decisions so they can enable ‘discharge to assess’ – these are then ratified by the next CCG panel but again, prevents further delay as decision making is quick. **80% of patients are discharged within time.**
At KCH there is a **Monday to Friday social care service in A&E** to review social needs, but there is none at a weekend resulting in admissions which may have been avoided.

There is a Frailty ward based at St Thomas’s hospital where older patients are directly assessed admitted or discharged to this unit, thereby avoiding A&E or an unnecessary hospital admission. The standard turnaround time is 72 hours and is currently a pilot Monday to Friday.

**Integrated Commissioning - Older Adults. Lambeth CCG and London Borough of Lambeth**

The integrated commissioning team brings together health and social care to address combined needs for their local residents. They play a key role in the patient discharge process and work across the ‘system’ to address DToC issues which affects flow in and out of the acute provider hospitals. DToC levels for KCH are less than 2.5%, but it is the unreported patients that require attention i.e. MO and the delays around these.

A few **key external influences** have impacted care home provision in so far that the Council cuts are hitting very hard and cannot recruit staff. Lambeth CCG and Local Authority (LA) have prioritised investment into domiciliary care with an additional cost of £1.5m cost to the council.

Lambeth has good nursing homes and purchase on a block contract 300 beds. They are addressing the shortage of beds by getting patients home with care.

**Internally**, the view is hospitals need to be better at managing the risk and assessments as these do not have to be perfect. Discharge planning should run in parallel to getting patients fit for discharge or getting medically optimized. Often teams wait until the patient is medically fit before getting a section 2 in place which will trigger the discharge planning process and discharge to assess modes and extra care.

Lambeth CCG developed a discharge best practice guidance for Lambeth, Southwark, Bromley and includes a patient choice policy. This has been sent to Trusts so they should be using it and applying the guidance.

‘**Myth busting**’: The team work with providers to reduce the myth around discharge i.e: transfers are not discharge – they are safe environments. Choice is used too widely but should not prevent a patient who is MO from leaving hospital. The new discharge policy should help iron out these issues.

**HealthWatch Lambeth**

HealthWatch Lambeth (HWL) enhance patient flow with the local commissioners and authorities by working collaboratively to improve patient experience and advocate the family and patient voice. In collaboration with the CCG and Trusts HWL have developed the following initiatives:

- **Discharge to access** – with resilience funding a specific role is funded at KCH and GSTFT to identify patients ready for discharge
- Lambeth LA have funded **2 step down flats** to support early discharge and provides 24/7 social care
- System Resilience work – development of the **Discharge protocol** and agreed system side
- Volunteer programme – ‘hospital to home’ programme supports patients 6/52 post discharge
- Red Cross input
Kings College Hospital – Princess Royal University Hospital

The DTToC team met with the Director - Transfer of Care at Princess Royal University Hospital (PRUH). There has been a key area of focus on discharging process since the McKinsey review in the summer of 2015 to implement the changes recommended.

Kings College Hospital and the PRUH merged 2 years ago and the first year was challenged in terms of understanding flow given the data issues. McKinsey identified that the PRUH had a combined total of approximately 70-100 patients who were either MO or formal delays.

Since this time, the team have re-designed their internal discharge teams to develop an integrated Transfer of Care Bureau – hosted by the CCG to look after Bromley patients only, which brings together social workers, senior nurses, case managers to work together to improve and focus on flow, and have case worker on every ward. The initiative started in October 19th 2015 on 4 wards which had a high number of patients whom needed a supportive discharge. By 25th November 2015 all wards went live. The result of this has seen a positive reduction in the number of delayed patients. The number of MO patients range now between 20-30 patients.

The team have implemented the ‘Best Practice for Discharges’ which has been agreed in the SEL area. At the time of the visit, the PRUH has been hit with seasonal norovirus which in turn has increased the MO patient cohort as external placements have been difficult to mobilise due to concerns around infection control.

What Works Well:

1. The Transfer of Care Bureau work with internal and external agencies to improve the patient discharge process
2. Discharge to assess model: The home team (social worker and nurse) assess appropriate patients in A&E and then complete the assessment process at home. Mitigating admissions
3. CCG commissioned 30 nursing home beds for rehabilitation. Level 1 & 2 are still a gap however
4. Access to extra care housing- step down facility

Princess Royal University Hospital Summary

The PRUH site and team have made significant changes to their internal and external pathways and patients following external reviews. The Trust is clearly addressing the patient flow issues and has engaged with all agencies to help move patients into the best and most appropriate location once they are deemed ready for discharge. Better Care Funding (BCF) has underpinned this work since October and the relationship between the Trust and Bromley LA/CCG appears to be positive with good dialogue between them. The Trust is looking at ongoing funding to sustain this team going forward.
The Interim Director of Delivery and System Resilience leads three boroughs of Bexley, Lewisham and Greenwich which are served by two main Trusts: Lewisham & Greenwich, Oxleas and to a lesser extent South London & Maudsley NHS Foundation Trust (SLAM) cover.

Our Healthier South East London launched in 2015 and partners with NHS England, Bromley, Greenwich, Lambeth, Lewisham and Southwark CCGs and aimed to transform the delivery of health and integrated care based on changing local demographics and needs.

Due to the high level of DTOCs and emergency performance at the time, in 2015, The CCGs commissioned a McKinsey diagnostic of internal processes, focusing on ED, capacity and discharge processes. Since this time, performance has improved its position to under 2.5%.

**Lewisham & Greenwich System Wide Actions Taken to Improve Performance**

- In October 2015 a **joint planning winter initiative** was undertaken for 5 weeks in the run up to Christmas and the New Year, this involved additional resource around stepped up interventions around bed capacity, discharge and hospital at home. However, this focus was unsustainable, and post-Christmas DTOC levels have risen, some of the additional bed capacity which was intended to close in January 2016 still remains open.
- **Discharge to assess initiatives**-these were commissioned, however, providers did not gain the intended benefits despite anecdotal evidence of efficacy, issues around complexity and the need for coordinated planning to reduce silo working, intentions of the SRG are to refresh the recommendations of McKinsey diagnostics to focus on underpinning processes.
- Following the report there is **good leadership** in place looking at the issues of delayed transfers of care as one system and there are noticeable improvements for example there has been a **3% improvement against the 4 hour standard** though the system is still not hitting the 95% target.
- Joint plans are now being developed against the 4 hour standards.
- Implementation of **ready to discharge lists** rather than a focus on delayed transfers of care, this frees up capacity and they have found it helpful using sitrep criteria to service ready to discharge lists.
- **Standardisation of documentation**: this is enabling improved communication and less handoffs
- Integrated service provision between secondary and community care, thereby reducing handoffs (Lewisham).
- Creation of a **“Health Help Now app”**, developed on the back of “Our Healthier South East” programme, launched in November 2015. Similar to 111 it enables improved health and care navigation.
- Smoother **repatriations** of patients within the system, due to surge hubs creating shared purpose.
### Summary of Areas for Improvement

<table>
<thead>
<tr>
<th>Area</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better care funding (BCF)</td>
<td>15/16 BCF has been used in a number of areas to improve flow and fund discharge to assess schemes as well as LA step down accommodation. However the CCG’s felt that these were often siloed integration plans rather than whole system innovation so did not benefit across the whole area. Sustainability is also key to ensure the benefits are realised on a longer term basis.</td>
</tr>
<tr>
<td>Patient choice delays</td>
<td>All CCG’s and Trusts identified delays due to family choice.</td>
</tr>
<tr>
<td>Discharge planning</td>
<td>Better earlier identification of the EDD</td>
</tr>
<tr>
<td>Health needs assessments</td>
<td>There is too much duplication of effort with the DST plus the London healthcare assessment tool</td>
</tr>
<tr>
<td>Variation in panel decisions</td>
<td>Lambeth CCG Panel will allow out of panel decisions for nursing care and ratify them at the next meeting. However Southward CCG panel will not make an out of panel decision and do not consider Funded Nursing Care.</td>
</tr>
<tr>
<td>Panels declaring a formal DToC</td>
<td>There is variation between CCG’s of when they formally report DToCS</td>
</tr>
<tr>
<td>Out of area decisions</td>
<td>Links to outside authorities is not streamlined</td>
</tr>
<tr>
<td>Medically optimised definitions</td>
<td>The need to define MO properly to enable a consistent approach across all hospitals was highlighted.</td>
</tr>
<tr>
<td>Variations in discharge processes</td>
<td>Develop a joint discharge protocol for the whole of SEL (as per KCH and GSFTF)</td>
</tr>
<tr>
<td>7 day Services</td>
<td>There was variation across the patch in 7 day cover. Although significant inroads had been made on all the sites, in some cases, therapy cover was not provided adequately at L&amp;G. Similarly, KCH and GSTFT are not fully driving a comprehensive 7 day service. Feedback highlighted gaps in pharmacy, therapy, clinical support, community cover and GP out of hours to support discharge at weekends.</td>
</tr>
<tr>
<td>Lack of nursing home capacity</td>
<td>Also includes complex placements for EMI, homeless, obesity patients</td>
</tr>
<tr>
<td>Self funders and family choice</td>
<td>This compounds the issues of family declining places</td>
</tr>
<tr>
<td>Lack of neuro rehab beds</td>
<td>Prevent timely repatriations to level 1 &amp;2</td>
</tr>
</tbody>
</table>

### Summary of SEL

- Overall SEL area can be viewed as a system that is striving to pull together to address community and acute provider flow. This is reflected in their DToC performance which falls under 2.5% in all cases. There were a number of areas of good practice seen in relation to integrated LA social care who provided 7 day cover.
- In particularly, Lambeth CCG had agreement for out of panel decisions which enabled fast track discharges and reduced delays due to panel decisions. Not all CCGS do this and this was raised as a concern. Lambeth & Southwark CCG investment in a repatriation manager has made a dramatic impact on particularly the out of area repatriations and should be role other areas can learn from. The development of standardised assessment paperwork and an agreed discharge protocols that have
involved the local authority as well as Trusts and HealthWatch is a key demonstration of a shared problem. Implementation and embedding this is now key to ensuring ongoing improvements are made.

- Lambeth CCG through their integrated commissioning for older adults, had good links with nursing home providers with one who provided excellent step down facility and provide specialist care as well as registered care facilities.
- PHRU’s transfer of care model was seen as an area of best practice and arising from the NHS England visit, other CCG leads arranged to visit the Trust to learn about their integrated care model.
- Lewisham & Greenwich CCG have undertaken a number of initiatives; however, not all of these are sustainable.
6. South West London (SWL) Area

Hospitals visited by the NHS England DTOC team in SWL:

### Summary of NHS England Visits in SWL

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Meeting</th>
<th>Area/Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston Hospital</td>
<td>Arranged but Trust did not attend</td>
<td>Hospital visit</td>
</tr>
<tr>
<td>Kingston CCG meeting</td>
<td>Director of commission and SRG lead</td>
<td>CCG meeting</td>
</tr>
<tr>
<td>St Georges Hospital</td>
<td>Head of operations CCG lead</td>
<td>Hospital visit</td>
</tr>
<tr>
<td>Richmond HealthWatch</td>
<td>Chief Executive</td>
<td>Richmond</td>
</tr>
<tr>
<td>Sutton CCG</td>
<td>Service Redesign and System Resilience Manager</td>
<td>Hospital visit</td>
</tr>
<tr>
<td>St Helier Hospital</td>
<td>Head of Capacity Management</td>
<td>Hospital visit</td>
</tr>
</tbody>
</table>

**Kingston Hospital - SRG action plan and trajectory 2016/17**

Action plan and trajectories submitted for MO & DTOCs. Linked to ECIP action plan.
The DToC Team met with the Kingston CCG who identified a number of challenges they consider impact on DToC/MO patients.

Externally, the demographics of the area is an older population with 65% of people self-funding their care. The CCG cited a shrinking market not just in this area but across London in terms of care home capacity and this comment has been reflected in a number of other London regions where nursing homes are stepping down from nursing to care home facilities due to funding constraints.

Further improvements around promoting therapy led discharge was believed to be a constraint, with not only occupation therapist (OT) staff shortages but also the view some are ‘risk averse’ in discharging from hospital and learning from other models of discharge to assess could improve this. Access to equipment is also a key issue and delays can arise from this.

There is a lack of 7 day cover at Kingston to drive an increase in flow and discharges over the weekend.

**What Works Well:**

- The Trust has a number of areas of good practice and the HealthWatch visits to wards also reflected this. The Trust has implemented an Electronic Patient Tracking List to have more visibility of the patient pathway.
- The SRG action plan demonstrates a need and plan to integrate social care, community and acute OT’s into a single workforce so this is less fragmented.
- There is proactive voluntary sector input and this is well utilised.
- Home care is another area of focus and extended scope for paramedics.

**Kingston Hospital**

*Site visited by DToC Team but Kingston Hospital Operations Team did not attend*

Kingston Hospital Foundation Trust (KHFT) is a 520 bedded acute NHS hospital in Kingston upon Thames, and has had challenges around the delivery of sustainable A&E flow and demand and capacity management, a meeting was set up with Kingston CCG to understand the challenges and collaborative solutions to facilitate improved delayed transfers of care within the system.

Kingston is an outlier for DToC performance and their trajectory aims to achieve 4% so it is clear that further system support is required to reduce this to the target level. ECIP were at the time of the project working with the Trust to improve performance around the emergency and discharge pathways. The ECIP action plans reflect a focus on discharges and workshops to address discharge process have been led and supported by McKinsey who have been commissioned to lead this work.
Richmond HealthWatch

Richmond HealthWatch (RHW) have just undertaken a review of Discharge from Hospital which looked at patient experience, key concerns and challenges and provided a set of recommendations.

Local residents attend KHFT, Hounslow and Richmond Community Healthcare and West Middlesex Hospital. A key concern for RHW is the need for more intermediate beds and a lack of capacity in social care homes. A number of successful initiatives undertaken with RHW and also noted in the other SWL meetings demonstrated:

- Learning from delays at West Middlesex Hospital. This is the only trust where we found (or it may be happening but not mentioned) a case review for long stay patients.
- SPGs are standardizing the referral forms. **However this will mean difference in forms in different areas i.e. North London and South London.**
- **Ward links with community nurses:** a referral is sent to the community nurse about a patient and allows the community nurses to ask the ward nurses directly questions regarding the patient.
- **Age UK Richmond** is funded by the SRG. This service is for older people living alone but not requiring rehab. Health Watch Richmond will be reviewing the service in Spring 2016.

**St Georges Hospital**

St George’s Hospital is one of the London’s largest teaching hospitals. It is part of the St George's University Hospitals NHS Foundation Trust which also provides a range of community based services to Wandsworth residents. The hospital has around 1,300 beds and provides general and tertiary services such as accident and emergency, maternity services and care for older people and children. It is also home to one of four major trauma centres and one of eight hyper-acute stroke units for London.

St George’s Hospital also serves a larger catchment area in the South East of England, especially the Boroughs of Wandsworth, Merton, Sutton, Kingston, Richmond and Lambeth.

McKinsey undertook a diagnostic exercise (OVT: **One Version of The Truth**) for St Georges which reviewed emergency care across the system and identified 11 key work streams for the Trust to transform the unplanned care system for the local health and social care economy.

Following the OVT review an implementation plan addressing key work streams has been developed and agreed with commissioner and the SRG. There are 6 key workstreams required to transform emergency care across the system, to include: ED, shortstay wards, internal processes, discharge processes, admission avoidance and discharge pathways. The SRG have appointed McKinsey to lead the implementation of the unplanned care system re-design plan following the OVT diagnostic exercise.

In addition to the OVT, ECIP also reviewed the Trust in January 2016 and developed a system wide action plan to address the external and internal issues.
Meeting with Head of Operations

Some of the issues influencing DToC performance include:

- Medically Fit for Discharge – 4 long waiters for specialised neuro-rehabilitation beds
- Waits for Social Service input to process – especially from Merton. It was suggested that Borough consider cross-Borough working and delegating decision making to a shared social service resource

Operations and ward meetings

There is a daily operations meeting which includes representation from operational management, ward staff and occasional attendance from Social Workers or their representatives. A ward discharge meeting was observed where treatment plans and discharge arrangements were discussed with the MDT including consultant-led and participation from ward staff, junior doctors, nurses, therapists.

Issues arising from the visit:

- Social services
  Communication issues with social services and the meeting noted the very different relationships with different social service departments- in particular Merton LA was highlighted as an outlier. There appeared to be good links with Wandsworth (community care).

- Health Needs Assessment
  Staff commented that they found the Health Needs Assessment (HNA) paperwork over bureaucratic and taking up to 5 days to complete.

The Trust reported that three patients were admitted for the completion of HNA forms. All three cases were reviewed via Platinum Command and all three patients had no medical reason for admission.

The Trust was making good progress to improve the patient reporting and have implemented as part of the action plans an IT report which allows the Trust to share patient level detail with other organisations including community and social services.

- Repatriations

There are an average of 20-30 repatriations each day. The Trust has a web based database to record all repatriations which are escalated within a locally agreed time. Queen Mary’s hospital was cited as a key challenge for repatriating patients.

Summary of visit

St Georges has a number of action plans in place which are being supported by the CCG’s and McKinsey and some benefit is being realised from these. However, as they continue to be challenged with external factors including serving multiple boroughs and also repatriations which have continued to remain at an average of 20 -30 per day. The DToC Team would strongly recommend a follow up review to see how the action plans are progressing and the impact this has had on patient flow in 3 months’ time (June 2016).
**SWL System Resilience Group**

The SWL SRG have developed a 16/17 Discharge Action Plan which brings together the 3 CCGs: Kingston, Wandsworth; and Richmond CCG. From a workshop they identified a number of key priorities for focus including:

- Develop a common assessment approach to be used for all patients at KHFT
- Develop consistent agreement across boroughs for Discharge to Assess at KHFT
- Develop a new Choice Protocol observed by all partners whose patients use KHFT
- Ownership of “the story of my mother?” at ward level at KHFT, 24/7, 7/7
- Develop best practice support arrangements for Care Homes
- Share resources to improve discharge in extended hours and at weekends
- Review of local neuro-rehabilitation capacity & resources
- Develop CHC process and services

In addition, they have also undertaken a self-assessment against the ‘High Impact Change Model-Managing Transfers of Care’ document. The self-assessment form consists of 8 domains to assist SRGs and Trusts to identify areas of the system that can support health and care systems to impact on discharges, reduce delays and improve flow. Success is measured by movement towards “exemplary practice” across all of the 8 domains. The Kingston System Resilience Group Meeting also regularly discusses DToCS and constraints (High Impact Change Model- Managing Transfers of Care, 2015).

**Sutton CCG & St Helier Hospital**

St Helier and Sutton CCG were highlighted as an area who had good practice initiatives in place which improved flow across the system. The visit included a meeting with the Head of Capacity Management at St Helier Hospital and the Service Redesign and System Resilience Manager from the CCG to understand their initiatives to improve flow. The majority of patients that come to the hospital are from Sutton (70%) and the remaining mainly Merton.

An example of improving flow is the **Sutton Integrated Digital Care Record (IDCR)**. Sutton CCG and LA have been awarded money from DH to develop the IDCR- this enables doctors, nurses and care professionals to view patient’s records (once consent has been agreed for social care data). This could reduce delays by up to half a day as basic patient information will be readily available to local health professionals. For example local GPs are able to see social care data and community and hospital staff will be able to see relevant aspects of the GP record.

The **Community In-reach (Swoop) Team** is a winter resilience initiative. It is multi-disciplinary team that has been formed to improve the patient pathway from the hospital back into the community and to support capacity management throughout the winter period within St Helier’s.

The team undertakes all non-simple discharge assessments, to inform the appropriate discharge destination with the patient. The team liaise with acute services to ensure that all diagnostic and treatments are completed and that referrals to appropriate services are made. The team works to deliver care closer to the home outside of acute hospitals such as working with the local voluntary sector. The team work in
several areas such as ED for admission avoidance, escalation wards and other wards requiring more community support.

The team work 7 days: 8am-8pm Monday to Friday and 10am -6pm on weekends including bank holidays. The team consist of community nurses, members of the Current Rapid Response Team, discharge practitioners, physiotherapists, occupational therapists; Age UK, representatives from Continuing Healthcare and mental health representative as required. The service is currently being evaluated.

**Older Person’s Assessment and Liaison Service (OPALS):** The team comprise of nurses, therapists and link to a social worker, they are also supported by one of the trust’s geriatricians. They screen all over 65 year olds and provide recommendations for care provision and discharge planning. A Comprehensive Geriatric assessment is completed where indicated. They are predominantly based on the Acute Medical Unit, but attend the ED white board with Swoop and in-reach into ward areas to provide specialist advice and support.

This service is aimed at preventing unnecessary admission into the Acute Trust.

**Table 5: Areas of improvement for SWL**

<table>
<thead>
<tr>
<th>Summary of Areas for Improvement</th>
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<tbody>
<tr>
<td>Punitive penalties</td>
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<tr>
<td>London DToC target</td>
</tr>
<tr>
<td>Health needs assessments</td>
</tr>
<tr>
<td>Out of area decisions</td>
</tr>
<tr>
<td>Medically optimised definitions</td>
</tr>
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<td>Repatriations</td>
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<td>Lack of nursing home capacity</td>
</tr>
<tr>
<td>Self-funders and family choice</td>
</tr>
<tr>
<td>Lack of neuro rehab beds</td>
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</table>

**Summary of SWL Area**

- St Georges McKinsey and ECIP action plans are reviewed in 3 months’ time to assess progress across the system.
- Bringing together the action plans for the whole areas as even within a locality, this is still split down into CCG level and appears to be siloed.

Good practice was seen in the SWL 16/17 action plan which includes CCG’s for Kingston, Surrey Downs, Richmond and Wandsworth. Similarly, the action plan for St Georges led by Merton CCG reflects efforts to streamline pathways across the system in the west part of the area.
7. North West London (NWL) Area

Hospitals visited by the NHS England DToC team in NWL:

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Meeting</th>
<th>Area/Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>London North West Healthcare NHS Trust</td>
<td>Site team, discharge team and Continuing health care nurses</td>
<td>Northwick Park Hospital</td>
</tr>
<tr>
<td>Brent and Harrow CCG</td>
<td>Head of Performance</td>
<td>B&amp;H CCG office</td>
</tr>
<tr>
<td>Hillingdon Hospital NHS Trust</td>
<td>Discharge workshop</td>
<td>Hillingdon Hospital</td>
</tr>
<tr>
<td>Brent and Harrow CCG</td>
<td>Head of DToC</td>
<td>B&amp;H CCG office</td>
</tr>
<tr>
<td>London North West Tri Borough, Surge and Resilience team</td>
<td>Strategic Lead for integrated care and joint commission</td>
<td>Triborough CCG</td>
</tr>
</tbody>
</table>

**Northwick Park Hospital - SRG action plan and trajectory 2016/17**

Slide pack submitted as well as the DToC trajectory but no MO
Trust overview

Northwick Park Hospital (NWP) is part of London North West Healthcare NHS Trust (LNWHT) and a major acute (general) hospital in the London Borough of Harrow. The hospital has 672 beds providing acute and emergency care to the Brent and Harrow population. It also offers a regional rehabilitation unit for patients with additional on-going acute medical needs and St Marks the specialist bowel hospital is based on site. One of eight hyper acute stroke units (HASUs) is also based at NWP.

The NWP economy was part of the Shaping a Healthier Future Initiative which recommended improved A&E services and the closure two smaller casualty units at Central Middlesex and Hammersmith Hospitals. This was cited as a key reason for increases in emergency activity and admissions which is also reflected in the Retrospective Review of Impact in NWL of A&E changes (October 2015). An urgent care centre is onsite for patients with minor illnesses and is open 24 hours a day, seven days a week.

In February 2016 a new ward block was opened providing 36 new beds to aid flow from A&E to a ward bed.

Though a lot of the recommendations have been actioned with noticeable areas of improvement, the system still experiences significant challenge and the narrative within the system suggests capacity issues in relation to increased demand following system remodelling, reduced nursing and residential placements, and a lack of suitable mental health crisis placement options.

LNWHT is comprised of the following sites:

- Northwick Park Hospital (including St Marks)
- Central Middlesex Hospital (CMH)
- Ealing Hospital (EH)
- Community sites at Denham, Willesden and Clayponds

How long stay patients and MO/DToCS are managed

There is a long stay patients review meeting of all patients on or > 8 Days length of stay (LOS) which is held twice a week, and this was attended during the site visit. Social services and the CCG representatives either dial in or are present at the meeting. The observations were this was extremely lengthy with little time to really explore the complex pathways in great detail. This may have been better managed within the divisions and a separate meeting to really focus on the complex long stay patients. A further meeting is held earlier in the day twice a week to review DToCs.

In terms of senior escalation and support, it was felt there could be more traction on the very long stay patients, simply because the numbers are not changing dramatically on a day to day basis and many of the issues are related to accessing external capacity.

NWP and CMH only have 2 continuing health care nurses working Monday to Friday completing CHC paperwork. The wards are required to complete the checklist which will trigger the London HNA and then decision support tools (DST). The CHC team support the ward and once the DST is completed, they complete the London HNA tool, then complete DST on line and email this to the relevant CCG. External panel decisions usually have to be chased and in some cases, communication is via a letter days later. The wards are often busy so the paperwork can be delayed or the forms are incorrectly completed.
The Trust have developed a DTOC dashboard (Figure 2 below) which showed a total of 42 formal DTOCs and 45 MO patients across LNHWT by CCG. For CMH and NWP combined, the total DTOCs/MO combined was 63 patients. The site team confirmed this was a normal average for them. This calculates at a daily cost of £11,760 (based on a bedday of £280).

Figure 2: The figure below shows a snapshot of the LNWHT DTOC Performance dashboard

![Figure 2: LNWHT DTOC Performance Dashboard](image)

Figure 3. Examples of patient delays and LOS

<table>
<thead>
<tr>
<th>Example 4: Complex social care. LOS 238 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 238 days Harrow CCG. Young patient with health and social care needs</td>
</tr>
<tr>
<td>• Non-compliant so requires placement.</td>
</tr>
<tr>
<td>• Too young for nursing home</td>
</tr>
<tr>
<td>• Ongoing discussions with Trust and CCG</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Example 5: 879 days (3 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Long stay tertiary patients. Out of area. Windsor, Ascot and Maidenhead CCG</td>
</tr>
<tr>
<td>• Complex young patient in St Marks Hospital.</td>
</tr>
<tr>
<td>• Looking at placement into regional rehab – Blackheath but lack of capacity</td>
</tr>
</tbody>
</table>

The above examples demonstrate a couple of extremely complex patient pathways. Whilst these are a minority of patients, the question arises whether there is a single ownership of these patients to help resolve pathway issues and find suitable placements.
Areas of good practice

Regional Rehabilitation

Inpatient Rehabilitation is provided at Central Middlesex Hospital, Ealing Hospital and Northwick Park and St Mark’s Hospital and its services extend into Clayponds Rehabilitation Hospital, the Denham Unit, Meadow House Hospice and Willesden Community Rehabilitation Hospital, the service has 50 intermediate care rehabilitation beds in Harrow and 30 in Brent as well access to an additional 18 Local authority re-ablement beds.

Extra care housing

There are a number of Extracare schemes based in Brent and allocated via referrals from Brent Adult social services they are Harrod Court in Kingsbury (38 one bed, 2 2 bed flats) Tulsi House in Sudbury (32 one bedroom, 4 2bedroom flats), Rosemary house in Willesden (40 one bed flats), Beechwood court (20 one bed EMI flats) these are purely local authority resources but residents can receive rehabilitative interventions.

The NWP Discharge team STARRS

The STARRS team (short-term assessment, rehabilitation and reablement service) provide a range of health care, rehabilitation and reablement services for patients in Brent, including:

- A rapid response service which provides a multi-disciplinary, holistic assessment of patients in their own home or in A&E, within two hours of referral. The service is for patients who are in urgent need of care and at risk of admission into hospital.
- Early supported discharge - facilitating early discharge for patients in hospital by providing hospital-at-home services in the community.
- Short-term rehabilitation providing neurological and general rehabilitation at home.
- A single point of access for referral to all of the above services.

Referrals are accepted from GPs and specialist healthcare professionals. The rapid response and admission avoidance teams in A&E operate seven days a week.

Summary of NWP Visit

During the visit, the NHS England team attended the bed meetings which reviewed the status of the hospital with focus on A&E and patient flow. There was a good overview and recording of patients identified for discharge or transfer were updated by ward. The NHS England team had an opportunity to shadow one of the CHC nurse who also gave some case examples given in this report of the delays and challenges they experience.

The site team and Trust discharge coordinators including the CHC team are clearly working very hard to manage their internal flow although feel considerably constrained by the external capacity and system pressures. The Trusts as part of their portfolio manage the community beds which at the bed meetings, appropriate patients are identified for transfer which keeps some flow moving. The attendance to the bed meetings did show good attendance from the Social services and CCG B&H although it was not clear from the visit whether this was getting enough traction to move patients or seek alternative solutions. The LOS of some patients and difficulties raised by the CHC team would suggest that this is not the case.
The overall impression is NWP is an extremely busy ‘hot site’ which also provides tertiary services but struggles to manage the daily demands on both emergency activity and on-going placements. The level of DToCs and MO on a daily basis reflects this although there could be more senior escalation and input.

Brent and Harrow CCG – Surge and Resilience Team

Graph 27: London North West Hospital DToC Trajectory Performance.

The above graph was produced by B&H CCG as part of the DToC action plan. There has been significant work to reduce the numbers of DToCs and progress to date includes:

- 60% reduction in DToC at LNWH
- ECIP audit of MO patients to identify root causes of delays to discharge.
- RED-Green & SAFER Pilot wards
- Continuing Health Care process training for ward staff with clear timeline for completion.
- 2 CCA nurses in place to support process & timely discharge.
- 2 additional staff for sourcing beds, 1 additional social worker to speed up joint assessment logistics. Brent Local Authority determining funding for additional social workers for weekend, appointing at risk.
- Directory of Community Services assisting clinical decision making and support.
- Reviewing Choice Policy so consistent across the 3 boroughs.
- Social workers now on acute sites from all 3 main LAs. Duty SOC on site at weekends
- Driving in-reaching of community hospitals to pull patients out when MO

Figure 4. The boxes below shows examples of patient delays and LOS

<table>
<thead>
<tr>
<th>Example 1. Residential placement DToC timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Residential placement selected by social care and patient / family as part of discharge planning process</td>
</tr>
<tr>
<td>• Bed unavailable until late December</td>
</tr>
<tr>
<td>• Discussion with social care on alternative placements. Temporary step down bed agreed</td>
</tr>
<tr>
<td>• Time to clear DToC: 30 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Example 2. Nursing home placement DToC timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient declined by 3 separate nursing homes following family viewing homes and agreeing for assessment</td>
</tr>
<tr>
<td>• Assessment completed by next available nursing home and accepted</td>
</tr>
<tr>
<td>• Time to clear DToC: 17 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Example 3. Mental health placement DToC timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Mental health admission from his sheltered housing accommodation onto acute medical ward</td>
</tr>
<tr>
<td>• Dec 2015: Assessed as MO for discharge with preferred discharge to a residential housing</td>
</tr>
<tr>
<td>• The HNA completed.</td>
</tr>
<tr>
<td>• Due to a lack of residential beds/housing the only other option was a nursing home placement.</td>
</tr>
<tr>
<td>• Social services declined placement due to funding costs and after much discussion between the SOC and CHC panels, a FNC was agreed to contribute to his nursing home costs.</td>
</tr>
<tr>
<td>• Bounced back from panel several times due to funding rejections. Remained in an acute ward awaiting placement with 1:1 RMN support 24/7.</td>
</tr>
<tr>
<td>• Admitted to a nursing home placement after LOS 80 days.</td>
</tr>
<tr>
<td>• Time to clear 60 days</td>
</tr>
</tbody>
</table>
**Integrated Care and Joint Commissioning London North West Tri Borough**

The Tri-borough system, brings together over 30 organisations and community groups to work together in developing a vision for whole systems Integrated care. The program enabled the design of a contractual structure for the tri borough element of the whole systems integrated care program needed to:

- Foster collective accountability of providers for outcomes
- Support integrated working
- Facilitate joint decision making
- Enable capitated funding

**Area covered by the Tri-borough system**

![Map of Tri-borough System](image)

**Figure 5: Map of Tri-borough**

**Source:** Whole Systems Integrated Care in Tri-borough - an introduction, NorthWest London Integrated Care

The lead for the CCG NHS Central London, Hammersmith and Fulham and West London CCG component enables and supports the escalation of blockages to patient flow within the system. The role undertakes a weekly dial in for Imperial DToC and MO patients. The role involves the following:

- Responsible for chasing progress between CCG and social care/ Local authority
- Remit allows for picking up critical themes impacting on discharge and flow and enabling dialogue and can pool work streams for better results between areas and across organisational borders (Hammersmith, Kensington, Westminster)
- Links in with NWL CCG
- Remit enables evaluation of unexpected consequences from integration (Health and Social Care)
Areas of Good practice

- 2015 winter ran system resilience workshops engaged local care homes, Social Care and tackled issues of streamlining discharge processes for MO patients
- Arrangements for spot purchasing of interim beds to unblock the system arrangements
- Rehabilitation: investment in step up/step down and interim nursing beds, good number of beds.
- Commissioned level 2b neuro-service; 10 bedded unit at Imperial, total of 19 beds across 3 CCGs.
- Working towards Neuro rehabilitation options for the Hillingdon hospital integrated rehabilitation service
- Reviewing current tri-borough bed capacity and need for services that further promote admission avoidance
- Social Care partner’s leading on integrated community care team, BCF funds have enabled alignment of social care teams to hospitals (West London Alliance) and operate using trusted assessor frameworks where 1 SW can assess on behalf of other boroughs being piloted on wards with good feedback.
- Held Multi-Agency Discharge Event (MADE) to consider issues being faced
- Single steering group feeding into SRGs- gives good system over view

Hillingdon Hospital

Hillingdon Hospital (HH) was not identified as a Trust to review as they have low levels of reported DTOCs. However the DTOC NHS England team were invited to attend a discharge workshop at the Trust, where the Trust was reviewing themselves against the self-assessment document (High Impact Change Model-Managing Transfers of Care, 2015).

Points raised during the self-assessment workshop included:

- Realistic bed numbers are required, also if there are empty beds then wards are closed which then impacts on capacity.
- Challenges with short term staff recruitment.
- Decision making thresholds- it is different for junior and senior staff. Need senior staff member at the front end as this helps with assessing patients and flow.
- It would be ideal to have a Discharge Co-ordinator in each ward.
- Patients / family choice can impact on patients leaving the hospital. A patient advocate who is ‘independent’ would be helpful for patients and their family to talk to. Also, leaflets about next steps would be helpful to patients, but with an advocate on hand to help explain them if required.
- There can be high referrals from some care homes to A&E - especially on the weekends and in August. This relates to when the manager is not there. Also, in general the quality of care in care homes is variable and there is pressure in London on care homes available. However, in Hillingdon a Care Home Forum has been established which help can facilitate discussions
- Ideally don’t want to have assessments in acute settings- the home is the best place. But need to make sure that the home is ‘safe’. There can be a feeling (whether real or perceived) that the home is not safe. Also, family members can feel reassured if they are in the hospital as there is 24 hours care.
### Table 6: Summary of areas of improvement for NWL

<table>
<thead>
<tr>
<th>Summary of Areas for Improvement</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DOH funding allocations</strong></td>
<td>For nursing homes does not adequately cover the costs for complex needs patients resulting in an inability to find longer term placements for some patients with complex needs. There is also a reluctance of some homes declining to take back patients where care resource usage has increased.</td>
</tr>
<tr>
<td><strong>Family choice delays</strong></td>
<td>In light of the limitations on care home capacity, this compounds the issues with families declining places.</td>
</tr>
<tr>
<td><strong>Regulation/CQC inspections</strong></td>
<td>9 homes locally placed into special measures in the NWP area so this capacity is lost.</td>
</tr>
<tr>
<td><strong>Health needs assessments</strong></td>
<td>There is too much duplication of effort with the DST plus the London healthcare assessment tool.</td>
</tr>
<tr>
<td><strong>Panels declaring a formal DTOC</strong></td>
<td>There is variation between CCG’s of when they formally report DTOCS.</td>
</tr>
<tr>
<td><strong>Out of area decisions</strong></td>
<td>The CCG gave an example of a patient occupying a community bed for one year due to a lack of housing.</td>
</tr>
<tr>
<td><strong>Medically optimised definitions</strong></td>
<td>The need to define MO properly to enable a consistent approach across all hospitals was highlighted.</td>
</tr>
<tr>
<td><strong>Variations in discharge processes</strong></td>
<td>Develop a joint discharge protocol for the whole of SEL (as per KCH and GSFF).</td>
</tr>
<tr>
<td><strong>Access to fast track end of life beds</strong></td>
<td>End of Life (EoL) patients are not always getting placements quickly enough. There is a palliative care team who complete the fast track process, however due to a lack of both nursing home capacity and hospice beds, the 48 hour standard can be delayed for anything up to 3 weeks. This offers poor patient experience. In addition to this, EoL patients often do not have access to side rooms as these are used to mental health outliers (see case example- Figure 4).</td>
</tr>
<tr>
<td><strong>Lack of nursing home capacity</strong></td>
<td>This was highlighted as a severe constraint by the NWP site team plus Brent and Harrow CCG DTOC lead. The CCG identified that 9 homes have closed recently due to poor CQC inspections and this has impacted on capacity.</td>
</tr>
<tr>
<td><strong>Lack of housing</strong></td>
<td>Lack of housing really needs addressing. There is a severe shortage in this area of London whereas in the south housing is not so much of a problem.</td>
</tr>
<tr>
<td><strong>Self-funders and family choice</strong></td>
<td>This compounds the issues of family declining places.</td>
</tr>
<tr>
<td><strong>Lack of neuro rehab beds</strong></td>
<td>Prevent timely repatriations to level 1 &amp; 2.</td>
</tr>
<tr>
<td><strong>Discharge to assess</strong></td>
<td>‘Model runs the risk around funding as social care may not fund at the end which means decisions have to be made.</td>
</tr>
<tr>
<td><strong>Mental health pathways</strong></td>
<td>There was a clear gap in the provision of mental health at NWP for acute MH patients. This was of concern to staff as there is an average of 5-10 patients at any one time with mental health needs being cared for in acute beds. The majority of patients require 1:1/2 RMN + security on the wards. This is not only costly, but blocks a bed for an acute patient and means the patients mental health needs are not optimized as they are not in an appropriate environment. (see case example- Figure 4).</td>
</tr>
<tr>
<td>‘Social care hoops’</td>
<td>The teams felt that overall the CCG/LA panel decision making is highly</td>
</tr>
</tbody>
</table>
variable and dis-jointed causing delays as well as out of area where communications and organizing care became very difficult. In addition, Panel rejections are high which means decisions are not made and there are regular disputes around budgets. The mental health patient example demonstrates how the focus is on funding rather than the patient.

**Summary of NWL Area**

The comparison across the NWL Area in terms of DToCs performance and integrated services is variable due to housing and nursing home capacity constraints.

The Trusts in the South East region including the Hammersmith Hospital, Chelsea and Westminster, Imperial, are all performing reasonably well on their DToCs at < 2.5%. The Tri-borough system had progressed to enable a unified vision amongst stakeholders which enable mitigation of risk. This model could be replicated across other CCG partners to learn from best practice. There is an opportunity to pool outcome of BCF projects which the providers feel are currently siloed.
8. North East London (NEL) Area

Hospitals visited by the NHS England DTOC team in NEL:

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Meeting</th>
<th>Area/Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Central London (NCL) CSU</td>
<td>Surge Programme Director</td>
<td>NCL CSU</td>
</tr>
<tr>
<td>Waltham Forest CCG</td>
<td>Director of Nursing and Deputy Director of Nursing/Safeguarding</td>
<td>NHS England Southside and Whipps Cross Visit</td>
</tr>
<tr>
<td>Barts Health</td>
<td>Deputy Director of Nursing/Safeguarding &amp; Head of Integrated Care</td>
<td>Whipps Cross site</td>
</tr>
<tr>
<td>Barking, Havering and Redbridge trust</td>
<td>Joint Assessment Discharge team and Director of Operations</td>
<td>Site visit to Queens Hospital</td>
</tr>
</tbody>
</table>

**Whipps Cross Hospital - SRG action plan and trajectory 2016/17**

Plan included a MO trajectory but from mid-March 2016 only and it is linked to the ECIP action plan.
North Central London Commissioning Support Unit

The DToC Team met with the Surge Programme Director to understand the overall context for the CSU who supports NEL as well as NCL area. From the perspective of the CSU, there are a number of factors which impact on the management of DToC and MO classified patients particularly for Barts Health.

Barts Health is a large Trust with 5 sites; therefore communication between the Trust sites can be poor which impeded transferring patients between sites difficult. Secondly, simple discharges could be managed more efficiently with more traction internally to get non-complex patients home quickly. Thirdly, there are still delays resulting from internal process issues and there could be a better ‘operational grip’ of the medically optimised to prevent them becoming a formal DToC. Additionally, band 7 nursing staff should be empowered more around the discharge process and undertake parallel planning.

NCL have invested in SHREWD resilience; a Single Health Resilience Early Warning Database live portal which is linked to all CCG’s, LA, and Trusts in North Central allow greater transparency between the organisations. This could be rolled out to other CCGS subject to investment. NHS England will also have access to this system.

The CSU holds a daily conference call with the Trusts (as part of winter resilience) to get an overview of the emergency pressures. Call cover in detail pressures, transfers as well as emergency flow. The CSU unlike SEL, are not involved in any patient level calls however the Waltham Forest CCG take an active part in this with Whipps Cross Hospital.

Director of Nursing - Waltham Forest CCG

The CCG senior nursing team place great focus on Whipps Cross hospital to help patient flow. They spend one day every week at Whipps Cross reviewing MO and DToC patients and understanding what the plans are. A number of initiatives have taken place in the past year for the Trust to take forward and improve performance. These include:

- The Urgent Care ECIP improvement programme. The ECIP team are currently working with Whipps Cross looking at urgent care which encompasses DToCs.
- Integrated Treatment Team (ITT) is based at the Trust as a key recommendation from ECIP to manage flow.
- McKinseys action plan developed in summer of 2015 - no impact made.
- Of concern is despite the above inputs, the view is little improvement has been made to flow or numbers of MO/DToCs.

The Director of Nursing from Waltham Forest (WF) CCG did a site visit in December 2015 and made a set of recommendations which have now been accepted by the Trust. The view is there is lack of internal grip and responsiveness which requires leadership across the sites to improve.

The multiple site arrangements is an issue as there are different classifications for DToCs across all the 5 sites so this is confusing even internally. For example; the Trust has been incorrectly reporting formal DToCs and including MO patients who are not yet formally a DToC. i.e. they should only record as a formal DToC once the CCG panel has approved funding and the patient is still in a hospital bed.
The CCG has now agreed 2-3 DToC/MO KPI’s with the Trust so these can be measured: these include:

- Identify and agree EDD on admission to hospital
- Family information important for choice
- Turnaround assessments within x days from start to finish (including panel decision)

The CCG nursing team are supporting the Trust with rolling out CHC assessment training and identifying CHC champions. In addition to formal training sessions, they visit the wards to train staff in efforts to improve the quality of assessments.

**Table 7: Areas for improvement for Whipps Cross Hospital**

<table>
<thead>
<tr>
<th>Summary of Areas for Improvement Specific to Whipps Cross Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nursing leadership</strong></td>
</tr>
<tr>
<td><strong>Discharge and Step down to assess models of care</strong></td>
</tr>
</tbody>
</table>
| **Standard approach to recording MO/MF**                     | The CCG strongly felt there needs to be clear guidance around when and how to record MO. The DON suggested that the Clinician writes in notes medically fit for discharged, then writes 'referral made to'. There is a legal requirement for consultant to medically manage patients in hospital. Once ready to leave, this must be recorded in the notes they are fit and patient has been referred to ITT. It then becomes the responsibility for the discharge to be organised by the relevant provider.  
This was also reflected in the conversations with NCL surge as several Trusts including Queens and St Georges do not record /MO as they don’t accept these as delays. The Homerton also has the same view and only records formal DToCS. |

**Whipps Cross Hospital visit**

Whipps Cross Hospital is one of the five Barts Health sites based over in NEL. St Barts has a total of 1127 acute medical beds across all sites however this excludes maternity and ambulatory care where DToC/MO would not normally exist. The site serves 3 boroughs (West Essex, Waltham Forest, and Redbridge which adds complexity to the patient pathways as each system works very differently and has variable community support.
Summary of Barts Health sites

<table>
<thead>
<tr>
<th>Site</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Royal London; Whitechapel</td>
<td>Major Trauma Centre. Tertiary Delays on this site due to HASU repatriations to out of area</td>
</tr>
<tr>
<td>Newham Hospital</td>
<td>DToCS is not a major issue</td>
</tr>
<tr>
<td>Whipps Cross</td>
<td>Has the highest level of delays from all sites. There are internal process issues and for 2 years DToC ran at an average of 70. This has reduced and the aim is to maintain a target of 15.</td>
</tr>
<tr>
<td>Mile-end</td>
<td>Mental Health</td>
</tr>
<tr>
<td>St Barts site – Smithfield</td>
<td>Acute site</td>
</tr>
</tbody>
</table>

The visit to Whipps Cross combined discussions with the Deputy Director of Nursing from WF CCG and the Head of Integrated Discharge Team, and attendance at the patient review meeting. None of the site senior management team were met although were contacted via the NEL CSU although the Divisional Manager chaired the meeting and had a good grasp of the processes.

**ED performance:** The position for Whipps Cross has been challenging with performance sliding from 88% in January to 72% at the end of February. The level of DToC and MO has also risen from an average of 35 to up to 60 during this period.

**Internal management of delayed transfers of care:** The Trust has had a number of reviews by external agencies including McKinsey and ECIP who undertook a trust wide review in February and the tripartite are now holding the Trust to account for the delivery of the action plans.

As part of the action plan, the AD for nursing will chair a weekly SAFER ward review meeting which includes CCG, LA and NELFT partners w/e from 19.2.16.

To manage the lack of rehab beds, the site has set up a rehab ward called ‘Victory’. Patients are identified and then transferred to this ward if an external placement cannot be found.

**Delayed patient review meeting:**

A list of 62 patients were reviewed which included formal DToCs as well as MO patients. A dial in arrangement was provided for each borough/CCG to attend. The patient list was divided by CCG and the meeting was chaired by an Associate Director.
Table 8: Table to show key points & issues raised for 3 NEL CCGs

<table>
<thead>
<tr>
<th>Waltham Forest CCG</th>
<th>Redbridge CCG</th>
<th>West Essex CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall impression:</strong> SOC was present at the meeting and offered alternatives and solutions. Out of all 3, better movement of patient flow. Trust not using all available rehabilitation facilities on offer.</td>
<td><strong>Overall impression:</strong> general handle on patients, although still delays at panel and lack of decision making.</td>
<td><strong>Overall impression:</strong> there was a general lack of grip from the CCG/SOC around the patient list, real delays in the panel process with either rejections on funding or lost paperwork.</td>
</tr>
<tr>
<td>Step-down flat beds available but not being used. Need OT to identify patients who meet criteria. Therapy staff can be very risk averse and nervous about placing patients in this facility.</td>
<td>Long delays in decision making at panel. One at 21/7 delay and rejected for more information.</td>
<td>Long delays for decision making at panel as no joint integrated structure so rejections are high and sent back to the Trusts. There were a few examples of the panel wanting more information and this caused further delay.</td>
</tr>
<tr>
<td>Delay in an inter trust transfer of a neurology patient (Whipps Cross to Royal London)</td>
<td>Lack of palliative care beds in nursing home. A fast track end of life patient was still unplaced after 7 days.</td>
<td>Lack of grip for some cases between the Trust and CCG/LA – unsure where the patient was in their pathway.</td>
</tr>
<tr>
<td>Nursing home delays (28/7) but there are beds elsewhere that are suitable.</td>
<td>60/7 delay as panel were confused around what nursing needs were required.</td>
<td>Funding without prejudice declined by CCG which delays placements.</td>
</tr>
<tr>
<td>Need to be more proactive at looking at alternative placements whilst the home of choice becomes available.</td>
<td>Several patients were waiting for OT reports</td>
<td>29/7 delay for family choice contributing to an overall LOS of 78 days.</td>
</tr>
<tr>
<td>Rehab capacity problems. Stanmore specialist neuro rehab</td>
<td>CCG has a backlog of CHC assessments. There is a lack of feedback</td>
<td>CCG was adamant that a self-funder decision had to go to panel despite dispute from the table.</td>
</tr>
<tr>
<td>No joint structure at panel which is essential to speedy and real time funding decisions.</td>
<td>CCG has a backlog of CHC assessments. There is a lack of feedback</td>
<td></td>
</tr>
<tr>
<td>Summary of Areas for Improvement – NEL Area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variations in discharge processes</td>
<td>This needs joint development to ensure there is consistency across the Trust as well as local authority providers and CCG. Waltham Forest as the lead CCG should lead this piece of work and develop KPI’s around the process. There was a variation in understanding of the health needs assessment process and training is required here.</td>
<td></td>
</tr>
<tr>
<td>Family choice delays</td>
<td>In light of the limitations on care home capacity, this compounds the issues with families declining places.</td>
<td></td>
</tr>
<tr>
<td>Community capacity</td>
<td>Some beds are empty as the criteria is too high. There needs to be better oversight of community capacity and better flow out.</td>
<td></td>
</tr>
<tr>
<td>Health needs assessments</td>
<td>There is too much duplication of effort with the DST plus the London healthcare assessment tool.</td>
<td></td>
</tr>
<tr>
<td>High risk aversion to using step down facilities</td>
<td>At the time of the visit, the Waltham Forest LA had empty facilities – they felt therapy teams could be too risk averse to using them</td>
<td></td>
</tr>
<tr>
<td>Out of area decisions</td>
<td>The CCG gave an example of a patient occupying a community bed for one year due to a lack of housing.</td>
<td></td>
</tr>
<tr>
<td>Medically optimised definitions</td>
<td>There needs to be an agreed MO definition to ensure a consistent approach in recording this across all Trusts</td>
<td></td>
</tr>
<tr>
<td>Lack of nursing home capacity</td>
<td>An overall constraint</td>
<td></td>
</tr>
<tr>
<td>Lack of neuro rehab beds</td>
<td>Prevent timely repatriations to level 1 &amp;2</td>
<td></td>
</tr>
<tr>
<td>Placements and social care packages</td>
<td>This includes the provision and quality of hours available. Council Council cuts are hitting very hard and cannot recruit staff.</td>
<td></td>
</tr>
<tr>
<td>NHS England lead for MO/DToCs</td>
<td>NHS England oversight was felt to be missing and there should be a POC who has oversight across london to help bring together the regions to drive forward more standardisation. There needs to be greater level of holding Trusts to account for reporting as this is currently very ad hoc and MFFD is not visible.</td>
<td></td>
</tr>
</tbody>
</table>
Barking, Havering and Redbridge University Hospitals NHS Trust

BHRUT was reviewed as highlighted by NCL CSU as an area of good practice with a performance on DToCS < 2.5%.

A reflection of how seriously the Trust took the informal visit from NHS England was the preparation of the day including a full agenda of meeting teams from ward to board.

Barking, Havering and Redbridge University Hospitals NHS Trust is based on 2 sites:

- Queens is based in Romford and is the local hospital for residents of Havering, Dagenham and Brentwood.
- King George Hospital is based in Goodmayes.

Both sites have an Emergency Department and Queens has a Hyper Acute Stroke Unit.

Operationally the DToC team found there was excellent clinical and support services engagement at all levels to support flow in Queens Hospital. During the visit, the team were invited to attend the daily bed meeting where there was full representation from nurses, infection control, therapies, social workers and consultants. In addition they observed MDT board rounds: consultant, specialist doctor, nurse, OT and Hospital Social Worker.

Joint Assessment and Discharge Team

The Joint Assessment and Discharge (JAD) Team operate 7 day cover and have three teams working at Queens Hospital on three Acute Elderly Units. The team work to specific wards to provide continuation of case management and cross cover. They also have a team working in ED. The JAD team were set up in June 2014 and they oversee Barking and Dagenham and Havering patients. It was reported that in the first quarter of 14/15 the JAD team reduced DToCs by 23% and improved LOS. The team also have out of panel decision rights so can pull patients out prior to panel decision.

The JAD team do not cover Redbridge patients. The challenge becomes where social workers from other boroughs who can take up to 72 hours to arrive to see referrals. This means that the patients can end up staying in hospital although they may be medically fit for discharge.

Key issues raised:

- Therapies and pharmacists are not covered 7 days. The lack of community services on weekends is also a key constraint
- HNA process can take up to 7 days
- Panel Disputes and out of area panel delays
- Two different LA’s (B&D and Havering) processes
- Health needs assessment paperwork is too time consuming
- Palliative Care Team Leader raised that 30% of patients in hospital require palliative care input
- Nursing home capacity and family choice
Areas of Good Practice:

- JAD 7 day working allows for key discussions with family at the weekend and increases the weekend discharges
- Social workers based in ED
- ‘Support at home’ will commence as a pilot on 1st April 2016

Community treatment team: Barking, Davenham, Havering and Redbridge

North East London Foundation Trust employs a community treatment team comprises of a team of doctors, nurses, therapists, social workers. They work in A&E at Queens Hospital where they assess patients and support return to home preventing admission wherever possible. They also work closely with King George, Whipps Cross and other local A&E’s to prevent admissions.

Summary of NEL Area

The comparison between the two hospitals in NEL visited in terms of DToC performance could be related to the integration of social services/LA input where at BHRUT they operate a 7 day on site service. The BHRUT JAD team are authorised to make out of panel decisions which is a key discharge enabler whereas the Whipps Cross review meetings demonstrated liaising with LA’s was more fragmented and models did not support local decision making.

Hospitals visited by the NHS England DToC team in NCL:

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Meeting</th>
<th>Area/Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Royal Free</td>
<td>Head of Continuing Healthcare &amp; Neuroscience Lead</td>
<td>Barnet Hospital</td>
</tr>
<tr>
<td>Barnet CCG</td>
<td>Head of Continuing Healthcare &amp; Neuroscience Lead</td>
<td>NHS England- Southside</td>
</tr>
<tr>
<td>University College Hospitals NHS Trust</td>
<td>Senior Nurse – Discharge Co-ordinator</td>
<td>UCL site visit</td>
</tr>
<tr>
<td>University College Hospitals NHS Trust</td>
<td>Patient Flow &amp; DToC Lead</td>
<td>UCL site visit</td>
</tr>
<tr>
<td>Camden LA</td>
<td>Whole Systems Co-ordinator</td>
<td>UCL site visit</td>
</tr>
<tr>
<td>North Central CSU</td>
<td>SRG director of performance</td>
<td>CSU</td>
</tr>
</tbody>
</table>

**Barnet Hospital - SRG action plan and trajectory 2016/17**

Action Plan and trajectories submitted but trajectories do not demonstrate a reduction in MO or DToC until June 2016.

**UCLH - SRG action plan and trajectory 2016/17 (Camden only)**

Action plan and trajectory submitted. MO trajectory was not included and it is not clear if the Trust is under reporting these. Camden LA opened 10 step-down beds and 7 more to open. Staffing problems has delayed opening.
CCG Barnet- Head of Integrated Care

The Head of Integrated care meeting provided a useful overview of the Trusts merge background and impact of the A&E closures including Hertfordshire. During the project, the CCG has provided regular updates on DToC numbers and there is a target for all sites not to exceed 15. This has been particularly high in the new year causing the overall % to rise > 2.5%. The majority of DToCs are at Chase Farm.

A key issue highlighted by Barnet CCG was the impact of A&E closures in the Hertfordshire area (Hatfield) which has directly impacted on emergency activity to this site. This is in addition to the closure of A&E at Chase Farm in 2014. The clinical strategy merger plan was to close 3 wards at Chase Farm. However, they have only managed to close 2 with one remaining open as a re-ablement ward to take patients from Barnet and is used as a step down ward.

The Royal Free Foundation Trust - Barnet Hospital Site

The BH visit was hosted by the Barnet CCG Head of Continuing Healthcare who has an active presence on the hospital site. The NC/NE SRG Director raised that Barnet and Chase Farm sites could do more to link together to improve patient flow.

Barnet Hospital, part of the Royal Free London Foundation Trust, was opened in 2003. The other Royal Free sites are at Chase Farm hospital and Royal Free Hospital. The Royal Free Hospital Trust acquired Barnet and Chase farm hospitals on the 1st of July 2014.

Barnet has 445 beds and operates a full range of acute medical services. It is configured as the ‘hot’ site with emergency care whereas Chase Farm is the ‘cold’ site housing mainly elective care. The hospital serves the population of the London Borough of Barnet with a population of circa 400,000 based on ONS projections and also provides flow from Hertfordshire.

Barnet CCGs Recovery plan states that the non-elective excess bed day cost for the locality are in excess of £2.8 million pounds per annum and a review has been commissioned to examine the reasons for incurring excess bed costs which include patient flows into the community, delayed transfers of care, gaps in service provision, social care delays and equipment requirements.

The narrative within the system seems to suggest deteriorating A&E performance since the reconfiguration of Chase Farm hospital and closure of the A&E department in December 2013. It was raised that the A&E facilities were not substantially upgraded to accommodate additional activity from Chase Farm.

Operational meetings

The DToC Team attended the bed management meeting which was well represented and had a clear focus of reducing pressure on the A&E department by maximising discharge and improving flow.

Facilities management, and patient transport leads were also present at the meeting which gave a holistic system overview. The team met the Post-Acute Care Enablement Finder whose role is to proactively “seek and pull” patients who can be safely discharged and cared for in less acute or home settings.
The Trust demonstrated an MDT approach to reducing delayed transfers of care this being evident in the inclusive approach observed in the discharge lounges and the high turnover wards, e.g. the Short Assessment Units.

**Therapies and Social Care**

The therapy teams are led by an assistant director who also attends the bed management meetings. Therapists are ward based and participate in ward and board rounds.

Social workers for the Barnet and Enfield / Ealing Economy are ward based which helps the discharge process. However issues were flagged repeatedly in respect of cross boundary issues impacting on expedient discharge, from non local CCGs and Social care providers e.g. Herts Valley, Harrow / Hillingdon/ Islington. See Table 10 below.

**Areas of good practice**

- **Team work:** The Hospital and Barnet CCG lead work well together on the issues impacting on their performance and in some cases these are outside their sphere of influence. However the use of diverse workforce skill, buy in from clinicians and management into improving A& E performance was notable. The CCG is often in the hospital out of hours helping to deal with complex problems.
- A PACE Case Finder works alongside a hospital consultant to identify and then own the arrangements for the patient to go home.
- The CCG in partnership with the trust are committed to reduce DToCs within their economy and this is referenced in their recovery plans which look to examine the reasons for incurring excess bed costs as well as patient flows into the community, delayed transfers of care, gaps in service provision, social care delays and equipment requirements.

**Table 10:** Table highlighting key issues for Barnet hospital

<table>
<thead>
<tr>
<th><strong>Summary of Key issues for Barnet hospital</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social care delays for out of area</strong></td>
</tr>
<tr>
<td><strong>Inappropriate admissions to hospital</strong></td>
</tr>
<tr>
<td><strong>Lack of intermediate care provision locally</strong></td>
</tr>
<tr>
<td><strong>Health needs assessment forms</strong></td>
</tr>
<tr>
<td><strong>Lack of nursing home capacity</strong></td>
</tr>
<tr>
<td><strong>Lack of internal flow between hospital site</strong></td>
</tr>
</tbody>
</table>
Summary of Trust Visit

Internally, Barnet hospital seems to operate well to help manage flow through the hospital. The bed meetings applied good focus on the performance issues in A&E and there was a clear commitment throughout the organisation to maintain flow. There was good engagement from all levels from ‘ward to board’ and all disciplines including managerial, clinical, AHPs, estates, facilities management. The Hospital-wide MDT meetings are held three times a day and consultant-led ward rounds are held 3 times a day during the week and once a day on weekends.

CCG/LA DTOC Review meeting

The DTOC lead dialled into the patient review meeting. This weekly meeting chaired is by Barnet CCG and all DTOCs and medically fit patients by CCG/LA including Hertfordshire, Enfield and Barnet are reviewed. Examples of key patient delays are highlighted below:

Table 11: Examples of patient review meeting delays

<table>
<thead>
<tr>
<th>Patient Delay reason</th>
<th>Delay issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting placement</td>
<td>Self-funder delayed 7 days so ‘care home select’ are supporting the family making options for a home in Bedfordshire. Family are reluctant to get see the nursing homes and this is a common problem with self-funders.</td>
</tr>
<tr>
<td>CHC approved for EMI nursing home</td>
<td>Patient is out of area and Herts Valley need to confirm the recommendation. Herts want a separate social worker report for the DST and then goes to the panel with the CHC assessment</td>
</tr>
<tr>
<td>Complex discharge</td>
<td>Patient is independent but requires regular suctioning which he does himself, so family and patient just need more training and equipment. MO but needs to make sure everything are place before he goes home.</td>
</tr>
<tr>
<td>Complex placement – long term rehabilitation</td>
<td>CU bed is blocked since July 2015. Brent and Harrow patient delay 156 days on critical care. Patient has been on CCU for 156 days and because of this complex needs and the staff know him, they are reluctant to move him. This has been escalated, since 10th July 2015.</td>
</tr>
<tr>
<td>Out of area</td>
<td>Medically fit but needs a rehab location in Herts Potters Bar. Referred to Community rehab in Herts. Could be a long wait.</td>
</tr>
<tr>
<td>Out of area</td>
<td>Kent patients waiting for a placement. Date for discharge in early March and Kent social care need to organize ongoing care</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>Waiting for Level 1 rehab at Blackheath patient still waiting for placement at 58 days then became medically unfit. Became fit again but it could take a further 5-6 weeks to get a bed at Blackheath.</td>
</tr>
<tr>
<td>Out of area</td>
<td>B&amp;H complex patient social issues that concern housing. A 51 year old has waited for new adapted housing and her own house was inappropriate. The patient is self-caring and could be offered an interim placement but the patient will not accept other options as will have to relinquish her home and be deemed homeless. This has caused 2 periods of delay. The first one of 91 days due to a change in circumstances then a further one of 13 days. Needs more input from Brent and Harrow CCG.</td>
</tr>
</tbody>
</table>
Overview of Trust

UCLH is hosted in the London borough of Camden and serves the local community for Camden and Islington and a minority from Westminster. UCLH has reported 4.85% DtoC in November 2015. The majority of delays are caused by waits for ‘further non acute care’ which was also flagged during conversations with the Local Authority and patient flow managers.

Team visit overview

The DToC team attended the review meeting which takes place every Tuesday. In the first half of the meeting Camden DToC figures are reviewed and for the second half Islington numbers are reviewed with social workers from each borough attending. A senior nurse from the UCL integrated discharge team and social workers from both Islington and Camden also attend.

Camden CCG/SRG

The DToC/MO trajectory and action plan submitted from the Camden CCG and discussions with lead for integrated care at the LA demonstrates that Camden has a 7 day social services cover who work across the community and the hospital. This works well although delays have been attributable to recent high numbers of Islington social care delays. The 2 split LA teams poses a key issue for UCLH.

The Islington social worker who were previously embedded in UCLH, have been transferred to community teams, leading to delays in assessments. New plans are in place to revert to the previous arrangements and to embed social worker resources within the Trust. It is anticipated that this change will provide better and strengthened management to recalibrate the number of DToCs to sustainable levels. 45% of admissions are Islington patients so therefore having no onsite Islington social worker has a significant impact.

The key delays arise from waiting for placements due to the absence of sufficient capacity in local borough nursing and residential homes. In addition, waiting for placements in specialised commissioning beds such for neuro rehab is a key constraint; as are complex placements including patients with tracheostomies.

Whilst UCLH report high number of DToCs, it was not clear from the meetings if the trust is capturing all their medically optimised patients. The data submissions in the snapshot record an average of 8 per day and this was not transparent during the meeting with the Discharge and LA.

Camden LA have taken steps to address capacity and have taken the following steps to support the Trust:

- 10 Beds opened in the new Camden step down facility at St Pancras.
- Additional 7 beds commissioned but not yet opened due to staffing issues.

Camden are also developing a ‘trusted assessor’ role to access the step down pathway. It is expected that change in the current process could potentially reduce the time to get into the step down facility by as much as 80%.
Areas of Best Practice for Camden

The model of the integrated discharge team funded by Camden Local authority work closely with UCLH and have good working relationships with staff which improves patient flow.

- Camden local authority are organising and running three one day training events for UCLH & Royal Free on ‘hospital discharges and transfers of care’. NHS England have informally been invited to this training event (verbal invite at meeting)
- **Electronic recording**: Hospital has an electronic system for transferring patients information i.e self populates section 2 and 5. (though informed that all hospitals have a system like this- though more likely to be specific to their own Trust)
- There is a ‘**Continuing Care Nurse**’ who just focuses on CHC- this helps with the flow. In addition to this all staff are able to complete the form.
- **Weekend social workers** in place and on site

Table 12: Table highlighting summary of key issues for NCL

<table>
<thead>
<tr>
<th>Summary of Key issues for NCL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social care delays for Islington patients</td>
</tr>
<tr>
<td>Out of area decisions</td>
</tr>
<tr>
<td>Variation in panel decisions and rejections</td>
</tr>
<tr>
<td>Lack of intermediate care provision locally</td>
</tr>
<tr>
<td>Health needs assessments forms</td>
</tr>
<tr>
<td>Lack of nursing home capacity</td>
</tr>
<tr>
<td>Delays in nursing homes assessing patients in hospital</td>
</tr>
<tr>
<td>Standard approach to recording MO/MF:</td>
</tr>
<tr>
<td>7 day services</td>
</tr>
<tr>
<td>Complex needs placements including neuro rehab</td>
</tr>
</tbody>
</table>
Summary of North Central London

The NCL hospital sites at Barnet and discussions with SRG and CCG’s demonstrated an area which is constrained by capacity in nursing homes and housing placements. Emergency flow for all Trusts is high as a result of increased emergency activity across the board plus the impact of merging Trusts and reconfiguration of A&E’s. To the North of the area, out of area patients are a particular challenge to repatriate as require their own social services to make assessments and ongoing care providers which is not within the gift of the Trusts. The patient examples provided from the Barnet DToC meeting demonstrate the delays resulting from complex discharges, however the CCG is giving exemplary support to the acute trust and offers not only expert advice but also works with them to expedite wherever possible.

Towards more central London for UCLH, these common themes are also apparent with waits for rehabilitation and also intermediate care being a particular issue. The input from CCG is variable, whilst Camden works well as a LA with the Trust, the view was Islington LA pathways could be better supported and there are variations in process and discharge protocols.
10. The London Rehabilitation Context

In almost every system it was inferred that the lack of inpatient neuro rehabilitation beds (level 2) meant that provisioning the rising demand for inpatient neuro rehabilitation has been a challenge and as a result patients experience substantial delays in acute hospitals.

For example the North West London Triborough area has reported that these delays account for at least 40% of all patient delays for further NHS care – known as Category C delays.

The average wait per patient is approximately 15 days with some patients waiting for up to 3 months. This is based on 2013/14 and 2014/15 monthly data.

Preliminary audits of delayed transfers of care in the boroughs of Kensington and Chelsea and Westminster showed that 50-60% of acute bed days lost were associated with delays in accessing neurohabilitative care.

These delays for rehabilitative interventions impact on the user experience and longer-term outcomes in respect of independence, social isolation and mental wellbeing.

Appendix 2 provides a breakdown of NR and level 2 beds available across London

- Reasons for DToCs attributable to neuro rehabilitation delays
- Community provision for Neurological rehabilitation is inadequate (level 2b)
- Complex referral pathways and unclear acceptance criteria for admission to bedded units
- Variations in funding for level 3 rehabilitation units (some level 3 stroke units are not commissioned to take on non-stroke neuro-rehabilitation patients)
- Local variations and DToCs often correlate with decreased rehabilitative provision i.e. reduced rehab beds in the South of London
- Lack of placement options for complex patients who cannot be managed within a community/home environment
- Poor collaboration between health, social care and 3rd sector organisations
- The incidence of stroke and its associated disability adds pressure on an already pressured and depleted level 2b bed base

Rehabilitation

Rehabilitation usually consists of a range of enabling interventions including assessment, diagnosis and enablement/re-enablement through specific treatments. Rehabilitation often supports self-management and symptom management of long-term conditions, enabling patients to maintain or recover function including social participation and vocation.

Our findings were that all Trusts had AHP led rehabilitative (Intermediate care) services as part of their interventions to facilitate patient flow, however, there was significant variation in terms of AHP composition, referral pathways, skill mix, inclusion and exclusion criteria, and ability to work across health and care boundaries to effectively reduce the risk of inappropriate admissions.

Allied Health Professions deliver services involving the identification, evaluation and prevention of diseases and disorders; dietary and nutrition services; and rehabilitation and health systems management. As
autonomous practitioners they often have a whole system overview they have a critical and often underplayed role to play in facilitating smooth transfers of care.

Front door interventions have appropriate admission avoidance, rehabilitation, reablement, health and care navigation and self-management initiatives at their core. The taskforce found the AHP workforce to be critical in Front Door Rehabilitative Interventions such as:

- Accident and Emergency Triage Schemes
- Discharge to Assess Schemes
- Rapid Response / crisis intervention teams
- Advanced paramedic Practitioner roles
- First Response Duty Team’s

Examples of some innovative front door admission avoidance/ rehabilitation schemes were found at:

- LAS Frequent Callers Initiative:
- King’s Older Persons Advice and Liaison (KOPAL) service:
- Northwick Park STARRs Team
- Greenwich Joint Emergency Team (JETS):
- NELFT Community Treatment Team (CTT):
- Homerton First Response Duty Teams:
- Integrated Community Response Teams from Hounslow and Richmond Community Healthcare
- AMU/ AAU therapy teams at West Middlesex University Hospital:
- PACE Team Barnet and Chase Farm
- Hounslow Integrated Community Response Service

**Neuro-rehabilitation**

A strong recurrent theme from the DToC/MO taskforces finding was that the need for neuro-rehabilitation was a significant contributory factor for patient delays, with patients sometimes exhibiting protracted lengths of stay.

Specialist rehabilitation services play a vital role in management of patients admitted to hospital by taking patients after their immediate medical and surgical needs have been met, and maximising their recovery and supporting safe transition back to the community. NHS spending on neurological care has also skyrocketed by over 200% in the last ten years. As our population continues to grow and life expectancy increases, the number of people with a neurological condition will continue to rise ([www.neural.org](http://www.neural.org)).
11. National Reviews and Guidance and Literature Review

A number of reviews have been published to analyse the reason why there has been a drop in A&E performance to meet the 4 hour emergency standard in 2014/15. Monitor in a report published in September 2015 developed a framework of 10 hypothesis that could be driving A&E waiting times. They concluded that Trusts’ performance fell dramatically in the third quarter of 2014/15 because hospitals inpatient wards lacked capacity and became blocked up. Despite this, A&E departments coped well with the surges in activity and flexed up to manage the average rise overall by 6% last winter.

Appendix 3 provides a summary of the Monitor (2015) 10 hypothesis tested.

In summary the Monitor review of the key tier 1 A&E Trusts established that the impact on A&E was due to:

- Higher numbers of patients attending A&E via ambulance
- Higher numbers of admissions
- Higher levels of bed occupancy

Furthermore, Monitor recommends that hospitals need to address other factors as well as DToCs to ease occupancy rates. Their research suggests that up to 20% of occupied beds are ‘wasted’ because patients are not directed by the most appropriate care pathways or settings i.e: the medically optimised cohort of patients. These conclusions are also supported through NHS England DToC review which demonstrates clearly that whilst ensuring patients receive emergency treatment Trusts’ also need to concentrate on smoothing the flow of patients through inpatient wards, to the point of discharge and beyond.

Externally having enough capacity in social and community is important and although much is beyond the control of hospital Trusts, there are many ways to free up acute capacity that hospital managers can consider, from schemes to provide care to patients closer to home and more standardised management of non-complex elective patients, to smaller-scale but continuous operational improvements across the board.

 Definitions and Guidance

A number of papers including guidance and best practice was reviewed for this report- the full report can be found in Appendix 5.

NHS England published a set of national definitions and guidance (NHS England October 2015) to be used by all organisations reporting DToCs via SITREP. It arose from the above Monitor report which recognised the need for a standardised data set based on common definitions of DToCs and MO patients.

Whilst the guidance is helpful, the feedback from the users i.e.: Trusts and CCG’s suggests that the definition for MO requires more clarity and in particular, when and who records this information. We found a number of Trusts were not recording MO at all so the overall picture is not transparent. For 16/17, this should be recordable and as aspirational target agreed.

NICE have also produced a guideline on the ‘transition between inpatients hospital settings and community or care home settings for adults with social care needs in December 2015. This guideline considers how
person-centred care and support should be planned and delivered during admission to, and discharge from, hospital.

Overall the literature in Appendix 5 highlights the need for multi-disciplinary teams, 7 day working and working patterns to reflect demand, working with primary care to reduce unnecessary admissions to hospital especially for older people and IT solutions such as interoperability.
12. Findings discussion

Arising from all the hospital visits and meetings, there were a number of common themes identified by all the key stakeholders. This section consolidates these themes into a discussion and provides potential solutions based on best practice. From these findings, a set of recommendations are made for future steps with the SRG’s as part of 2017/18 winter planning.

Patient experience

As discussed in chapter 1, every day a patient is delayed in hospital is a patient safety risk. Throughout the review the impact on patients experience cannot be underestimated. The patient review meetings often demonstrated how funding issues can became the focus of decisions rather than the patient and this needs to change.

Kingston Hospital demonstrated an excellent way of learning from delayed events and work with Richmond HealthWatch to review their patient feedback and also learn from case examples. Richmond HealthWatch noted that a lack of communication between staff and patients can increase anxiety, often patients did not know they were going to be discharged until the final moment. They also integrate the community nurses into the discharge process by ensuring a handover discussion has taken place ahead of discharge home.

The case examples reflect how and why patients are delayed and sometimes it was unclear who had overview of the case. There needs to be greater ownership of the patient pathway to mitigate delays and too many handoffs. The integrated social care teams work very well to mitigate this in particular when they have authority to make out of panel decisions and can make spot purchase care packages to reinstate or arrange home provision.

Examples where more voluntary sector services such as the Red Cross and Age Concern are well utilised in the SEL area provides practical help to patients, support in relation to shopping. They also take training of volunteers very seriously to ensure staff are capable and equip to deal with patients in their home environment.

Health needs assessment tools

Paperwork: It is vital that a thorough MDT assessment is made however the mechanism for discharging should not delay the patients ongoing journey and the paperwork can take 5 days or more to complete. There was unanimous view that as The London Health Needs Assessment tool is a duplicate of the Checklist the LHNA should therefore be removed.

Some Trusts were proactively taking steps to circumvent or shorten the practice. Most notably Kings had agreed with (CCG) to remove the LHNA form and likewise the Southward joint care assessment team took out of panel decisions from the relevant information to help expedite the ongoing journey.

Panel Decision Making: The other major complaint was the time waiting for panel decisions, and many examples were given where delays in decisions, lost paperwork, lack of joint representation at panels all impacted on the LOS for a medically fit patient. With the frail elderly this result in them becoming medically
unfit again. There needs to be a shift in focus from funding to the patient. Assessments are often rejected either for more information or because the panel has not agreed if its health of social care.

Panels should have joint representation at all times to enable good decision outcomes and then the decision needs to be communicated back to the Trust within an agreed timescale; same day would be best practice. For those out of area local authorities, the SRG may want to consider how they either support LA with out of area placements and potentially lead these on their behalf, or work more closely with them to agree the core KPI’s required for assessing patients and undertaking panel decisions. LA who have trusted assessors had much greater authority to spot purchase and facilitate early discharges.

Fundamentally a key area for SRG’s for next year is to ensure they agree a standardised approach to the HNA process with all their CCG’s including out of area. This includes agreeing a set of KPI’s for panels to ensure the timeliness of the checklists are concluded and communicated back to trusts. Obtaining out of area assessments and decisions was a major cause of patient delay. The NWL tri-borough were the only area found who were piloting their social workers undertaking assessments on behalf of out of area boroughs.

Training: Internally, staff need to be appropriately trained to complete the tools. This includes ward staff as well as social services and therapists. The PRUH Transfer of Bureau have used their BCF to progress a more case management approach to patients discharge which allows continuity and also expertise in both organising care packages but also having difficult conversations around choice with families. They were very strong in these areas.

Camden LA is organising and running three one day training events in spring and summer 2016 for UCLH & Royal Free on ‘hospital discharges and transfers of care’. In addition, UCLH are currently filming a training video on ‘discharge from hospital’ and how to ensure that the patient is at the centre of the process. This film will assist student nurses in understanding the discharge process and will become part of UCLH’s e-learning portfolio.

Defining and recording Medically Optimised patients

One day MO snapshot: as MO is not recorded routinely, getting a total view across London for the extent of how many patients were medically optimised/fit for discharge was a real challenge. The DTOC team undertook the one day snapshot for all London Trusts via the surge calls. It was not possible to collect all Trusts as a number do not record MO, however, despite this the snapshot demonstrated an average of 9% across the total acute medical bedbase. This was sense checked and the NCL SRG confirmed that 16-18% beds occupied in there most challenged Trusts by MO / DTOC patients was not unrealistic.

Recording MO: some Trusts have started to record MO via their internal Patient Administration System (PAS) or are planning to roll out CUR a decision support tool as part of CQUIN for 16/17. NCL had commenced the roll out of SHREWDS which has already been implemented in Kent and offers visibility of all delays including MO and DTOCS.

MO Definition: The majority of leads stated that a working definition of MO is required as the current guidelines is seen as non-specific. CCG Director of Nursing and directors were keen to be involved in this process of finding a workable solution and also defining when, who and how this is recorded in the medical notes.
Increased Emergency Activity

15/16 winter has seen an unprecedented rise in emergency activity across London with Trusts struggling to manage and maintain ED performance. The problem is compounded by the level of DToCs including repatriations plus medically optimised patients who cannot be discharged in a timely way.

For those Trusts who record weekend activity, the Sitreps demonstrated discharges at weekends are poor across the board plus there is variability across the week, suggesting that patient review meetings probably offer focus on a particular day. Trusts need to be able to flex up across the week with additional staff to help cope with flow and tap into resilience monies to come up with more innovative ways to fast track patients out of hospital. To be more streamlined, services must be efficient and effective all the time to help patients get home of to the next destination of their care.

Likewise in the community, services need to be providing resilience and operating out of hours and 7 days a week. SRG’s need to be working closely to understand what primary care is doing to support the acute providers, i.e. is there adequate community staff to provide more ambulatory care (IV' and palliative care). There appeared to be a lack of visibility of the impact walk in centres are having and how can we encourage more patients to go there.

The impact for Trusts is combined with winter pressures, junior doctor strikes, they often have difficulty ‘catching up’ as have to cancel elective work which in turn loses income and extends waiting times for patients.

7 day services

In those areas of London that have worked together to address weekend provision for social services, spot purchasing packages of care and using stepdown facilities, this has significantly improved their flow and also helped admission avoidance.

Conversely, a number of Trusts still only had discharge co-ordinators working Monday to Friday and there is overall lack of cover and expertise to maximise even simple discharges. Whilst complex patients will always require more planning and support to facilitate a safe discharge from hospital, simple discharges are often lost at a weekend due to both a lack of internal and external support.

Internally, Trust infrastructures need to ensure they have provided cover not only diagnostics, pharmacy, ward cover but also senior clinical decision making. Across the board this is still highly variable and a key focus for next year if flow is to be maintained across the week.

SRG areas need to establish governance frameworks to look at issues at a system level and focus on the areas that require more investment for further transformation and pathway re-design.

NHS Improvement and NHS England have oversight of the agreed ten 7 day services quality standards and the prioritised subset of 4 of these for implementation by 2020 nationally. However these do not include Standard 9 which relates to community, primary and social care: this standard requires ‘seven day support services must be available to ensure the steps in the patients care pathway can be taken’. (Seven Days Services Clinical Standards February 2016 - NHS Improving Quality & NHS England)
There needs to be more radical thinking by healthcare systems to address the ‘backdoor’ despite the focus on the four standards. Some areas across London have started already to work collaboratively to put in place infrastructures and teams to integrate services better and focus on discharges. SEL are a good example of this and are working smartly forming collaborative arrangements with local authorities; Trusts and voluntary sectors to manage discharge flow.

NWL have also made good progress and agreed a joint discharge form with the CCG, Trusts and local authorities, despite local authorities having to work within severe capacity constraints.

Visibility of discharges over the weekend should be a key requirement for next winter plus MO data.

There needs to be clear visibility of MO. Evidence showed a number of Trusts are not recording this metric and also some are under reporting these.

The development of Accountable Care organisations (ACO’s) is emerging as a concept to control and manage whole care system including the community. This opens the door to controlling the ‘back door’ and target those areas of constraint.

Nursing homes and Residential care

The graphs in chapter 1 demonstrate nursing home capacity is a key constraint and there are problems in completing home assessments, agreeing family choice, meeting admission criteria and placing complex patients. This is the largest cause of delayed discharges and reflected in all visits.

**Family choice.** Lead CCG’s need to agree a clear policy across their system for Trusts to follow. Using the case management approach as seen at PHRU, staff need to be highly experienced at having more difficult conversations and making families part of the discharge process.

**Admission criteria.** SEL cited a nursing home who extends its model of care to take more complex patients from the acute sector including rehabilitation, tracheostomy patients, trained staff ect.

**CQC inspections:** Several health economies are severely constrained by a lack of nursing homes beds due to CQC inspections and subsequent closures. In the NEL area over 120 nursing home beds were closed due to quality and safety concerns.

Trusts are dependent on homes and the impact of bed closures has had a major impact on acute flow. This was seen most acutely in the NWL area where at the time of review, 9 homes were closed due to CQC inspections with no clear timescales communicated to Trusts or clear contingency plans to provide an alternative solution. The SRG’s, Trusts and nursing homes need to work on a model of integration as are highly dependent upon each other. Governance frameworks could be supported with acute provider input to help drive quality improvements. In addition, there are opportunities for cross training and securing a well skilled and sustainable workforce.

Part of the solution to help improve nursing homes is that Trusts need to get more integrated with local homes to help support and drive quality. To counterbalance the CQC inspections which around London has seen a number of closures, the failing of standards in nursing homes should be recognised and supported. The Director of Nursing at NHS England suggested more support is given to Trusts who fail quality standards but none is given to the homes. Large sector nursing homes may have governance processes in place, however, the small privately owned homes, simply may not have the means to address the quality
and staffing issues. There is a key opportunity here to look at how Trusts and health care professionals can work together to drive quality improvements, training etc. and ensure capacity is secured.

**Provision of Intermediate Care**

The National Audit of Intermediate Care Report Summary 2014 review found a key constraint for all providers was intermediate care (IC) provision. IC includes nursing home, re-ablement, home care, community services etc. Some areas of London were addressing this problem with developing good relationships and links with nursing homes to develop models for discharging patients demonstrating a ‘shared problem’.

The extract and graph below from the Audit, shows the level of overall investments CCG’s use to fund intermediate care. The audit findings show that although a small number of health economies are investing at high levels in home based IC services (2 of which significantly alter the weighting), there is no evidence that nationally higher levels of investment are being made.

**Figure 6: Commissioner Budgets for Intermediate Care (2014)**

Source: the national audit of intermediate care summary 2014

**Discharge to assess:** there are a number of models of discharge to assess models and the Kent CHC team are leading new ways of working and implementing pilots with BCF. However, discharge to assess is variable across London and there needs more drive and authority devolved locally to spot purchase care packages where possible. There also needs to be resources available to deliver care packages once agreed. This can also be a constraint.

CCG’s and trusts need to be focusing on more Hospice at home and encouraging families to care at home if hospice beds are not available.
Community beds

Whilst outside the scope of this project, there is variable traction across the community in terms of managing LOS and this is not visible. Patient review meetings provided anecdotal evidence of patients residing in community hospital beds sometimes for one year waiting for housing or another placement. Some trusts have an integrated model with the community and therefore have more flexibility to provide more clinical and AHP support to ensure LOS is managed appropriately. Whilst not all community hospital are vertically integrated, there is still an opportunity for SRGs to gain oversight of both capacity and LOS.

Pulling the ‘System’ together

In areas of London where there are good links between CCG’s, boroughs, providers, voluntary sector and private providers, the data demonstrated better discharge performance and reduced DToCs > 2.5%. In the case of SEL and the tri-borough system in NWL, both areas developed a Whole Systems Integrated Care Programme with jointly developed action plans in place. Both areas utilised BCF to identify various improvements. The NWL tri-borough system including Hammersmith, West and central London ran a winter resilience work shop and engaged with local nursing homes, social care to tackle and streamline the discharge processes for delayed discharges.

A number of senior managers welcomed more oversight by NHS England to pull the system together, including sharing best practice, oversight of BCF schemes across London and how these link together and holding providers to account for managing the discharge and ongoing pathway process.

Information and Reporting

There is no single system for sharing information between agencies planning for and responding to season pressure events or major incidents. Timely and fit for purpose information is crucial to the management of capacity and patient throughput at a time of excess demand on NHS emergency and acute care services.

NCL are rolling out ‘Shrewd Resilience’ as part of their resilience programme to ensure they have the system wide view across their local health economy which also feeds into NHS England.

Similarly, CUR is a key CQUIN for 2016 offering agencies a decision support tool to help manage flow internally and externally.

Trust Dashboards: A number of Trusts including NWP and PRUH had a DToC/MO dashboard in place to provide visibility around the number of beds occupied. NWP reported delays with a cost per bedday which offered a powerful way of demonstrating the impact of cost wastage in addition to impact on ED performance.

Visibility at NHS England of how many patients are medically optimised was poor across most areas of London with the exception of NCL who provided this as part of their daily performance report. Winter surge calls did not routinely capture this information although formal DToCs numbers were reported, these were not always discussed. Only during the 2 weeks manual collection of data were the DToC team able to understand the number of MO patients. In addition there are a number of Trusts who do not record MO
patients (including the Homerton and Newham hospitals) as they do not agree with the descriptor provided in the NHS England guidance.

**Better Care Funding**

Despite financial constraints, a number of organisations have been very innovative and by working across the systems and used BCF to drive forward initiatives to improve patient flow and discharge.

The BCF Planning Requirements for 2016/17 were published in February 2016. Health and Well Being Boards (HWB) are required to sign off pooled budgets as well as the constituent Councils and CCGs. These plans should cover as a minimum, the value of the pooled fund detailed in both CCG and Council funding announcements. The majority of London funds are expected to increase in value from 2015/16.

The review demonstrated a number of providers have utilised funding to

- Progress on seven day services
- Improve data sharing between health and social care
- Joint approach to assessments and care planning as seen with the LAS model
- Investment on out of hospital services (new for 2016/17)
- Agreement on a local action plan to reduce delayed transfers of care (new for 2016/17)
13. Recommendations

Following the report a set of key recommendations have been identified to take forward for further improvement.

1. Agreement of a Common Terminology and Descriptor for Medically Optimised Patients
   • Agreeing a MO descriptor for London. Form a focus group comprising of clinical leads from CCG’s and Trusts to define what is and constitutes MO. Involvement will improvement engagement and ownership to improve the success of getting clarity around this cohort of patients. Agreement also needs to be reached on how this should be recorded in the medical notes and then onto the Trust.
   • Take a view on an aspirational target based on the London average of 9%. Apply this as a joint aspirational target for the whole system.
   • Ensure Trusts are recording MO as part of their daily SitRep reporting

2. Performance Management
   • DTOC should be a joint system target not just applied to Trusts
   • Ensure all Trusts are reporting MO patients as part of their SitRep during 16/17 (once the definition has been agreed)
   • Develop an aspirational target for MO patients once a clear definition has been agreed

3. Streamlined Health and Social Care Assessment Processes
   • Standardise paperwork and have one Health Needs Assessment/Decision Support Tool across London.
   • HN Assessment panels need to be streamlined and represented by health and social care with immediate communications back to Trusts on outcomes.
   • CCG’s and LA identify authorised staff who can make out of panel decisions and spot purchase packages.
   • Following the NWL tri-borough social services model, CCG’s and LA agree how they can provide HN assessments on behalf of out of area borough patients and develop better relationships to facilitate out of panel decisions.
   • All systems need to drive better training and education for staff to use the HNA.
   • Using best practice, Trusts, LA’s and CCG’s need to formulate joint plans on how to address out of panel decisions to facilitate earlier discharges.

4. Managing Emergency Activity and Community Provision
   • SRG’s ensure Trusts and the community providers are flexing up over the whole week to help flow. Resilience funding can support this.
   • 7 day submissions data required to capture MO/DToCs, admissions and discharges across the week including weekends.
   • Increase visibility of community capacity including LOS. Many Trusts have an integrated model allowing more control over community beds.
• Ensure SRG’s have the means of monitoring community flow as in the case of NCL, SHREWD will link with NHS England and captures MO and DToCs but may also be developed to monitor LOS in the community.
• Review what more can be provided by GPs and urgent care centres to prevent admissions to hospital.
• CCG/LA review how they are providing traction and support to deliver pathway improvement for fast track of End of Life pathways in the absence of nursing home and hospice capacity.

5. 7 Day Services
• SRG’s review their system of 7 day cover using the self-assessment tool. Prioritise the key enablers to develop plans.
• Trusts need to ensure they have discharge co-ordinators, senior clinical decision making, diagnostics and social services 7 days a week to maintain flow over a weekend.
• Community providers assess 7 day cover and in reach to hospitals

6. Nursing Homes and Residential care
• SRG’s to apply best practice guidance across London using the Lambeth and Southwark Integrated care discharge policy.
• Ensure Trusts have experienced case managers who can manage the family choice issues effectively and prevent delays to nursing homes.
• SRG’s engage their Trusts and local nursing homes to work together to drive quality improvements and criteria for placements.
• Explore ways in which to improve training in nursing and residential homes to take more complex patients as seen in SEL.

7. Provision of Intermediate Care
• Driving investment and ensure 16/17 and 17/18 BCF plans across London include access to joint intermediate care schemes to reduce variability of provision in the community and drive more care at home.
• Explore more joint models of providing rehabilitation, re-ablement and stepdown in both the care home sector and homes.
• Drive more discharge to assess with spot purchase of care packages where possible
• Clear policies on family choice as outlined in SEL discharge plans. Lead CCG’s need to agree this across their system and implement and embed.

8. Rehabilitation
• Focus on increasing equity of access to neuro-psychology interventions (cognitive therapy and neuro-psychiatry) for patients and carers across London and in residential/nursing home settings
• Focus on improving the provision of specialist nursing and residential care rehabilitation services and consider the introduction of extended scope domiciliary services to work with mainstream rehabilitation services.
• Develop systems for Neurology Early Supported Discharge from acute settings by jointly commissioning social, community care and voluntary sector organisations e.g. Brain Injury
Rehabilitation Trust with specific neuro-rehabilitation expertise and assistive/supportive technology

- Simplify and standardise referral processes between services, consider investment and roll out of innovative IT solutions
- Consider the use of trusted assessor protocols for neuro-rehabilitation provider referrals within the system.

9. People
- More ownership around the patient pathway through models such as case management and ensure there is continuity in the decision making process provided by experts
- Greater operational ‘grip’ at Trust level to manage the simple as well as complex discharges
- Training to develop skills of staff to complete HNA tools and increase the understanding of the process
- Using the example of Waltham CCG who provide in-reach training to trusts on CHC assessments, CCG’s and trusts need to develop the skills of staff to complete the HNA tools and increase their understanding of the process. This should be extended to other roles including AHP and social workers.
- Engagement plans to include the whole local health economy as seen in the NWL tri-borough action plans
- Trusts and community providers provide flexible work-plans to ensure cover across the week including weekends

10. Governance
- Trusts should be linking in the long stay patients into their governance processes and using these as case examples. Kingston Hospital review patients who have been delayed using patient feedback and with the involvement of Health-watch to improve their pathway.
- CCG/CSU’s have oversight and involvement in system wide patient review meetings and work closely with their providers to proactively resolve delays and blocks. SEL (Lambeth CCG) and NEL (Barnet CCG) were an example of best practice in this area.

11. Pulling the System Together
- NHS England provide system leadership and recommend key areas of focus for winter 16/17 in relation to key priorities for monitoring and measuring and managing the patients who are delayed in hospital
- Feedback to SRG’s and key stakeholders the key areas of good practice across London
- Identify a key lead at NHS England who will help drive change across London, have oversight of the MO and DToC agenda including where the blocks and enablers are.
14. Recommendations for Further Work

- Paediatrics and transition for CAMHS: Waltham Forest CCG highlighted a need for a separate review of paediatrics and young CAMHS patients DTOCS.
- Follow up visit to St Georges hospital to review the progress made against their action plans. Propose this takes place in June 2016 (3/12 review).
- Develop a DTOC dashboard to include Mo/DToC data, admissions and discharges across the week – see Appendix 4 for draft dashboard snapshot
- CCG/LA review what more can be done in the community to help alleviate emergency flow to A&E and avoid admissions to hospital. This includes urgent care centres as well as how can GP’s support elderly cohorts of patients and undertake annual health check reviews etc.
- Work with London community hospitals and rehabilitation centres to monitor and manage the on-going patient journey and monitor LOS.

Acknowledgements
The DTOC team would like to thank all the staff who we spoke to during our visits. We very much appreciate their time and recognise that without their valuable input we would not be able to produce this report.

We would also like to thank the staff at the Hospitals for ensuring our visits went smoothly, in particular the senior nursing staff on the wards who took time out of their busy schedules to show us around the wards and give us their insights.

Prepared by DTOC Taskforce Team
Anna Bjorkstrand, DTOC Taskforce Project Lead
Christine Angee-Otim, A&E Taskforce Programme Manager
Sobia Chaudhry, DTOC Taskforce Manager
Andrew Nwosu, DTOC Taskforce Manager
Chris Costa, DTOC Taskforce Manager
References

1. The Public Sector Executive (March 2016) Bring Forward social care funding to tackle rising care transfer delays – ADASS.
9. Seven Day services Clinical Standards - NHS Improving Quality and NHS England (February 2016)
<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>An Accident &amp; Emergency (A&amp;E) department is based in a hospital (also known as emergency department or casualty) and deals with genuine life-threatening emergencies.</td>
</tr>
</tbody>
</table>
| CCG        | Clinical Commissioning Group- are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. CCGs are membership organisations of the practices within their boundaries. They are responsible for meeting the health needs of their populations and their main focus is on local issues. Services CCGs commission include:  
  - most planned hospital care  
  - rehabilitative care  
  - urgent and emergency care (including out-of-hours)  
  - most community health services  
  - mental health and learning disability services  

There are 32 CCGs in London. |
| DTOC       | Delayed Transfer of Care is when a patient is ready for transfer from hospital and is still occupying a bed.  

A patient is ready for transfer when:  

a. A clinical decision has been made that patient is ready for transfer AND  
b. A multi-disciplinary team decision has been made that patient is ready for transfer AND  
c. The patient is safe to discharge/transfer. |
| MO         | Medically Optimised -This is a patient for whom a clinical decision has been made that they are ready to transfer. This is from a medical perspective only and is a decision made usually by the consultant or team who are responsible for the patient.  

The patient has not had a multi-disciplinary team (MDT) decision at this point and, indeed, may need further therapy or social care in-put prior to a MDT decision being made, so is not a reportable delay |
| ECIP       | The Emergency Care Improvement Programme (ECIP) is a clinically led programme that offers intensive practical help and support to urgent and emergency care systems, leading to safer, faster and better care for patients  

ECIP is focused on helping to improve patient flow through the system, this starts with patients contacting NHS 111, their GP, or the ambulance service, moving through A&E and, where appropriate, into the hospital as an in-patient or returning home quickly and safely with the support they need. |
There are 28 ECIP systems across the country and 5 are in London:
- Kingston SRG
- Bromley Lambeth & Southwark SRG
- Wandsworth Sutton & Merton SRG
- Tower Hamlets, Waltham Forest & Newham SRG
- Brent & Harrow SRG

These areas were selected based on performance against the emergency care 4 hour standard in 2014/15 and quarter one of 2015/16 and have been identified by ECIP as being under the most pressure.

<table>
<thead>
<tr>
<th>‘Funding without prejudice’</th>
<th>Where the patient is in hospital and is medically fit for discharge, the CCG and the LA will urgently agree an interim package of care, including a ‘without prejudice’ funding arrangement. When the on-going joint package is agreed, funding responsibility will be backdated, to reflect the responsibilities of each commissioner, from the date the person became eligible for the JPOC.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FNC ‘Funding Nursing Care’</strong></td>
<td>Relates to a £140 contribution made to fund nursing care element of a social care package.</td>
</tr>
<tr>
<td><strong>EDD</strong></td>
<td><strong>Expected Discharge Date.</strong> Date patient can expect to be released from hospital.</td>
</tr>
<tr>
<td><strong>UCC</strong></td>
<td><strong>Urgent Care Centre.</strong> This deals with less severe injuries/sickness than an A&amp;E Department.</td>
</tr>
<tr>
<td><strong>SRG</strong></td>
<td><strong>System Resilience Groups</strong> are the forum where all partners from across the health and social care system come together to undertake the regular planning of service delivery to ensure a robust system is in place. In London there are 17 SRGs.</td>
</tr>
<tr>
<td><strong>LA</strong></td>
<td><strong>Local Authority.</strong> Is an organisation that is officially responsible for all the public services and facilities in a particular area. There are 33 LA in London.</td>
</tr>
<tr>
<td><strong>TDA</strong></td>
<td>The <strong>NHS Trust Development Authority</strong> provides support, oversight and governance for all NHS trusts helping them to deliver the best patient care possible.</td>
</tr>
<tr>
<td><strong>LOS</strong></td>
<td><strong>Length Of Stay.</strong> Number of days patients is staying in hospital</td>
</tr>
<tr>
<td><strong>CHC</strong></td>
<td><strong>Continuing Healthcare Checklist</strong> – this is used by NHS and Social Care professionals to determine the level of care (if any) a patient is eligible to receive.</td>
</tr>
<tr>
<td><strong>Intermediate Care</strong></td>
<td>Short term care and usually for older people. Its aims are to help people avoid going to hospital unnecessarily and to stay as independent as possible. The care can be delivered in a range of settings such as people’s own homes or residential homes.</td>
</tr>
<tr>
<td>Trust</td>
<td>Formal DToCS all</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------</td>
</tr>
<tr>
<td>L NC Barnet Hospital</td>
<td>8</td>
</tr>
<tr>
<td>L NC North Middlesex Hospital</td>
<td>15</td>
</tr>
<tr>
<td>L NC Royal Free Hospital (Capacity)</td>
<td>5</td>
</tr>
<tr>
<td>L NC University College Hospital (only UCL site &amp; exclude specialty beds Queens square)</td>
<td>17</td>
</tr>
<tr>
<td>L NC Whittington Hospital (excluding community beds)</td>
<td>4</td>
</tr>
<tr>
<td>L NE Homerton University Hospital</td>
<td>11</td>
</tr>
<tr>
<td>L NE King George Hospital (KGH)</td>
<td>2</td>
</tr>
<tr>
<td>L NE Newham University Hospital (Barts )</td>
<td>8</td>
</tr>
<tr>
<td>L NE Queens Hospital Romford</td>
<td>14</td>
</tr>
<tr>
<td>L NE Royal London Hospital Barts)</td>
<td>28</td>
</tr>
<tr>
<td>L NE Whipps Cross Hospital (Barts)</td>
<td>16</td>
</tr>
<tr>
<td>L NW Charing Cross Hospital (includes St Marys Hospital)</td>
<td>31</td>
</tr>
<tr>
<td>L NW Chelsea &amp; Westminster Hospital (includes West Middlesex)</td>
<td>14</td>
</tr>
<tr>
<td>L NW Ealing Hospital</td>
<td>5</td>
</tr>
<tr>
<td>Hillingdon Hospital</td>
<td>10</td>
</tr>
<tr>
<td>L NW Northwick Park Hospital and CMH</td>
<td>32</td>
</tr>
<tr>
<td>L SE Kings College Hospital (2 sites)</td>
<td>16</td>
</tr>
<tr>
<td>L SE Lewisham Hospital (UCH &amp; QEH)</td>
<td>8</td>
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<tr>
<td>L SE Queen Elizabeth Woolwich Hospital</td>
<td>0</td>
</tr>
<tr>
<td>L SE Guys and St Thomas</td>
<td>17</td>
</tr>
<tr>
<td>L SW Croydon University Hospital</td>
<td>27</td>
</tr>
<tr>
<td>L SW Epsom Hospital</td>
<td>23</td>
</tr>
<tr>
<td>L SW Kingston Hospital</td>
<td>12</td>
</tr>
<tr>
<td>L SW St George's Hospital</td>
<td>14</td>
</tr>
<tr>
<td>L SW St Helier</td>
<td>19</td>
</tr>
<tr>
<td>Totals</td>
<td>366</td>
</tr>
</tbody>
</table>
Appendix 2: Breakdown of beds available across London
### Appendix 3: Monitor summary of and confidence in the findings from the 10 hypotheses tested

<table>
<thead>
<tr>
<th>Summary of the findings of the 10 hypotheses used in Monitor</th>
<th>Evidence confirmed this to be true</th>
</tr>
</thead>
<tbody>
<tr>
<td>H1 Nationally there was a higher number of A&amp;E attendances and this had a negative impact on A&amp;E performance against the four-hour target</td>
<td>No</td>
</tr>
<tr>
<td>H2 Nationally there was a higher proportion of sicker people attending A&amp;E and this had a negative impact on A&amp;E performance against the four-hour target</td>
<td>No</td>
</tr>
<tr>
<td><strong>H3 Nationally there was a higher proportion of people attending A&amp;E via ambulance and this had a negative impact on A&amp;E performance against the four-hour target</strong></td>
<td>Yes</td>
</tr>
<tr>
<td>H4 Nationally the variability of attendance patterns (in terms of the time and day of arrival) changed and this had a negative impact on A&amp;E performance against the four-hour target</td>
<td>No</td>
</tr>
<tr>
<td><strong>H5 Nationally there was a higher number of people admitted via A&amp;E and this had a negative impact on A&amp;E performance against the four-hour target</strong></td>
<td>Yes</td>
</tr>
<tr>
<td>H6 Nationally there was a higher proportion of sicker people admitted via A&amp;E and this had a negative impact on A&amp;E performance against the four-hour target</td>
<td>No</td>
</tr>
<tr>
<td>H7 Nationally A&amp;E departments had more problems with their staff related resources and this had a negative impact on A&amp;E performance against the four-hour target</td>
<td>No</td>
</tr>
<tr>
<td>H8 Nationally A&amp;E departments had more problems with their non-staff related resources (eg IT, diagnostics) and this had a negative impact on A&amp;E performance against the four-hour target</td>
<td>No</td>
</tr>
<tr>
<td>H9 Nationally other hospital departments had more problems working effectively with the A&amp;E department and this had a negative impact on A&amp;E performance against the four-hour target</td>
<td>No</td>
</tr>
<tr>
<td><strong>H10 Nationally other hospital departments had higher rates of bed occupancy and this had a negative impact on A&amp;E performance against the four-hour target</strong></td>
<td>Yes</td>
</tr>
</tbody>
</table>
Appendix 4. Draft DToC Dashboard—below is an example page from the DToC Dashboard
<table>
<thead>
<tr>
<th>Report</th>
<th>Source</th>
<th>Findings</th>
</tr>
</thead>
</table>
| Protocol- Best Practice for management of Discharge from an NHS Bed August 2015 | Guys and St Tomas NHS Foundation Trust and Kings College Hospital NHS Foundation Trust and Princess Royal University Hospital | Protocol is based on 9 key Principles such as:  
- All patients should be returned to their home wherever possible, on discharge from an NHS bed (Principle 1)  
- Patients cannot remain indefinitely in an NHS bed if a suitable care package has been offered (Principle 3)  
- Acute hospital beds should be used for delivering acute care (Principle 6)  

There are 11 steps to follow and are identified for planned and unplanned admissions.  

A key initial step is to identify the patients estimated discharge date (EDD) and if a community package of care is required following discharge.  

A best practice pathway is outlined.  

The protocol contains draft letter templates issued from the hospital to the patients. The templates are specific to the appropriate step in the pathway and can be adapted for each patient (Lambeth Health watch assisted with the design and wording of the letters to ensure that they were clear and easy to understand.  

Two interventions reviewed:  

a). Improving the Flow of Older People. The Health Foundation (2013)  
b). Length of Stay Case Study.  

http://www.health.org.uk/publication/improving-patient-flow | Findings:  
The main findings saw that most patients were over 75 years and increasing number over 90 years of age.  
However, whilst these patients were in the hospital- only 50% of these patients were receiving actual acute specialist medical, nursing or therapy care. The rest were waiting for discharge downstream- but were waiting on health and social care services outside of the hospital.  
Closer look at the data showed that the mode (most frequently occurring) length of stay was 24 hours after admission. Though there were also a number of patients who could spend a few months in hospital.  
Reviewing the notes, it was shown that patients could have been discharged earlier, but often this was missed due to mismatch of capacity and demand for the patients. |
<table>
<thead>
<tr>
<th>Sheffield Teaching Hospitals &amp; Nuffield Trust (2014)</th>
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<tbody>
<tr>
<td>This meant that due to the delayed discharge some frail patients deteriorated and others moved to other parts of the hospital.</td>
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<tr>
<td>It was found that 90% of emergency patients referred to ‘geriatric medicine’ by their GP or A&amp;E staff did so between 8am-6pm:</td>
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<tr>
<td>- Those referred to hospital, presented to hospital after midday.</td>
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<tr>
<td>- Those coming as emergencies to hospital did so in the early afternoon.</td>
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<tr>
<td>- Those coming via A&amp;E did not get referred to ‘geriatric medicine’ or a ‘medical assessment unit (MAU)’ for at least four hours.</td>
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<tr>
<td>Therefore, often the frail patients would arrive on MAU in the early evening (around 6pm) and therefore would be seen (assessed) by junior medical staff. Therefore, patients would need to be seen by a consultant, which would now be in the morning, when they did their ward round. And often they were first seen by an ‘acute physician’ before being seen by a ‘geriatric medicine consultant’.</td>
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<tr>
<td>Therefore, having to wait for the ‘specialist geriatric medicine assessment’ meant frail older people had to stay in hospital overnight unnecessarily. Therefore a key issue in the emergency system was the length of time taken for a patient being assessed and given a ‘care plan’.</td>
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<tr>
<td><strong>Solutions</strong></td>
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<tr>
<td>Having identified some of the areas that led to delays and blockages, changes were introduced to tackle these. This included:</td>
</tr>
<tr>
<td><strong>Medical capacity</strong></td>
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<tr>
<td>- Changing consultant working pattern – covering the demand period of 8-6pm. A significant change for geriatric medicine consultants to change their on call duty rotas.</td>
</tr>
<tr>
<td>- Changing working times of junior doctors</td>
</tr>
<tr>
<td><strong>Frailty Unit</strong></td>
</tr>
<tr>
<td>- Establish a frailty unit (need not age- so all frail individuals could come)</td>
</tr>
<tr>
<td>- Put in a multidisciplinary assessment team- this allowed for the co-location of all the staff that work with frail patients, such as medical, nursing, and therapist. This helped with communications.</td>
</tr>
</tbody>
</table>
### Speed up discharge
- Merged inpatient and outpatient care
- Safety emphasis on safety such as falls

### Benefits
- Found that there was an impact on timeliness of assessment and treatment. The earlier in the day a patient can be assessed by the medical team, the more quickly they can get the care they need to be moved or discharged.
- Improved communications across departments internal and external.
- Calmer environment especially beneficial for patients with dementia.
- 37% increase in patients who can be discharged on the day of their admission with no re-admissions (meaning that the speeded up process did not have detrimental effects)

### Resources
Provide skill update to staff to ensure sustainability.

<table>
<thead>
<tr>
<th>Unblocking a hospital in gridlock</th>
<th><a href="http://www.health.org.uk/publication/improving-patient-flow">http://www.health.org.uk/publication/improving-patient-flow</a></th>
<th>Key findings:</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Warwickshire NHS foundation trust.</td>
<td>The Health Foundation April 2013</td>
<td>Flow Cost Quality Improvement programme looked at the Emergency Care Pathway for all adult patients.</td>
</tr>
</tbody>
</table>

It was shown that patients arrive during working hours (i.e. when consultants and senior decision making staff are available) but often they are not in the ‘right’ place by the time senior staff leave at 6pm.

Therefore due to working patterns of surgeons i.e. 8am-6pm, if the patient arrived after 6pm they would need to wait in the hospital till the morning to be seen.

The patient would then be referred to another specialist consultant if required. This meant that some patients needing specialist review were not seen till day three of admission.

Senior decision makers hypothesised that if they were at the assessment wards after their morning rounds (when people would be discharged) they could see patients and refer them to a bed while the beds were still available.
A dedicated elderly care consultant also began working alongside the Medical Assessment Unit (MAU) so that they could provide acute assessment as soon as diagnostic results were available.

Found that due to the demand in the MAU, needed to extend week working hours and also weekend working. Therefore consultants worked 8am-8pm. This meant that patients could be assessed and put on the right care management plan on the day they present.

This meant lower bed occupancy on the MAU and a higher % of patients on the ‘right’ wards. Another key issue was ‘diagnostics’- especially blood sciences and imaging.

It was found that blood tests requested on the ward on day one were drawn on day two and then not reviewed till day three. Therefore it was found that the phlebotomists work practices and the doctors ward rounds were out of sync and hence the delay. This was reviewed and adjusted and then had 80% same day blood test results available.

The need to electronic solutions was also evident – an electronic work management system (Heart Beat) was introduced. This allowed staff to know where their patients were and what assessment/ treatment was required. There was also an electronic system displayed on a large white screen which assisted with communication and to support workflows across different members of a MDT.

Key learning:
- “the place where flow appears to be blocked is often not where the real problem is”
- “Engage clinical staff”
- “Keep focus on the patients”
- “improving quality improves staff morale”

| Quality Care for Older People with Urgent & emergency Care Needs ‘Silver Book’ | British Geriatrics | Number of people over 85 years will be increasing in the next 20 years. Currently the number of older people attending emergency departments and accessing urgent care has increased. Growing concerns for safety of older people who are admitted to acute hospitals. It has been found that older people are admitted more frequently to hospital, have longer length of stay and occupy more bed days. | http://www.bgs.org.uk/index.php/bgs_campaigns-715/silverbook |
| Society et al 2012 | Document it aimed at first 24 hours of an urgent care episode whether in the emergency department, acute medical unit or community setting.

Report contains standards such as what older people accessing urgent care should be assessed for i.e. falls and mobility; depression; delirium and dementia etc

It also covers discharge planning and that older people being admitted following an urgent care episode should:

- have an expected discharge date set within 2 hours
- when preparing for discharge be provided with details of local voluntary organisations who can provide independent advice about benefits, home improvements as well as helping with completion of forms.

Importance of Primary care was also noted i.e. continuity of GP care is associated with lower emergency admissions and that a 1% decrease in primary care response to a crisis can result in 20% increase in demand for secondary care.

Role of social care being involved early in actual or potential discharge will benefit the older person by improving the patient journey.

A lack of timely social care can lead to older people being referred to ED or admitted to hospital rather than there being a clinical need

A whole systems approach is required – a multidimensional assessment and multiagency management of older people leads to better outcomes.

Importance of out of hours care- acutely ill older people are very sensitive to delays in care.

Introducing ‘interface geriatricians’ to assess and manage frail older people attending ED or AMU. They can help by reducing inappropriate hospital admissions through front door assessments and community assessments. |
This is a care home with nursing and is based in Lambeth London. It is privately owned for 53 residents- these are for adults from 30 years of age.

It is for those with physical disability and also sensory impairment. The care home also provides specialist care for individuals living with: AIDS/HIV • Cancer Care • Cerebral Palsy • Epilepsy • Head/Brain Injury • Motor Neurone Disease • Multiple Sclerosis • Neuropathic • Orthopaedic • Parkinson's Disease • Stroke

The care home recently passed the CQC inspection.

It would be useful to review this

| High Impact Change Model-Managing Transfers of Care | http://www.local.gov.uk/documents/10180/7058797/impact+change+model+managing+transfers+of+care/3213644f-f382-4143-94c7-2dc56c6e3c1a. | This document is a self-assessment tool for Trusts to review how they are preforming against 8 key interventions that can improve flow in hospitals. The 8 high impact areas are:
The idea is for all key departments in the Trust to come together to review how they are performing against the 8 standards.

1. Early Discharge Planning
2. Systems to Monitor Patient Flow
3. Multi-Disciplinary Discharge teams including the voluntary and community sector
4. Home First/ discharge to assess
5. Seven Day Services
6. Trusted Assessors
7. Focus on Choice
8. Enhancing Health in Care Homes |

| A&E Delays: Why did patients wait longer last winter | www.gov.uk/monitor | This report reviewed A&E for 2014/15

The report highlighted though there was an intense demand for the service during this time period it was in keeping with historical trends. |
The report makes a number of recommendations to ensure A&E performance does not decline in the future. This included ‘improving patient flow through urgent care systems to increase processing capacity’, as well as understanding the ‘impact of social and community care’ and ‘supporting local efforts to tackle challenges e.g. through SRGs.

### Monthly Delayed Transfer of Care Situation Reports

<table>
<thead>
<tr>
<th>Definitions and Guidance</th>
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<td>5 October 2015</td>
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This document provides the definitions and guidance on what constitutes a DToC and MO and how they should be recorded and categorised.

It highlights the reasons that be cited as a delay for NHS or Social Care:
- Awaiting completion of assessment
- Awaiting public funding
- Awaiting further non-acute
- Awaiting residential home placement or availability
- Awaiting nursing home placement of availability
- Awaiting community equipment and adaptions
- Patient or family choice
- Disputes
- Housing (patients not covered by Care Act)

It also details the financial penalties that NHS and Social Care can impose on each other for DToCs and gives examples of DToC cases.

### NICE Guidelines 27

**Transition between inpatient hospital setting and community or care home settings for adults with social care needs**

December 2015

This guideline considers how person-centred care and support should be planned and delivered during admission to, and discharge from, hospital.

It addresses how services should work together and with the person, their family and carers, to ensure transitions are timely, appropriate and safe.

There is an accompanying costing statement that concluded that overall the guidelines would result in a cost saving as a result of shorter hospital stays, reduced hospital admissions and reduced care home admissions.

### ECIP Tools and

[http://www.ecip.nhs.uk](http://www.ecip.nhs.uk)

The Emergency Care Improvement Programme (ECIP) website includes a comprehensive list of
<table>
<thead>
<tr>
<th>Resources</th>
<th>tools and resources to support local ECIPs including reference documents and improvement tools</th>
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<tbody>
<tr>
<td>Operational productivity and performance in England NHS acute hospitals:</td>
<td></td>
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<tr>
<td>unwarranted variations</td>
<td></td>
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<tr>
<td>Lord Carter of Coles</td>
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<tr>
<td>February 2016</td>
<td></td>
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<tr>
<td></td>
<td>This report discusses the variation in NHS and how this can be reduced to improve the overall</td>
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<tr>
<td></td>
<td>system. It highlights a number of areas of good practice.</td>
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<tr>
<td></td>
<td>It also focuses on DToCs and that delays can cost the NHS £900 million a year. The report</td>
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<td></td>
<td>also discussed how the delays have a knock on effect for elective operations which are</td>
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<td></td>
<td>cancelled due to lack of bed capacity.</td>
</tr>
<tr>
<td></td>
<td>The report makes two recommendation regarding DToCs:</td>
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<td></td>
<td>It also highlights good practice undertaken in Dudley where ‘ services work personally</td>
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<td></td>
<td>with families and beyond the traditional care hours model to support people to move to</td>
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<td></td>
<td>a care home of their choice’- an area that was highlighted throughout this NHS England</td>
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<tr>
<td></td>
<td>London DToC report.</td>
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<tr>
<td></td>
<td><strong>Recommendation 10</strong>: DH, NHS England and NHS Improvement, working with local government</td>
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<td>representatives, to provide a strategy for trusts to ensure that patient care is</td>
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<td></td>
<td>focussed equally upon their recovery and how they can leave acute hospitals beds, or</td>
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<td>transfer to a suitable step down facility as soon as their clinical needs allow so they</td>
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<td></td>
<td>are cared for in the appropriate setting for themselves, their families and their carers.</td>
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<td></td>
<td><strong>Recommendation 11</strong>: Trust boards to work with NHS Improvement and NHS England to</td>
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<td></td>
<td>identify where there are quality and efficiency opportunities for better collaboration</td>
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<td></td>
<td>and coordination of their clinical services across their local health economies, so that</td>
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<td></td>
<td>they can better meet the clinical needs of the local community.</td>
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