Adult Social Care DToC Pathway Peer Review

IOW




APPENDIX 2

The Brief

The Peer Review was carried out by the SE Collaborative which brings together the LGA Care and Health Improvement Programme (CHIP), the SE ADASS SLI Peer programme and the NHSE/I Improvement offer combining local, regional and national expertise and support. The Team was invited to the IOW by Carol Tozer, the Director of Adult Social Services to specifically examine the contribution of Adult Social Care to the flow of people through the acute hospital.

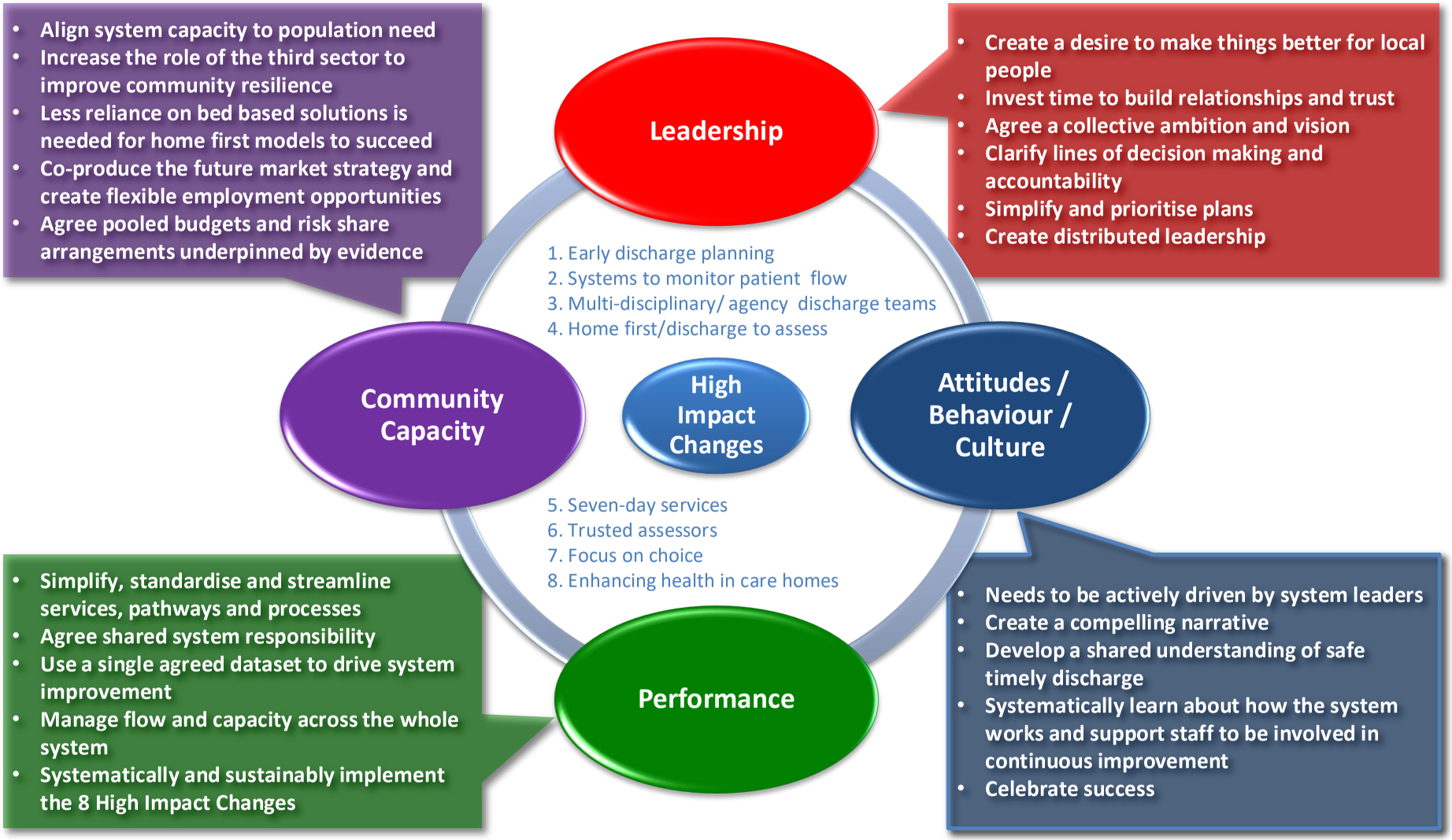
The Peer team consisted of :

Sarah Mitchell – Care and Health Improvement Adviser LGA
Jane Simmons – SE ADASS
Natalie Jones – NHSE/I Better Care Programme
Avril Mayhew – LGA lead Hospital to Home
Shelley Head – Area Director ASC Surrey County Council

The team were asked to address five questions:

1. Does the hospital SW team operate efficiently and effectively in receiving and responding to S2s and S5s so that people are discharged to the right place, with the right support at the right time? Are there any ASC internal issues withing the hospital Social Work Team that need improvement? And is the Integrated Complex Discharge Service fulfilling its core objectives?
2. Does the departments SPOC brokerage service operate effectively in securing the right support for people leaving hospital, whether people are ASC funded or self funders?
3. Is the departments Reablement Service (both bed backed and home based) operating effectively in facilitating peoples discharge from hospital and onwards progression? And is the progress towards establishing a Regaining Independence Service with the Trust happening in the right way with the right pace?
4. Are the ASC weekend hospital discharge arrangements operating effectively? How can they be improved?
5. What needs to change/be sustained in partnership working between ASC and the IOW Trust and IOW CCG in order to improve patient flow and effect better hospital discharge?

What Good Looks Like



Answering the 5 Questions

Hospital Social Work Team

- The social work team are exceptionally good – clear in their responsibility at the front and back door and take accountability for the work they need to do. The peer team were particularly impressed with their attitudes, values, commitment and knowledge.

- The processing of S2s and S5s needs reviewing to enable a more collaborative, multidisciplinary way of working. The social work team office needs to be co-located and staff need parking permits. The social workers in A&E are very effective alongside the Advanced Nurse Practitioner.

- Ward staff find making referrals to the Integrated Discharge Service for pathways 3 and 4 confusing and so sometimes refer to both pathways. All discharges need to be made earlier in the day.

- Ward staff need support and training to ensure that Pathway 0 and 1 are delivered in a timely away to avoid drift into Pathway 3 and 4 – make it easy for staff to do the right thing.

- EDDs are not adhered to and MFFD and Therapy Fit dates create confusion. The system is relying on a white board system not underpinned by an effective electronic record, and we saw no evidence of using the SAFER or Red to Green approach.

- Relationships are improving, helped by the daily morning Board round meeting run by the new COO and attended by the ASC Service Manager. Whilst ASC say that they are being held responsible for poor flow and DToC, the team did not hear any blame being attributed.

Answering the 5 Questions

SPOC

- The SPOC Brokerage service operates well, supporting self funders and LA funded placements – the leadership of the Commissioning Team is well respected by the market. The team work at the weekend and meet with reablement and social work teams to facilitate discharge.

- Information sharing is key to a successful package of care or placement and assessment details passing from the social worker , through SPOC to the provider could be improved. The changing acuity of patients requires detailed and accurate information about the person. SPOC cannot access eCareLogic or System One. DPS needs reviewing – does it fit with older people leaving hospital.

- Building on successful weekend discharges there is an opportunity to work through with the market and health and social care colleagues to build confidence and develop trusted assessment/discharge.

- The PA Scheme for discharge is innovative and responsive and could be expanded further to support adults with complex needs. There is huge potential for a joint approach with the CCG, already demonstrated through CHC cases.

- The nursing homes report being inundated with applications from nursing staff, yet the hospital has had to bring in nurses from abroad which led the peer team to question the Islands joint approach to workforce.

- The IOW demographic and demand is changing rapidly. A refreshed approach to the market and Joint Commissioning with the CCG and with self funders.

Answering the 5 Questions

Reablement

- There is clearly very strong joint working between the health and social care reablement and rehabilitation teams, but the offer across a number of different schemes, commissioned differently, feels confused – who goes where and why? Beds are not an alternative to providing care at home.

- The Peer Team was surprised at the number of reablement beds given the population of the Island and believe that it perpetuates a bed based culture of discharge. Proposals for change of use in The Adelaide and The Gouldings needs to be considered in this context.

- The OCIT is an excellent new service, pulling people out and providing short term care at home for two week. Scaling this up will reduce the reliance on short term beds.

- The community ward with 22 beds is in effect an overnight discharge lounge Although clearly assuring the system that people can move on from an acute bed this model adds to the number of beds across the system. Reviewing the patients referred to the community ward to ascertain why they could not go straight home would provide useful intelligence as there may be duplication with other beds and the Onward Care Team.

- There has been difficulty in obtaining GP support, without paying retainers and prevents continuity of care for patients. The Nurse Consultant model in West Wight works well and accepts direct referrals.

- Developing integrated health and social care localities, with PCNs, gives an opportunity to review the local resources and tailor them to local need.

Answering the 5 Questions

Weekend Discharge

- There are a number of good examples of weekend working by social care staff from the senior leaders to the reablement teams, SPOC, A&E and MAU social work staff and the social work team. The key is to make best use of this resource through having criteria led discharge in place, adequate and responsive Consultant cover and transport and pharmacy support in place at time of discharge.

- Care homes and domiciliary care providers need to be supported and encouraged to accept people at the weekend –the Peer Team heard about an inappropriate discharge on a Friday night which will discourage providers from taking on the responsibility, especially if they are unsupported by clinicians in the community.

- The new Executive Lead in the hospital at weekends has made has made an impact. It will be important that does not replace clinical leadership and that the response to weekend cover is proportionate and targeted so as not to exhaust valuable resources.

- The Choice policy is not being actively applied to ensure that patients do not stay in over a weekend when they do not need to.

- There are 3x day list meetings at the weekend which has made a real impact – keeping these under review will help to ensure best use of staff time at the weekends. Similarly, the Friday DToC and DToC Plus meetings may need reviewing now that performance has improved so significantly.

Answering the 5 Questions

Partnership Working

- Relationships between key operational staff are very good and we saw some impressive joint working between health and social care staff in a range of different services.

- There has been a culture of blame which is now changing. It is clear from our visit that the responsibility for the effective flow of patients needs to be shared across all organisations with a joint ambition and a shared understanding of what works to create that flow.

- Senior leaders need to change the narrative and develop a new one – staff are working well together but need one version of the truth to work to. Given the size of the population and the hospital and the lack of complexity in the system, inefficient flow and DToCs have a disproportionate impact on patient and staff wellbeing.

- Partnership working needs underpinning with effective IT systems to enable sharing of records, assessments and to establish real time electronic boards.

- The new partnership arrangements for the Trust and the creation of PCNs as part of the ICP create an opportunity for a new strategic leadership approach which needs to be grabbed. It would be a pity to take some of the " myths and legends" about what is the cause of poor patient flow into these new arrangements.

- We did not hear of a joint plan, shared by leaders and staff, to address the flow and DToC issues.

Our Reflections

- **The IOW has some great staff doing great work in health and social care and they need to be empowered and supported, with the right tools to do their job.**

- System Leaders might want to pause and reflect on their current strategic approach before developing the ICP further. Speaking with one voice as one leadership team to a shared refreshed narrative which gives clear intent for staff, residents and providers to understand and work with would be welcome.

- There are a number of different schemes – bed based and home based – put in place to tackle poor patient flow and discharge. They are innovative and responsive but need to be part of the whole jigsaw of health and care provision. The frailty model and a delirium pathway need to be part of the jigsaw.

- There appears to be a need for a number of key joint strategies –

1. Workforce – the Island has recruitment challenges but they are not unique and need a joint approach with the private care sector as well as joint health and social care appointments.
2. Commissioning – a joint health and social care approach to supporting the market to examine the numbers of beds needed on the Island in what needs to be a home based model, based on personalised care.
3. IT – we heard a lot of concern about the inability to share records and the lack of integrated systems.
4. Integrated Care – will the IOW Health and Care Plan deliver the opportunities for one public service which the Island could embrace.

Quick Wins

- Introduce an admission and discharge information pack for staff, families and carers.
- Introduce a clearly defined communication sheet to clearly identify the social care contribution.
- Create a SPOA and triage system for the Integrated Discharge Service to enable ward staff to refer to one point and allow the IDS to allocate the appropriate resource.
- Replace S2 and S5 with the Care Act definition of Assessment Notification and Discharge Notification and use the daily Board rounds to pull patients through.
- Ensure EDDs are established and maintained and use these support a proactive pull approach
- Develop a culture of early discharge times – before lunch.
- Use the daily Board Ops meetings to drive daily grip and measure all LLoS and delays
- Grow OCIT to pull people from hospital
- Consider use of MFFD and Therapy Fit – how do these terms help or hinder patient flow
- Review 7 day working – equality across all disciplines – TTOs and discharge summaries need to be in place
- Build on the Patient Navigation Team – well led and pragmatic approach
- Build on mini MADEs – working well having an impact
- Train Ward Clerks to use eCareLogic
- Involve ASC in training of new nurse recruits
- Walk in each others shoes – develop a programme of shadowing and shared learning

Questions we want you to answer!

Leadership

- Do we have clear leadership, vision and ambition demonstrated by our CEOs across the system?
- Are we aware and do we accept the shared challenge to reduce delays and LLoS?
- Do we have strategic alignment with STP, BCF and A&E Delivery Plans ?

Culture

- Do we have an understanding of the change required by all to achieve improved performance?
- Do we have a shared language amongst staff to prioritise safe and timely discharge?
- Is there distributed leadership across the system working together to deliver improvement?
- Is our culture now one of true collaboration or still blame?

Performance

- Do we have standard operating processes and escalation plans developed and agreed across the local system?
- Do we have targets for key metrics agreed across our system which are deliverable through the project plans in place?
- Do we understand the trends in the data, the correlation between data sets and how their improvement plans will affect the month on month outturn?
- Are our plans based on evidence and best practice Safer Better Faster, High Impact Changes, Planning Guidance?

Community

- Do we have a shared understanding of resource gaps in primary, community health and social care ?
- Do we have an understanding of the needs and behaviour of our population?
- Do we have a shared understanding of our local care market?
- Do we have effective active engagement of the voluntary sector?
- Is our CHC process effective and appropriate?

Successful Change – What Good Looks Like

Leadership teams at all levels learn together with a culture of co-creation. We recognise and respect the differing cultures across organisations and professional groups. We support individuals doing the doing to test new things and be innovative – A seek forgiveness not permission culture. Formative evaluation is the norm where at all levels we can reflect, learn and adapt our approach as required. Joint OD work has supported integrated working and supports individuals when it gets tough

We set up the Integrated Discharge Hub as a physical building in which front line staff from each part of the system work exceptionally well together as a single team with a single high quality leader

What have you done to establish healthy working relationships with other leaders in your system?

I believe that the quality of personal relationships is the cornerstone of success and that these need to start at organisational leadership level but extend to all levels, and in particular to front-line operational level

Good planning, communication and trust is key - we share responsibility for delivery of key transformation programmes and targets through a collaborative, team based approach

How do you maintain those relationships and maintain resilience when times get tough?

Senior leaders will step in to provide support for teams to prevent relationships getting overly strained. Staff have become more mutually supportive as joint working has advanced. We use data as a basis to problem solve and respond to issues. We have built resilience by sharing resources across organisations. We Support people to *get things off their chest* when needed

We insist on a no blame culture so that when things get tough, all of our energy goes into problem solving and none is wasted on arguing, accusing or being defensive. It is my observation that when things are particularly tough, staff relish the challenge and morale and motivation actually rises

What are the key elements of your change management approach that have delivered your success?

We have conventional structures to oversee all change management. However, more importantly we set great stock on the people issues: enlightened leadership and a supportive management style, strong staff engagement, good team working, appreciation of work well done and a healthy, multi-disciplinary, no-blame culture

We have a Jointly agreed vision and use of evidence to state the case for change – agreed across system leaders and with teams. We have supported staff in working together and celebrated success of joint working. Honest conversations between leaders to contribute to formative evaluation. We have sustained the effort and focus on improving even when it has been tough and progress slower than we would like

The key elements of our change management approach is for all services to focus on improved outcomes for local people as an absolute priority, to ensure that joint implementation is focused and straightforward and to empower all staff to work together to drive innovation and service improvement. This closes back the loop on good relationships at the top as the key driver of success