Item XX

CCG Governing Bodies

XX. North West London seven day services programme

Authors: Rachel Tustin, Assistant Director, 7 Day Services, NWL CCGs

Sarah Warran-Smith, Discharge Initiative Lead, 7 Day Services, NWL CCGs

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1. Introduction

1.1 Everyone Counts: Planning for patients 2013/14 committed the NHS to move towards routine services being available seven days a week. Inspired by the clinical benefits of 7 day services, North West London applied for and was successfully selected in 2014 as an Early Adopter for 7 day services (7DS). Subsequently NWL was selected as a "Phase One" delivery site as part of the government's refreshed 7 Day Services programme, which is now part of national guidance.

1.2 The Discharge Initiative was established as part of the 7DS programme to support implementation of Standard 9 of the national standards in urgent and emergency care. Standard 9 sets out the requirement for a 7 day discharge pathway.

1.3 Based on feedback from NWL Providers, CCGs and the Collaboration Board, the 7 Day Services team was tasked with scoping a possible piece of work on improving discharge pathways across NWL. This work was discussed with the Shaping a Healthier Future Programme Board & Clinical Board, and with the CCG Collaboration Board, all of which supported it.

1.4 Initial scoping work highlighted that existing discharge pathways across NWL are fragmented and difficult to navigate for both patients and staff. Consequently the following problem statement was agreed in principle at the Collaboration Board in July 2015:

- Community Healthcare services available to support patients, vary geographically by name, provision, referral criteria etc.
- Referral/ assessment forms & processes for these community services also vary across NWL depending on provider, service and geographical location. This can cause confusion for the hospital staff and GPs managing the paperwork.
- Often, the assessment of patient need carried out by hospital staff is not trusted or accepted by community teams, who require a reassessment of the patient which can delay discharge by up to 48 hours.
- These issues cause problems particularly when the discharge crosses a CCG or local authority boundary. Hospital staff are unfamiliar with services, geographical boundaries,

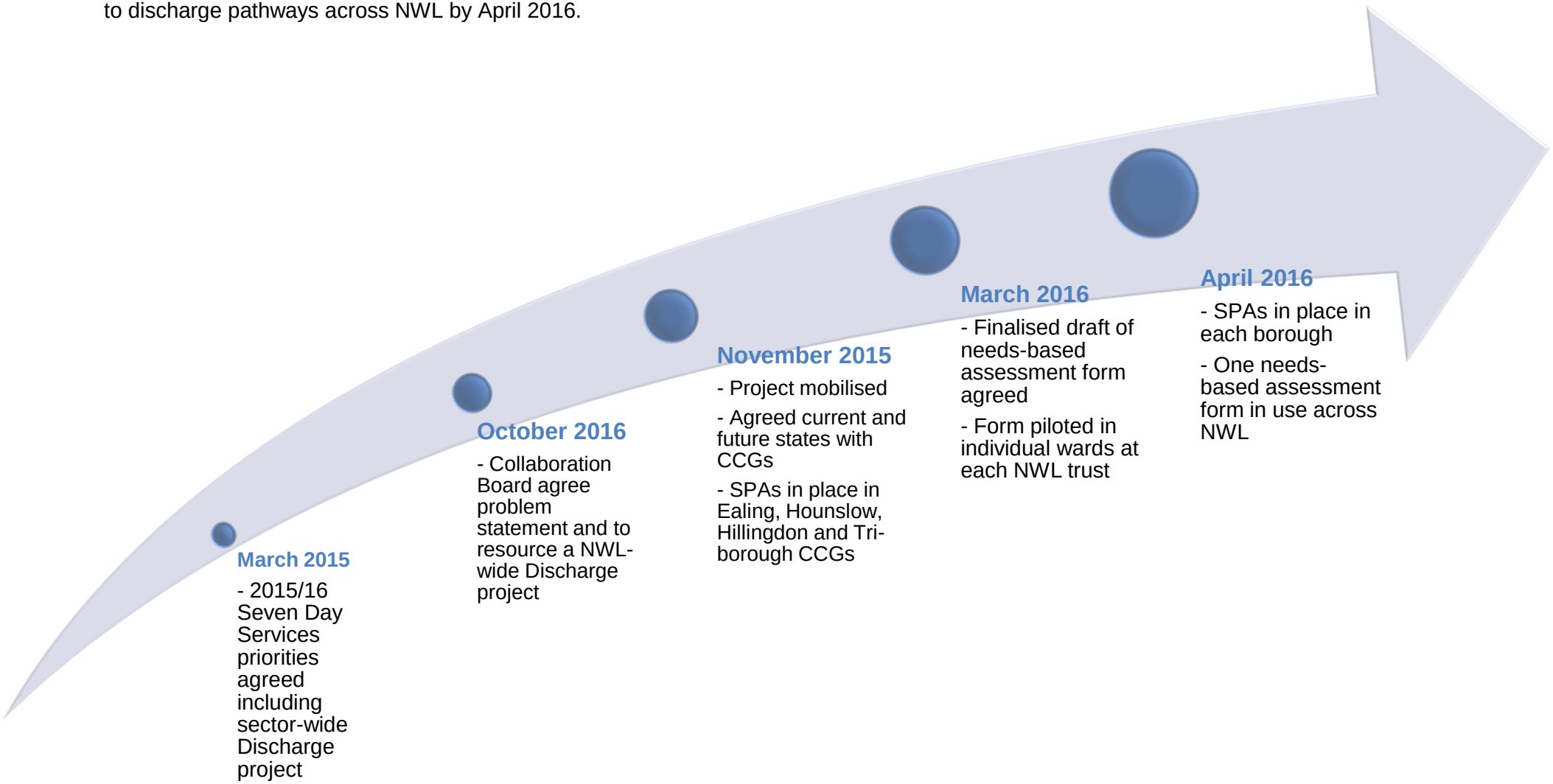
referral processes & assessment forms for that area and community staff are less likely to rely on the hospital assessment of patient need.

1.5 The initiative is closely aligned to existing work being undertaken by the West London Alliance which is focussed on improving the discharge pathways in hospitals across the tri-borough area by bringing together adult social care and community teams. In order to manage the overlap with this work, the 7DS discharge initiative and WLA have established a single programme, working together to deliver one discharge pathway across health and social care in NWL.

1.6 This paper summarises the progress to date of the discharge initiative.

2. Background

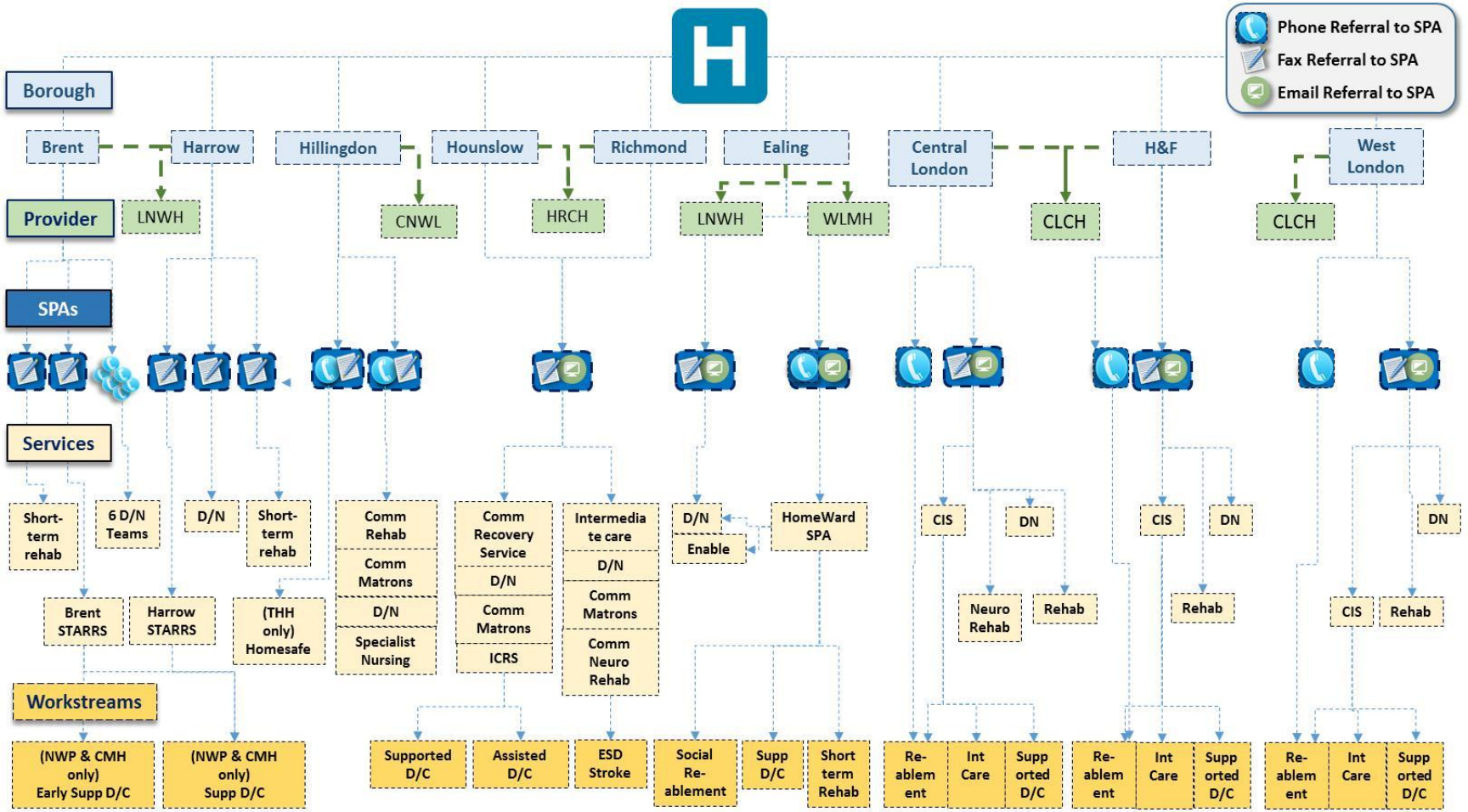
2.1 The 7 Day Services team began scoping work on the Discharge Initiative in July 2015, and is aiming to implement the agreed changes to discharge pathways across NWL by April 2016.



3. Key proposals / key findings

Current State Baseline

3.1 The 7DS team mapped current community services that support discharge (excluding any residential services) across NWL, including referral processes, criteria & forms; opening hours; service type/ provision; availability of Single Points of Access/ Single Points Of Referral (and services available through them).



Proposed Solution

3.2 North West London (NWL) CCGs recognised that their existing discharge pathways do not meet the clinical standard for discharge as they are fragmented, difficult to navigate for patients and staff and vary considerably across boroughs. Collaboration Board therefore agreed to mobilise a project to standardise the discharge pathway based on an innovative discharge model designed by the CCGs, whereby decisions about which community healthcare service(s) are most appropriate to support a patient are made by staff based in the community.

3.3 The scope of the project is limited to the discharge of inpatients with a new or changed need for community healthcare support in their home on discharge from a hospital ward, including those that cross CCG boundaries. This is further detailed in the table below.

In Scope	Out of Scope
Discharges from acute inpatient wards & assessment units	Admission avoidance in A&E Discharge from inpatient community facilities (e.g. inpatient rehab, step up/down etc.)
Patients that have been identified as having a new or changed requirement for healthcare support in the community.	Patients that do not require support upon discharge. Patients restarting an existing support service on discharge.
Services provided by community health trusts in patients' homes including: intermediate care, rapid response, early supported discharge, district nursing, specialist nursing, rehab, etc.	*Services provided/ funded by social services*[1] Mental Health services. Continuing healthcare. Services provided by community health trusts in an inpatient facility including: inpatient rehab, step up/down, etc.
Discharges that cross the boundaries of CCGs or Local Authorities within the NW London area + Richmond.	Discharges that cross the boundaries of CCGs or Local Authorities outside the NW London area.

3.4 The 7DS team are supporting the 8 NWL CCGs to implement this model, standardising discharge pathways across NWL and delivering the following by April 2016:

1. One Single Point of Access in place per CCG to cover (at a minimum) services provided by community health trusts in patients' homes including: intermediate care, rapid response, early supported discharge, district nursing, specialist nursing, rehab, etc.

[1] The form has been designed so that it contains the information which would be required to refer into Adult social care services. Where NWL boroughs have Single Points of Access which have social care involvement, or where local authorities have indicated they are prepared to accept the needs-based assessment form, services provided/funded by social services will be included in the scope of this work. However, this will not be possible for all boroughs in NWL and depending on local progress, will be implemented over the next 12 months.

2. A shared NWL-wide needs-based assessment form that is accepted by all of the Single Points of Access described above.
3. Patients referred and accepted into the new Single Points of Access.

Benefits

3.5 The new discharge model will help standardise discharge pathways across NWL, build relationships between hospital and community based staff and improve the quality of information provided at discharge. A range of other benefits are also expected, including:

- A reduction in inappropriate referrals to community services;
- Patients receiving the right package of care, in the right place at the right time as all services will be accessed through a SPA in each borough;
- Reduced duplication of effort as staff will no longer need to complete different forms or chase hospital based staff for additional information in order to accept referrals into a service;
- Increased patient and carer/ family involvement in decision making;
- A reduction in LOS, and;
- Improved quality of patient care and patient experience.

3.6 Initial analysis also suggests savings of up to £5.16M per year could be achieved for commissioners by implementing this model. This figure is based on reductions in excess bed days, an assumption that an excess bed day costs £200 and high level data which shows that the average Length of Stay for cross-border[2] admissions is 0.7 days longer than for admissions within a CCG boundary. If the average LoS for all cross-border admissions could be brought in line with admissions within a CCG boundary then up to 70 beds could be released across the system, resulting in this level of saving.

Progress to Date

3.7 We have engaged with key system leadership over the last 9 months in each of the 8 NWL CCGs as well as each the community healthcare providers and acute trusts. This has been through attendance at boards and meetings across NWL (e.g. SRGs, CCG Collaboration Board & SaHF Programme Board) as well as through on-going contact with key individuals. The following highlights the progress that has been made:

Single Points of Access

- Mapped existing community healthcare services by borough;
- Agreed current and future state discharge pathways with each CCG;
- Produced a draft specification for Single Points of Access;
- SPAs in place in Ealing, Hillingdon, Hounslow and Tri-borough CCGs;

[2] For tri borough area all cross border activity is defined as all activity excluding Imperial and Chel West. Ealing CCG cross border activity is all activity excluding Ealing Hospital. Brent CCG cross border activity is all activity excluding Northwick Park & Central Mid. Harrow CCG cross border activity is all activity excluding Northwick Park. Hounslow cross border activity is all activity excluding West Mid. Hillingdon cross border activity is all activity excluding Hillingdon and Mount Vernon.

- Providing on-going support to Harrow CCG during re-procurement of their community service provider;
- Establishing joint governance arrangements across the tri-borough CCGs to align with the West London Alliance initiatives and other on-going discharge improvement plans;
- On-going alignment with Better Care Fund schemes 2, 2.5 and 3 across Brent CCG and Brent Local Authority to develop a SPA

Shared Needs-Based Assessment Form

- Draft needs-based assessment form developed by the West London Alliance in conjunction with tri-borough CCGs and local authorities;
- Comparison of draft form to existing referral paperwork used across NWL undertaken;
- Feedback gathered from CCGs, community providers and acute trusts;
- Workshops held with representation from CCGs, community providers and acute trusts to refine the content of the form;
- Co-production session with lay partners held;
- Form to be piloted in selected wards in early March 2016 and rolled out from April 2016.

Recommendations

4.1 The Board is asked to note the progress of the Discharge Initiative, and to endorse the proposed discharge model.