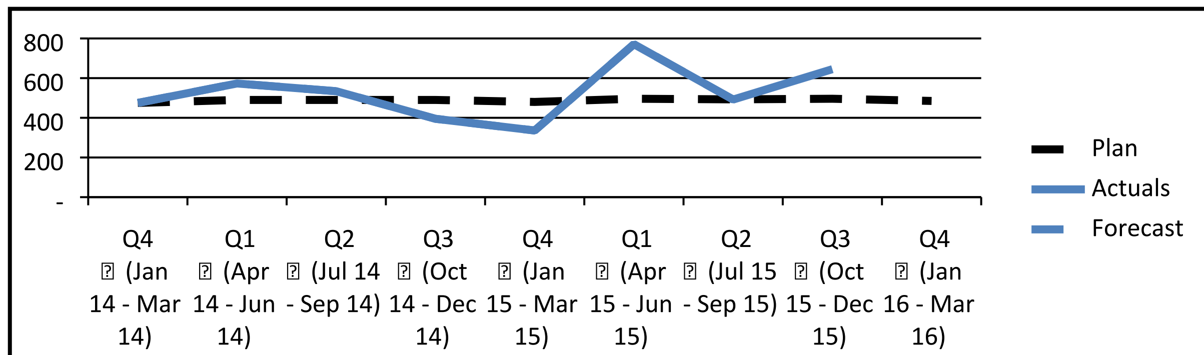
Slough BCF DTOC plan for 2016

Slough's performance against the DTOCs metric for BCF has varied significantly. There have been large fluctuations in the variance and the graph below shows performance going from 30% below target in Q4 of 2014/15 to 55% above in Q1 2015/16 and then back to 0% on Q2.

Overall numbers of delays are lower compared to other Berkshire areas and the national picture but we do recognise the need to ensure we continue to focus on ensuring patient flow through the acute hospital is optimised and delays are kept to a minimum.



Slough has a hospital social work team based within the Frimley North acute hospital which works very effectively in rapidly assessing people for discharge. There is also the RRR service which provides short term reablement and intermediate care for people leaving hospital, or where short term support needed which can avoid an unnecessary admission. The Berkshire Foundation Healthcare Trust also provides support for people through an Intensive Community Treatment team and its ARC service. Together these provide a range of step up and step down services for people in Slough.

Our approach to improving our performance in relation to DTOCs is described below. This mirrors the exemplar described within the Bracknell BCF submission in March 2016. The Bracknell experience and proposals reflect their primarily ***Frimley South*** facing stakeholder relationship and engagement pattern. The vast majority of Slough residents attend ***Frimley North (Wexham Park)*** hospital for acute care and we are confident that similar analysis and approach will deliver improvement to our overall DTOC performance - and support the collaborative aims and joint approach relevant across East Berkshire, reflected in and reinforced by the new STP.

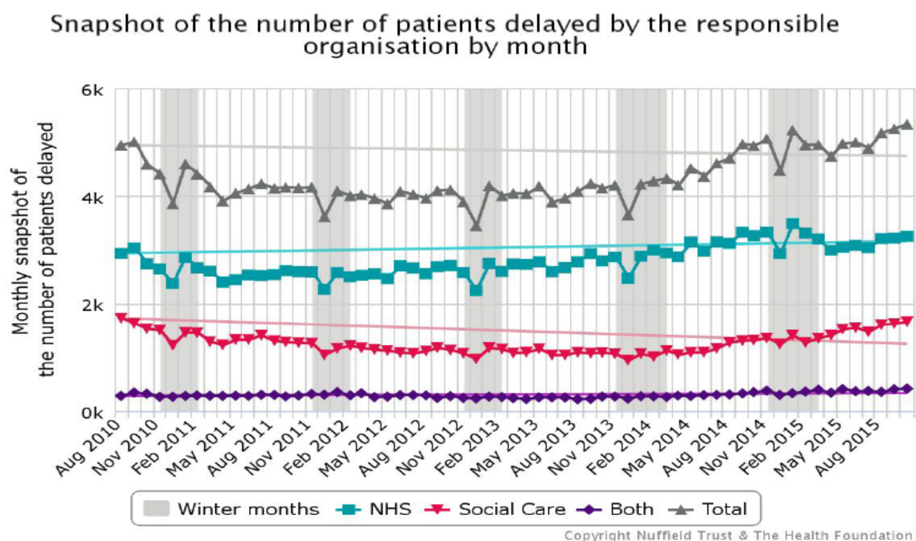
1. National context: National DTOC performance monitored at the following https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2015-16/ shows a month on month increase in DTOCS nationally over the last 11 months.

This builds on the similar NHS England 14/15 performance report that highlighted the continuing upward trend that started in 2013/14. Nationally, the largest increases were seen in delays due to patients awaiting care packages in their own home, and delays due to patients awaiting further non-acute NHS care. https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

Whilst we see DTOCs as an ongoing issue throughout the year, the additional impact that can be seen during the winter pressure period is of particular concern. Early identification of those at risk and in need of support is key to the overall success of the integrated, whole system joining the NEA programme of work to the discharge/DTOC agenda.

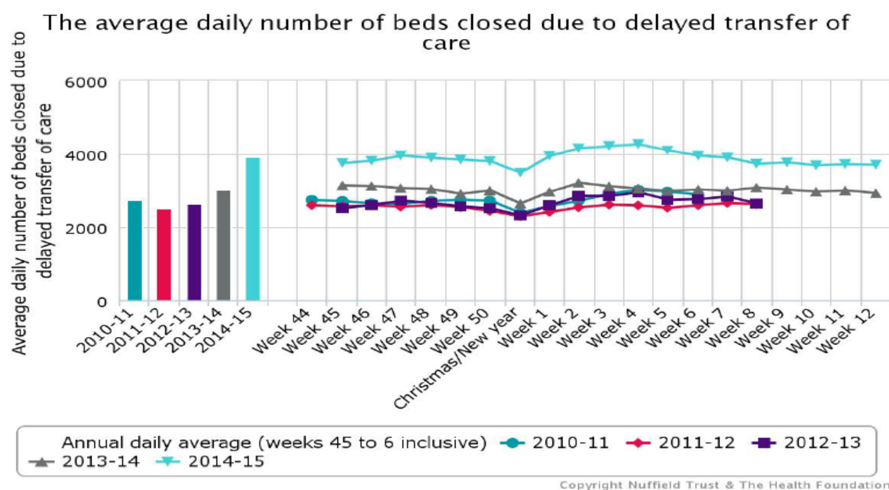
Independent scrutiny of the national Winter Pressure/DTOC picture was undertaken by Quality Watch on behalf of the Kings Fund for the 5 year period 2010-15. Their findings provide some additional context relating to the overall organisational responsibilities for delays depicted in the graph below.

Figure 3.6: Snapshot of the number of patients delayed by the responsible organisation by month (NHS England, 2015d)



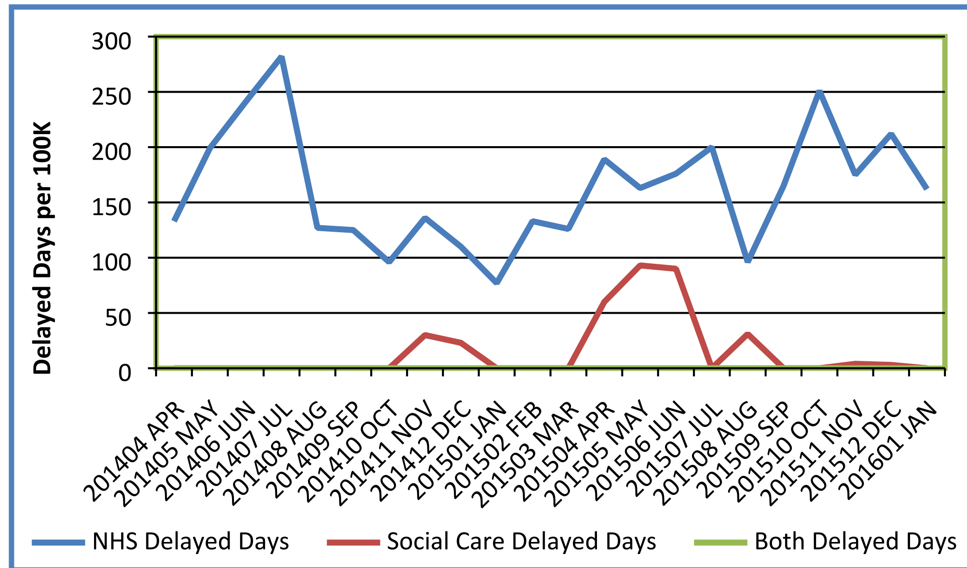
This reinforces the balance of organisational responsibility for DTOCs emphasising the need for strong collaboration with our secondary care colleagues. The impact of bed days lost due to DTOCs during the period of winter pressure is further supported by the data below.

Figure 3.7: The average daily number of beds closed due to delayed transfer of care (NHS England, 2015c)

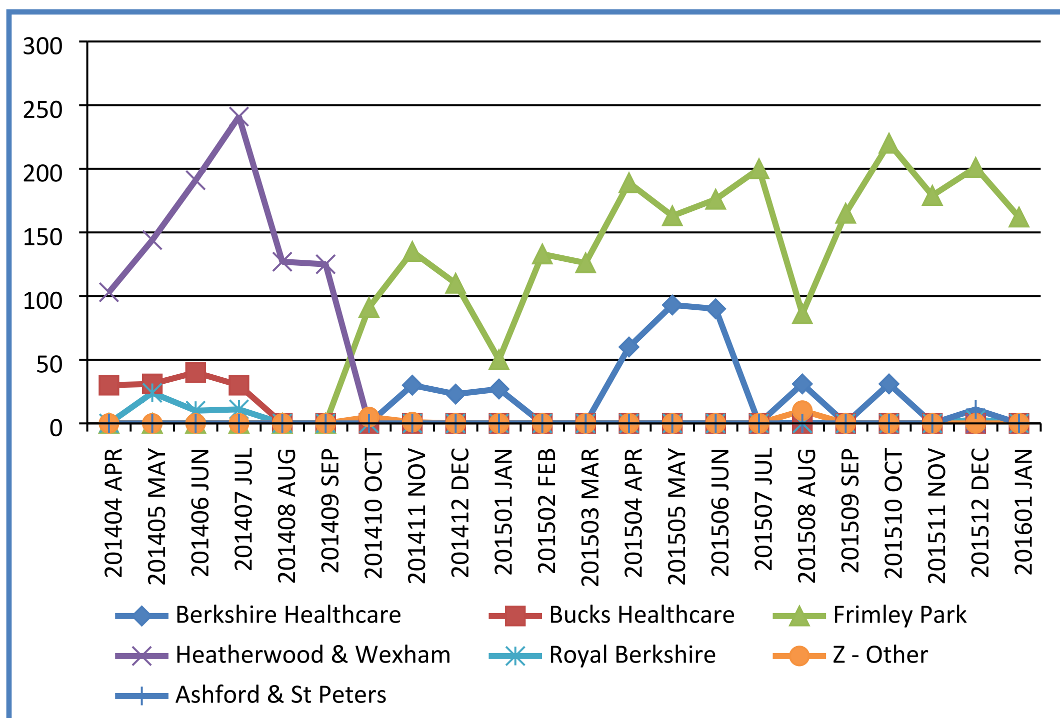


1. Situation analysis: DTOC – Slough BCF - Analysis of the last 12 months and causes of delay by organisation.

The most recent BCF report Month 10 15/16 - shows the following aggregated picture of all delays in the acute sector for Slough residents:



This graph shows the Monthly Delayed Transfers of Care by Provider. It shows that the majority of acute delays for Slough patients are at Wexham Park Hospital. The graph identifies delays at Wexham Park up until October 2014 (in purple) when the acquisition with Frimley Park NHS Trust took place. Delays shown after this point (in green) are still those at the Wexham Park Hospital site, although labelled as Frimley Park.



Some of the variation seen may be attributable to the successful introduction of the Alamac system at Wexham. This was trialled in 2015 following sponsored by the System Resilience Group. Alamac is a system wide dashboard to which all partners across the health and social care system contribute key data on a daily basis.

This data reveals key indicators which can be used to predict system pressures and enable actions to be taken on a whole system basis to ensure demands on the system are forecast and can be mitigated. This is supported by a daily system resilience call where this real time data is discussed and any actions agreed. Slough participates in daily conference calls and senior managers from both the CCG and Council will attend calls when the hospitals declare a "black" status. Examples of data items included within Alamac are numbers of attendances at A&E, ambulance handover delays, number of discharges to Integrated Care Teams etc.

After some early challenges, the system is demonstrably supporting better proactive management of discharges and prevents delays by forecasting increases in demands on services at Wexham. It is now being introduced at Frimley South but will take time to bed in and for the working relationships from all key stakeholders to become as well-honed as they now are at Wexham.

Item 4 East Berks
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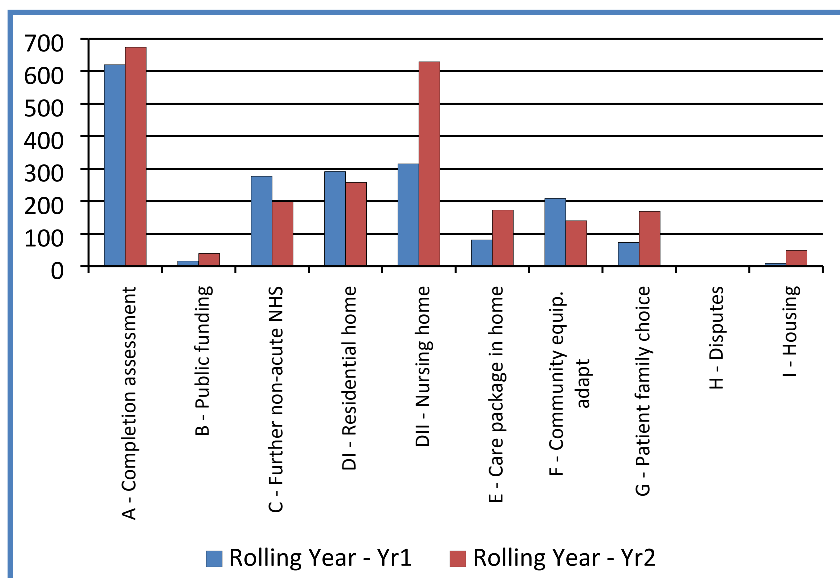
2. Reasons for delayed discharges and on-going activity:

The chart below shows the Monthly Delayed Transfers by Reason for Slough patients and compares between last year and this year (on a rolling year). It demonstrates that the main causes of delays are around completion of assessments and in nursing homes placements in the Slough area. However we are also seeing increases due to care packages in the home, patient and family choice and housing issues.



A review carried out by Healthwatch WAM in 2015 assessed the Transfer of Care process for patients with Dementia from Wexham Park into the Community. Although Slough has a younger population compared to the other East Berkshire CCGs, and therefore lower prevalence of dementia, patients over 65 were experiencing delays above national levels. However the data indicates that these delays are a result of inpatient services offered by NHS bodies other than the Frimley Health NHS Foundation Trust and that the low level of social care delays in Slough indicated good practice in achieving timely transfers of care for their residents.

Delayed Discharge Report Healthwatch \

3. DTOC plan for 2016- whole system approach

An East Berkshire wide transformation programme to improve performance on DTOC and improve the out of hospital process is being developed as part of the East berks Operational plans for 16/17. This will ensure a coherent narrative will be adopted in discussions with the acute trust providers across all 3 CCGs. Slough Borough Council and CCG will represented on the programme. More information will be available on this as the project develops.

Alignment and overlap with the themes and analysis from the Out of Hospital Transformation programme have already been identified. The project outline was proposed and supported at the Slough Joint Commissioning Board meeting in January this year.

OoH JCB Jan16.pptx

4. Methods of engagement with the relevant acute trusts and risk sharing arrangements in place to manage DTOC within the local system.

Slough has through its Joint Commissioning Board representation from its NHS provider partners both in the acute and community trusts. The JCB review the BCF Performance dashboard at each quarterly meetings and this promotes and provides opportunity for system wide discussions around DToC and related activity and is invaluable in achieving a greater consensus around not only the pressures and priorities but our shared aspirations in transforming the way we work together.

During 15/16 two System Resilience Groups have been meeting separately, with different membership, in relation to the issues identified in the two Trusts, Frimley North (Wexham) and Frimley South. Terms of Reference for the Frimley North (Wexham) SRG is attached. It has the purpose to develop, oversee and assure that the necessary actions are taken to enable integrated, quality, sustainable delivery of urgent and elective care, by applying a whole system approach within the local economy of care.

Wexham Park SRG ToR 8.09.15.docx

The ORCP SRG role is to build on existing initiatives that are underway and complement activities that are taking place as a result of the previously established Frimley System Urgent Care Board and Planned Care Groups, the Better Care Fund and the Integrated Care Agenda (see sample Terms of Reference attached). The diagram at the final page of the System Resilience Group Terms of Reference attached shows the reporting lines / interface between the Better Care Fund, Health and Wellbeing Board, CCGs and System Resilience Group. (See page 6)

Frimley System
ORCP SRG ToRs v8.p

The first combined ORCP SRG meeting took place on 14 April 2016 with Frimley north and south members meeting together to explore the opportunity/viability of joint working. This joint meeting went well with a performance review from ALAMAC across the Frimley system (north and south) together with presentations on sharing innovation and sharing ideas around an Emergency Care Improvement Programme. This again reflects the influence of the new STP and Frimley “axis” as a central platform for collaborative progress although likely that a local sub group(s) will continue to address more local, tailored issues.

The ORCP for Frimley North has been where our plans for preparing for winter resilience are developed and co-ordinated. Slough has invested in several areas including GP liaison, social work cover and additional reablement capacity and the frailty unit. This gives us opportunity to trial these activities and discuss at SRG with opportunity to trouble-shoot and problem solve at that stage. Those activities that work will then be brought forward for ongoing investment and further embed through our BCF (e.g. a proposed pilot for discharge to assess model).

ORCP 2015-16
Summary as at 05042

5. Additional opportunities for improvement:

In addition to the opportunities already highlighted above and the work being done as part of the Out of Hospital Transformation programme, there are several other key Slough BCF related projects and investments that will complement the capacity of the health and social care community based services to support those being discharged from hospital:

- Active support for the new **Transfer of Care Policy** - following our regular participion on the East Berks wide CCG working group led by Deputy Director of Nursing -Quality and Safety
- **Gap analysis** - comparing local performance and measures to the best practice interventions. We are using the high impact change model to benchmark ourselves and identify opportunity areas for improvement
- The **Complex Case Management** model of GP supporting those at risk of NEA as well as those who are discharged from hospital and in need of additional support
- Further review and enhancement of the **stroke coordinator** role and support services from the Stroke Association in the light of current remodelling discussion for the HASU and collaborative recommissioning across East Berkshire.

- **Review of the Intermediate Care Services (**supported by Tricordant, external consultants) - by involving DTOC CCG project lead in all relevant workstreams. Evidence shows that community Intermediate Care services in to people's homes
    - People to live independently in their own homes
    - Improve the persons experience
    - Reduce admissions and or support timely discharge from hospital
    - Realise significant financial savings either through re-ablement prevention or "rightsizing" support, reducing the extent of long term support required. This in turn can release capacity in the domiciliary care market
- Creation of an Integrated Hub for rapid access by professional referral into a range of short term services including step up/step down facilities helping to route patients to the right service first time.
- Working with our newly commissioned **SPACE consortium** (Slough Prevention Alliance and Community Involvement) strengthening community capacity and providing integrated support for vulnerable and targeted cohorts - including carers and those living alone.
- Our newly commissioned **Slough advocacy service** providing a range of advocacy support (IMHA, IMCA, ICAS and Care Act Advocacy) including to those in hospital who need advocacy support with their discharge arrangements.
- Piloting of our **Responder service** providing early help to people in need of urgent assistance but not a medical emergency diverting people from unnecessary A&E attendances.
- Investment in **Telehealth and Telecare technology** as we as equipment as part of our overall BCF transformation agenda.

6. The metrics adopted for Delayed Transfers of Care for the 2016-17 Slough BCF submission:

As already highlighted, Slough performs well on DTOC in the acute sector, but wants to build on this, maintain good practice and work closely with Wexham Park hospital and our community services to address response shortfalls.

		15-16 plans			
		Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	462.1	459.3	462.1	446.5
	Numerator	496	493	496	485
	Denominator	107,339	107,339	107,339	108,614

15-16 actual (Q1, Q2 & Q3) and forecast (Q4) figures				16-17 plans			
Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)
718.3	458.4	600.9	441.9	432.7	428.1	428.1	427.9
771	492	645	480	470	465	465	470
107,339	107,339	107,339	108,614	108,614	108,614	108,614	109,839

Our activity profile anticipates a slight improvement at the last quarter of 2015/16. We have then profiled a further incremental reduction during the consecutive quarters of 2016, finishing at an improved DTOC of 470 delayed bed days in quarter four (Jan 16 - Mar17). This last quarter is set against an increase in the denominator (population of Slough residents 18+) of 1,225.

Through this plan we also aim to reduce the variation in DTOC activity that is seen through 2015/16 and bring our *average rate* per quarter over the year from 555 in 15/16, to 429 delayed days per 100,000 (18+) in 16/17.

This is a challenging target but one that reflects the range of measures that have been collectively proposed and have been or are to be implemented during this year in order to contribute to achieving this target.

Mike Wooldridge

21 April 16