Review of hospital discharge

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Content of slides

- System vision, principles and objectives
- Foundation Trust Improvement Plan – Improving patient flow
- Discharge Pathways
- Governance framework
- Discharge Policy
- Hospital discharge data
- Discharge escalation process. Eg. Diagnostic Virtual Ward
- Communication
- Transport & Medication
- Working relationships with carers and voluntary sector
- Command and Control
- Discussion

Our system vision: Home First

We will :

- Provide **quick and easy access to support at times of crisis**, so people can be cared for in the **comfort of their own home,** rather than in hospital.
- *Ensure hospital stays are as short as possible, and that wherever possible, people are supported to* ***return home to recover, regain their confidence and maintain their independence.***

Our system level principles for integration

Achievement of our ambition requires a 'whole system' approach, with great partnership working and effective collective leadership. To this end, we have adopted the following principles that will build a collaborative culture and guide our decision-making and behaviour:

- Our **active participation and engagement** in the integration programme will give us the best possible chance of success.
- We take a **person-centred approach** in all aspects of care and support – putting the needs of our population before those of our own services or organisations.
- We are **equal partners** who act in good faith and support each other in the spirit of collaboration.
- **Integration is the default** position when designing and commissioning services.
- We **co-produce and co-design** effective models of care and support, involving people who receive care, informal carers, practitioners, clinicians, the voluntary and community sector and other partners.
- We **harness and align our collective resources** to deliver the best possible outcomes.
- We **build trust** through open and honest conversations, and transparent, evidence based and ethical decision-making.
- We take **collective accountability** for our decisions, and **responsibility** for our actions.
- We take **managed and shared risks** to find innovative and creative solutions.
- We **champion and promote health and social care integration** within our own organisations, and are mindful of the impact of our organisation's actions on the whole system.
- **Doing the right thing** will yield better outcomes and cost benefits.

Home First - Why Not Home? Why Not Today?
Our Strategic Objectives

1. Early discharge planning
2. Systems to monitor patient flow
3. Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector
4. Home first
5. Flexible working patterns
6. Trusted assessors
7. Focus on choice
8. Improving discharge to care homes
9. Housing and Related Services

where best next?

Discharge Pathways
Patient no longer has care needs that can only be met in an acute hospital

Pathway 0
Home

Pathway 1
Patients needs can be safely met at home

Integrated Locality Team
Up to 6 weeks

Pathway 2
Unable to return home – patient requires further rehabilitation / reablement

Community Based Beds/Residential rehab and reablement

Pathway 3
Unable to return home – patient has very complex care needs and may need continuing care

Discharge to Assess/rehab in a nursing setting

Pathway 4
End of Life

Decision Support Tool assessments in the community to establish ongoing needs

Pathway 0 / Pathway 1 outcomes:
- Self Fund / Self Care
- LA Funded Home Care

Pathway 2 outcomes:
- Pathway 1
- LA Funded Residential Care
- Self Fund Residential Care
- Self Fund / Self Care at Home

Pathway 3 outcomes:
- CHC Funded Care
- LA Funded Care
- Self Funded Care

Pathway 4 outcomes:
- CHC Funded Care

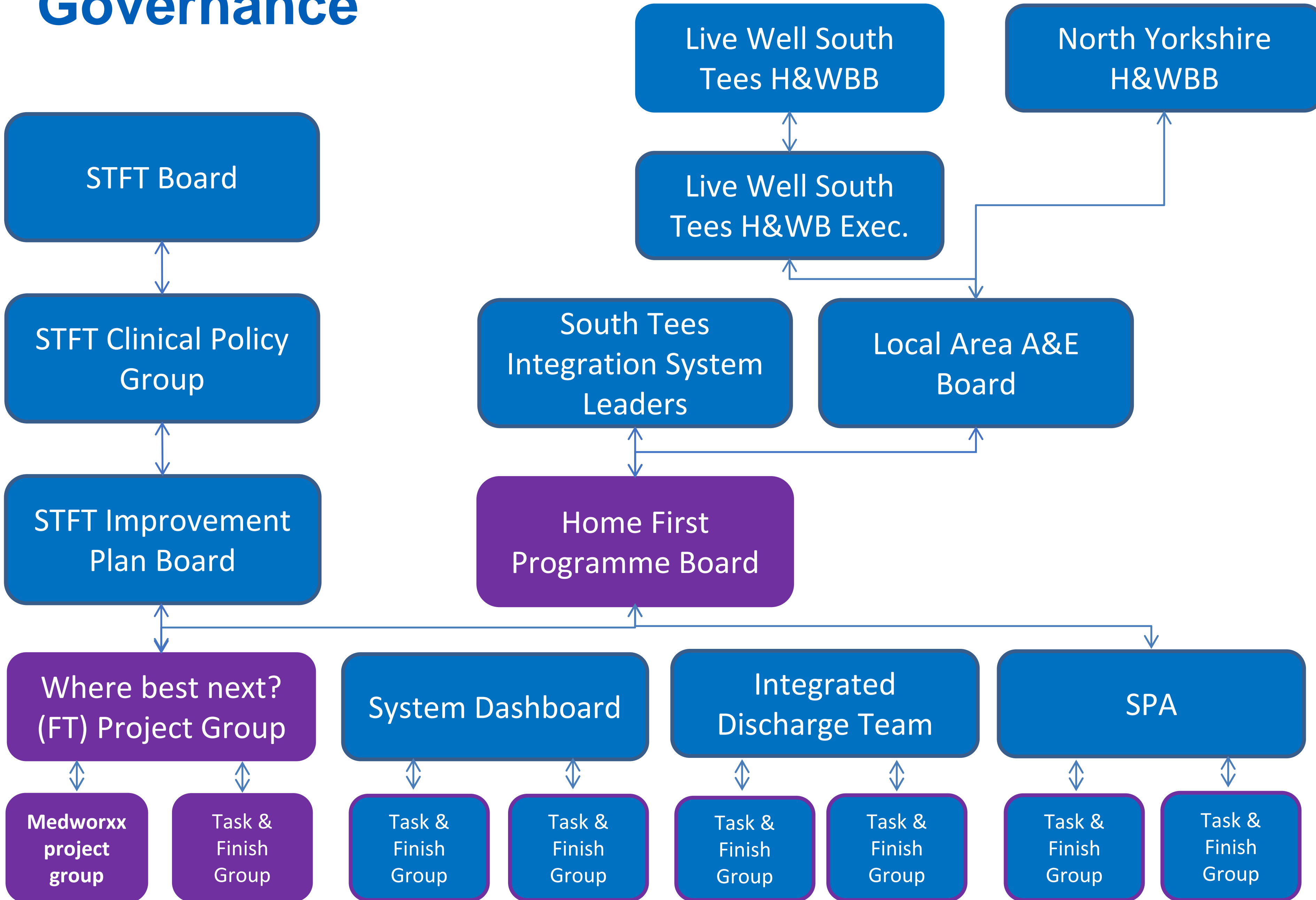
Phase 1 Foundation Trust Improvement plan actions: Improving patient flow

Priorities	Summary Actions
Embed SAFER	Embed SAFER bundle across all wards • All patients to have a senior review before midday by a clinician able to make management and discharge decisions. • All patients to have an expected discharge date and clinical criteria for discharge if patients medically fit • Flow of patients to commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units to ensure the first patient arrives on the ward by 10 am (inc. model ward) • Early Discharge - 33% of patients will be discharged from base inpatient wards before midday (N/A day cases). • Tomorrows TTOs prescribed today. A systematic multi-disciplinary team review of patients with extended lengths of stay (>7 days – 'stranded patients') with a clear 'home first' mind-set. • Patients with a >21 day LoS to have Consultant led weekly MDT review. • Decision by Directorates (Yes/No) to consider implementing consultant of the week to support rapid discharge • Further embed SBAR (Situation, Background, Assessment & Recommendation) to improve quality of capture of patient information
Supporting timely discharge	Ensure discharge summaries are completed prior to patient leaving the hospital or within 24 hours.
	Implement Clinical Utilisation Review – MEDWORRX.
	Implement regional choice policy, divert policy and repatriation policy.
	Create an integrated discharge team with appropriate ward based support
	Review of over 14 day LOS and implement follow on actions
	Embed discharge escalation process
	Undertake a detailed review of end to end discharge pathways
	Develop a diagnostic virtual ward
Patient Pathways	Undertake a detailed process review from Referral to Discharge for key patient pathways documenting the outcomes
Review Hospital Social Care Team	Review current service provision against service need to support timely discharge
Detailed capacity and demand planning	Undertake detailed Capacity and Demand Planning to support Flow

Phase 1 Foundation Trust Improvement plan actions: Improving patient flow

Enablers	Summary Actions
Digital command and control centre	Review and improve bed meeting format including: • Bed management processes
Embed Medworx	Training and adoption of existing solution and new functionality
Consultant advice	Explore opportunities to implement a communication system to support patient flow
Staffing resource (patient flow inc. site resource managers and discharge lounge)	Review current model and services . • Define future state Operating Model(s) in line with 'To be' requirements • Engagement • Implementation
Staff training relating to 'Flow'	Develop a comprehensive training pack and deliver training: • Ward staff training • Service managers/assistant service managers • Flow team members
Safecare	Review and embed to ensure safe staffing of wards aligned to acuity and dependency of patients

Governance



Discharge policy

- One policy for discharges from across our Hospitals
- The trust discharge policy (G40) is reviewed every 4 years. It is currently being reviewed and the latest version will be available in March 2020. Each time the policy is reviewed any changes/developments in the discharge processes are included in the new version and staff training will be provided.
- Developing an Integrated Discharge Team
- Reviewing discharge documentation – most of the forms are electronic but working on consolidating forms and electronic notification to social care team
- Discharge pathways developed but need fully embedding

Where do the patients get discharged from?

Front of House

- Accident & Emergency
- Urgent Care Centre

Non elective areas

- Emergency admission & discharge – initial assessment / ambulatory care

Elective / planned areas

- Discharge following a stay on a Hospital ward

Community Hospitals

- Redcar Primary Care Hospital
- East Cleveland Primary Care Hospital

Discharge lounge

- Patients accessed the lounge between 10am and 6am Monday to Friday and 12pm-6pm Saturday and Sunday
- The highest number of discharges occur on a Monday
- Discharges increase in the afternoon

Discharge to Assess/Trusted assessor

A brief guide:

D2A enables timely discharge and for people to be assessed for their ongoing care needs in the most appropriate setting, avoiding long term decisions being made while they are in crisis and need time to recover. A hospital environment is an alien setting and can disable people, limiting their opportunity to manage core activities of daily living independently.

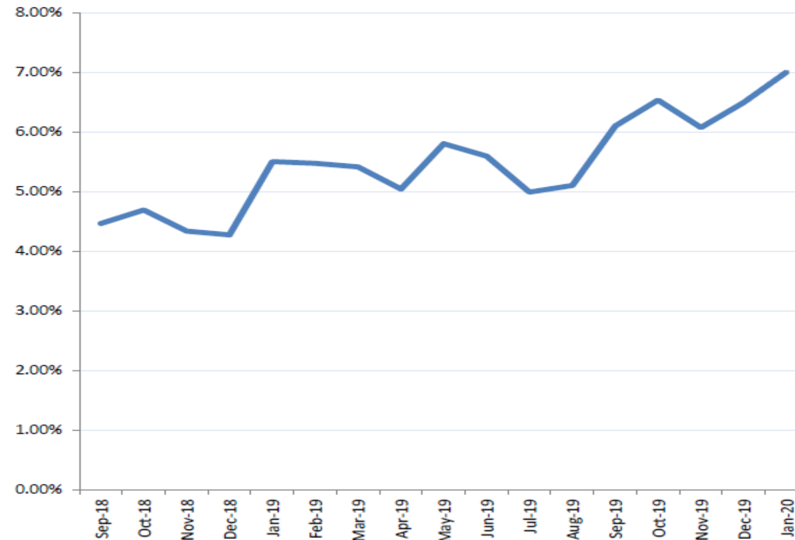
The principles of Discharge to Assess are:

- Assessment in the most appropriate setting
- Applying the principles of Trusted Assessment, reducing duplication of assessments
- Create strength-based person-centred plans of care and promote independence
- Build confidence of person, family & carers
- Sensible solutions of care which reach across organisational boundaries, finding ways to make best use of all resources on the person's journey from hospital to home.

- Trusted assessors assess for care homes – Care Home Selection (Middlesbrough), Meadowgate (Redcar) and North Yorkshire patients
- Reactive service and usually seen on same day
- Collaborative working between health and social care professionals – liaising with Occupational Therapy, physiotherapy, ward staff
- Open communications between clients, family members, carers
- Rapid response from care providers – same day if appropriate

Delayed Discharges

- Above the target of 3.5%. Weekly data is now showing a reduction.
- Why not home? Why not today? multi agency board are working together to solve problems and refine discharge pathways
- Daily reports shared and actioned
- Daily call to review patients waiting for discharge
- Escalation process has been developed and being implemented



Delayed Discharge Escalation Process

S

Senior review before midday by clinician able to make management & discharge decisions

A

All patients have an expected discharge date **(EDD)** and clinical criteria for discharge

F

Flow of patients commence at the earliest opportunity from assessment units. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10 am

E

Early discharge 33% of patients will be discharged from base inpatient wards before midday

R

Review A systematic multi-disciplinary team review of patients with extended lengths of stay (>7 days – 'stranded patients') with a clear 'home first' mindset

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Daily ward requirements

1. Nurse in Charge must review Medworxx and ensure Medworxx and PSAG board are accurately updated by 12 noon
2. Matron to review each individual patient and respectfully challenge:

- Does this patient need to be here?
- Where Best Next?
- Think ahead - refer on now for social support and CHC

Daily automated reports to Matron, ADNs, CDs

ESCALATION: CUR not met or ready for discharge

DAY 0

- Matron to resolve with local team and update Medworxx (Consultant, pharmacist, therapist)
- Matron to ensure that all patients who may require support of any kind have been issued with 'letter A' (Supporting Patient Choice policy)

Not resolved:

- Matron to work with Service Manager to escalate by midday to appropriate area, as detailed below:
  - therapy related delay to Professional Leads
  - diagnostic delay to relevant Service Manager
  - pharmacy delay to key contact
  - clinical assessment/intervention delay to CD
  - social care delay to relevant social worker

Not resolved but same day opportunity to expedite discharge remains inform relevant ADN and/or HoP

DAY 1 (same delay)

Unresolved - ADN or HoP refers to OD

Remains unresolved - OD refer to DoN / COO

Daily automated reports to Matron, ADNs, CDs

DAY 0

DToC call:

- Daily DToC call 9am to agree actions
- Complex Discharge Team to track progress of 'Supporting Patient Choice Policy' and support staff if 'letter B' is required
- Daily DToC 1pm follow up call to review actions and escalation

If feedback not received and no definitive plan in place then **escalate**:

- Social care issues to J Dobson or P Bateman
- CHC issue to J Dobson or P Bateman
- Therapy assessment delay to HoPs
- Repatriation delay to J Dobson or P Bateman
- Ward based assessment delay to Matron
- Summary of action required and actions fulfilled on site report by Complex Discharge Coordinator

where best next?

Medworxx/CUR system
Why we need robust information and how this supports discharge

- The “richness” of CUR data is designed to develop as use of the CUR tool evolves
- Consistency and accuracy of data input is essential to support you to address the internal causes of delay that are impacting on patient flow
- A robust set of reason and delay codes will ensure that data is meaningful and enables actions to be taken to reduce barriers to delay and improve discharge
- The CUR system is most effective when used on a daily basis at ward level to identify patients that do not meet the criteria for an admission or continued stay. Compliance from daily use will increase where ward-based clinical staff have confidence in the data and can view the reports / outputs from the CUR tool and initiate action to improve patient flow.

“What people think caused the delay may not necessarily be a major contributor to the problem. Hospitals need hard data to show what is happening and identify what needs to be changed”.

CUR guidance / categories

Met

- Requires an acute bed
- The patient is clinically appropriate for the level of care they are receiving
- Please select all options of the criteria that apply to ensure all medical treatment is recorded

Not Met

- May require on-going treatment however not clinically appropriate for the level of care they are currently receiving or patient is medically fit for discharge
- Potential reasons could be; waiting CT scan, physio review etc., or required service in local area has no capacity (e.g. Zetland Ward) or service isn't available in the local area, DTOC etc
- Select the main reason for the day of stay

If you select '**Not Met**' you will be taken to an additional screen which asks questions around the status of the patient in relation to the readiness for discharge.

Please ensure these questions are answered correctly, as this will determine if a patient is:

Not Met – Not Ready for Discharge

- The patient is awaiting further treatment; or intervention assessments; or consultation; and is not medically fit for discharge (e.g. CT Scan) or suitable service is not available/commissioned in local area etc.

Not Met – Ready for Discharge

- The patient is medically fit for discharge. The patient may be waiting on social assessments, bed availability, or placements but do not meet the criteria for the current level of care they are receiving etc. All patients who are declared as DTOCs should fall under this category.

where
best

Reducing the number of patients waiting for a diagnostic test when an inpatient…

NHS
South Tees Hospitals
NHS Foundation Trust

Diagnostic Virtual Ward

A patient can be discharged home but have a test on an inpatient timescale. A co-ordinator will track the appointment, attendance and result, and inform the patient's consultant

Which patient's are suitable?...

- Adults ✓
- Awaiting inpatient investigation ✓
- Referred by their consultant ✓
- Medically safe to go home (very low risk of clinical deterioration) ✓
- Support at home ✓
- Easy access back to hospital ✓
- Contactable by telephone (preferably mobile) ✓

where
best
next?

Call
07970
250355
or ext 56442
/ 56939

Referral through
Webice DVW
call 07970250355
or ext 56442/56939
Mon to Fri 8am to 5pm

Communication

- Planning discharge from admission
- Adult core document – captures social history, carer information, any concerns. This needs to be updated to reflect the discharge pathways (like North Tees & Hartlepool NHS FT)
- Medication reconciliation
- Ward teams – daily huddles, multi disciplinary team
- Written information – bespoke leaflets (procedure specific), new services, next steps
- Carer support
- Discharge summaries

Transport home

- Own transport – family / friends
- Volunteer Driver Service – Home but not alone scheme (could we access? Or extend Red Cross service)
- Discharge Ambulance Service – feedback monthly
- Specialist transport
- Public transport

To Take Out (TTOs)/medications ready the day before

45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%

12/02/2020 13/02/2020 14/02/2020 15/02/2020 16/02/2020 17/02/2020 18/02/2020 19/02/2020 20/02/2020 21/02/2020 22/02/2020 23/02/2020 24/02/2020 25/02/2020

- We are having a focusing on this to increase the % of TTOs ready the day before discharge which will facilitate the discharge of a patient before 12pm.
- Pharmacy are now part of the weekly Where best next? project group

Pharmacy initiatives

Short term:

- Re-launch over-the counter medicines campaign
- Wards to check if patients have their own medication supply
- Encourage patients to buy their own medications from a local pharmacy if this is accessible for them

Long Term Aspirations:

- Pharmacy clinical service on every ward
- EPMA/EPR solution

VCS and carers involvement

- Home from Hospital Team – Red cross including driver service
- Carers forum
- Signposting & internal/ external referrals (District Nurse, Social work & Multidisciplinary Service)

Command Centre
....together putting patients first

Progress to date

- Matrons are increasing their support to wards
- Focus on utilising discharge lounge
- Ensuring actions are followed up from bed meetings
- Visibility of complex discharges within the command centre
- Identifying patients fit to transfer to community
- Ensuring we follow up discharges from the previous day
- Learning lessons and amending Full Capacity Protocol
- Discussion with specialist commissioning and CCG to transfer long stay patients to Walkergate – spot purchasing beds
- Worked with CCG to remove steps to streamline DTA pathway
- Review of social work model underway
- Implemented system wide surge calls

Actions

- Review Site Resource Team Operating Model
- Create integrated discharge team – redeploy some of the resource that has supported social workers – creating a potential saving in bed days
- Work with LAs to re-design approach to DToC
- Create a multi-functional command centre – including bed bureau, SPOR, SPA, integrated discharge team
- Equip command centre with screens to ensure data is displayed at all times including elective/non-elective TCIs, live bed state, number of discharges etc.
- Explore development of a SDEC facility – options appraisal underway
- Expand virtual diagnostic ward
- CUR / Medworxx – single version of the truth
- Promote SAFER, discharge lounge, Medworxx etc
- Focus on home first – Where best next?
- Dedicated team for 6 months to focus on organisational flow /command centre

Any questions/points for discussion?