Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	14
Date of Meeting:	07 March 2019		

Report Title:	Emergency Care Intensive Support Team, (ECIST) System review of referral and discharge processes			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x			
Prepared by:	Gavin MacDonald, Winter Director			
Executive Sponsor (presenting):	Andy Hyett, Chief Operating Officer			
Appendices (list if applicable):	Full ECIST Report			

Recommendation:
No recommendations – for information only

Executive Summary:
Following a review of system referral and discharge processes by the Emergency Care Intensive Support Team in November 2018, there are several recommendations being taken forward and these are detailed in both a system and SFT improvement plan with timescales for delivery and responsible owners. This includes a clear plan for embedding the SAFER Flow Bundle in the clinical areas. The recommendations address the following themes: 1. Review of the overarching improvement plan to ensure it delivers the key objectives. 2. Reduce variation in ward discharge process processes and fully embed the SAFER Flow Bundle 3. Hospital and system pathway redesign including community demand and capacity planning and further development or trusted assessor 4. Discharge and administrative processes 5. Improvements to the hospital operations centre SFT have set up a weekly patient flow delivery group, chaired by the Chief Operating Officer to deliver improvements in hospital operations and patient flow, which includes the ECIST recommendations. A live patient flow dashboard with relevant key performance indicators (KPIs) has gone live across SFT, which is reviewed daily and is reported weekly to the Patient Flow Delivery Group and monthly to the Patient Flow Programme Board. The Finance and Performance (F&P) Committee noted a 30-40% increase in Delayed Transfers of Care (DTOC) which can be difficult in achieving the cultural change required to

deliver SFT internal improvements.

The F&P Committee agreed to have a strategic discussion around the gap between demand and capacity in community services.

It is recognised that to move forward some of the external delays, it is important to have delivered on the SFT specific improvements to inpatient flow. The F&P Committee has asked for a monthly report detailing progress against the ECIST recommendations.

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☒
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☐
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☐
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☐
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☒

Emergency Care
Intensive Support Team

Safer, Faster, better care for patients

NHS Improvement

Ms Cara Charles-Barks
Chief Executive and AEDB Chair
Wiltshire CCG

By email 21st h of December 2018

Dear Cara,

ECIST System review of referral and discharge processes

Thank you for inviting the Emergency Care Intensive Support Team (ECIST) to review the referral and discharge processes across the south Wiltshire locality. The purpose of the visit was to identify delays, review processes for improvement and offer recommendations to the system to improve patient flow. The review was carried out the 27th and 28th November 2018. We are aware that this visit was only a short period of time although we feel we have highlighted some observations and reflected discussions from teams on these days.

We undertook a review of the following processes as requested through the Accident and Emergency Delivery Board (AEDB):

- The integrated discharge team
- The site management and operational reporting
- A review of referral processes and pathways
- A review of community teams case management and transfer of cases.

The review consisted of an appraisal of data, observation on site and discussions with staff through the following:

- A review of board rounds on several wards
- A DTOC meeting
- A weekly stranded patient meeting held by an expert panel (Wednesday)
- Interviews with social care, community Trust and key staff in the organisation
- Review of the Acute Medical Unit (AMU)
- Site meetings

During the review we met with colleagues from the acute hospital, the community, and social care leads. The aim of this exercise was to assess how robust the systems and processes are and offer recommendations for any further development. This included the discharge process, escalation of patients and expediting patients safely back to the community.

This report expands on the verbal feedback we provided to system representatives at the end of the visit and sets out a series of recommendations for your consideration.

It is essential that everyone across the system recognises that delays in patient flow leads to a reduction in the quality of care and therefore the requirement to make improvements at pace is essential. Research into poor patient flow (resulting in high bed occupancy) has established links with some adverse patient outcomes and evidence suggests:

- For patients who are seen and discharged from an A&E, the longer they have waited to be seen, the higher the chance they will die during the following 7 days (Guttmann et al, 2013).
- The longer a patient spends in the Emergency Department (ED), the longer they stay in the hospital (Liew et al, 2003).
- 10 days in hospital leads to the equivalent of 10 years ageing in the muscles of people over 80 (Giles et al, 2004).
- Once a hospital is over 90% bed occupancy it reaches a tipping point in its resilience (Forster et al, 2003).
- Lowering levels of bed occupancy is associated with decreased in-hospital mortality and improved performance on the 4-hour target (Bowden et al, (2015).

Overall, we found several well-developed services aiming to deliver integrated pathways. It may be beneficial for the system to consider a review of their overarching improvement plan to ensure it delivers the key objectives. ECIST are happy to support the system leaders in this for urgent and emergency services in Salisbury / Wiltshire.

Key Messages /Observations

1.1 **The inpatient wards**- We visited four wards and observed the board rounds. . On those wards there were inconsistencies with the use of expected date of discharge (EDD's) and this is often set by nurses, rather than consultant led as recommended good practice. Daily ward rounds and board rounds are good practice and are essential to support the tempo of case management, timely discharges, and reduction in length of stay (LOS) to optimise patient flow. We **recommend** that the trust implements the SAFER patient flow bundle and compares their present action plans to identify gaps in the present system so these can be addressed.

1.2 There is a need to review the pathway for **frail older people** to ensure that they are managed assertively, their length of stay kept to a minimum and where possible patients should be discharged to their normal place of residence for all assessments once clinically optimised. The current front door service supports

some of this with the rapid response team. The principles of discharge to assess (D2A) and comprehensive geriatric assessment (CGA) should drive this change. reform. We **recommend** that the trust develops the frail older people's pathway using the Silverbook, time standards with improvement/outcome measures to understand the effectiveness of the pathway. Several assessments for discharge was observed rather than discharge to assess which needs to be adopted.

1.3 **Operations Centre -** We did not observe a predictive model in use in the management of operations the acute trust. It is recommended that predictive data is used to inform decision making in the Operations Centre; to provide a more proactive service rather than a same day reactive service observed currently. ECIST are happy to work with the system to develop system and processes to use the data available to improve flow across the system. Escalation triggers should be agreed, implemented and monitored, in conjunction with this work. We would suggest you consider using a 6-week rolling average predictor to support decision making and planning. **Amendment :** The Trust do have a predictive measure in the site dashboard but are not currently using this .

1.4 **Discharge process** – The discharge process appears fragmented and involves multiple handoffs. Handoffs can be reduced significantly, and we **recommend** the further development and implementation of the "discharge to assess", home first model. To achieve this, we **recommend** that a task and finish group is set up by the acute trust, partners and commissioners to fully understand the impact of the changes that were highlighted to us during the visit around market factors for social care and the residential and nursing home placement. It is important that discharge processes are universally agreed and understood by all stakeholders to improve the systems pathways that are in place. During our visit, we also observed a DTOC meeting and an expert panel meeting. Currently, the discharge team is consumed by collecting information and inputting data rather than working with the ward staff empowering them to support effective discharge. We would suggest that the Trust look at whether some of these functions could be conducted by supporting the discharge team (e.g. With admin support). This could release their expertise to provide coaching and guidance to ward staff around challenging discharge issues. We believe there are delays in wards referring early enough to the discharge teams, and we would **recommend** an audit of this process to identify any opportunities.

1.5 **Patients ready for discharge list**. The discharge teams appear to work on three lists rather than one. The Green to Go list also doesn't reflect stranded, super stranded and updates relating to each patient. We would **recommend** reviewing this and have one definitive list for all stakeholder to utilise and update. This would also need to be embedded within a clear process for reference, tracking and escalation.

1.6 **Community beds** The Trust do not have access to community beds locally but have access to pathway 2 and 3 beds in the community. Discharge to Assess

(**D2A**) is a concept whereby patients are transferred from acute hospital at the point where they no longer require acute hospital care through one of three **pathways**; either at home with support (**Pathway** 1), in community based sub-acute beds with rehab and reablement (**Pathway** 2) or in a care home with appropriate support (**Pathway** 3**)**

Amendment : SFT use 7% of the Community beds stock with additional ICT capacity . Home Frist is based on Discharge go assess principles . Pathway 2 is commuty hospital or ICT. Pathway 3 in Wiltshire is long term care.

1.7 **Home First** As noted earlier there are Home First delays in the acute hospitals. There are three teams in Salisbury area - South Amesbury, Wilton and Salisbury CityTeams. We **recommend** a review of the allocation on each team caseloads. It may also be beneficial to review staffing models to meet demand and ensure a timely review. We recognise that there were recruitment issues with domiciliary care and community staff. We understand the Trust are working jointly with the community trust to develop joint roles and opportunities.

We **recommend** the following to support timely discharge

- Ensure that the performance dashboard for pathway 2 and 3 beds is based on patient-related outcomes, e.g., return to home, availability of services, rather than on the traditional 21 / 42 days LOS contracted standards.
- We would **recommend** that the system implements the systematic use of expected dates of discharge (EDD's), clinical criteria for discharge (CDD's) and the use advanced nurse practitioner (ANP) roles across all community hospitals.
- Agree on the use of shared documentation across the system. Acute and community teams should continue the patient episode in the healthcare records of multi-agency partners.

General / Speciality wards, Bed Management & Discharge Planning

All patients (and the teams caring for them) need to know four things:

- **What is wrong with me or what are you trying to find out**? This is achieved by timely competent assessment by a decision-making clinician who is also able to answer the following question:
- **What is going to happen now, today and tomorrow?** This is achieved by the construction of an end to-end case management plan by a senior clinical decision maker who ensures that these 'inputs' occur promptly.
- **What do I need to achieve to leave Hospital?** This is achieved by setting individualised patient focused clinical criteria for discharge while maintaining appropriate monitoring of the progress of the patient and ensuring early

intervention if there is any negative deviation from the expected recovery pathway.

- **When am I going home?** This is achieved by setting the expected date of discharge which does not include the unnecessary waits known within the system. Assertive board rounding, and one stop ward rounds ensure that all tasks are completed on time and that as little of the patient's time is wasted waiting for the necessary inputs to occur.

Good practice is where a daily senior review of the care plans for every patient in every bed. Is undertaken This should be led by the patient's consultant. Most hospitals approach this through the implementation of the SAFER patient flow bundle, where the consultant leads the daily multi-disciplinary team (MDT) board rounds, to ensure their care plan is on track. Deteriorations are picked up quickly, and unnecessary delays can be addressed. We recommend that this system is reviewed if this is not in place throughout.

Length of stay (LoS) review:

ECIST observed a DTOC meeting and a "Expert Panel meeting" all relating to transfer/discharge of long length of stay patients. The purpose of these meetings was to identify whether the patient was medically fit and if so, what they were waiting for in an acute bed

We observed a good level of therapy support at these meetings and good practice by ensuring consent for patient records to be shared.

We would suggest there are a high number of assessments and checklists that are completed for patients to try to determine the level of care required before discharge. Delays can be incurred waiting for these assessments and this does not follow the spirit of home first (i.e.
assessment in the person's place of residence). There were a number of discussions regarding dependency charts and we were unclear what value these charts provided, as the behaviour and agility of a person observed in a hospital will be different to their capability in their own home.

We **recommend** a review of your systems and processes as it could reduce the large number of checklists and support flow and appropriate discharges while reducing the decompensation of patients in an acute bed as they wait for a care of discharge decision. The system needs to work on the principles that everyone returns to their place of residence with supported care, and all assessments are commenced there.

There was evidence of delays in the CHC and Fast Track processes during our attendance at the DTOC meeting, which is having a significant impact on the patients and relative experience at an already difficult time. The fast track care needs to be same or next day once there has been a decision and following conversations with patients and families. We observed an additional weekly meeting called "Expert Panel" and would urge the Trust to review the Terms of Reference for both these meetings as we were unclear what outcomes were gained from these two similar meetings. We **recommend** the system review their

current processes around the sign-off for fast track, CHC decisions and placement to address the current added delays.

We recommend the following:

The SAFER patient flow bundle summarises a small number of actions that if implemented simply, will significantly improve patient flow. The Trust should implement the SAFER patient flow bundle and Red to Green days using PDSA on a small number of exemplar wards.

- Focus on simple discharge. Expediting routine (simple) discharges can be more effective in releasing beds than only concentrating on complex discharges.
- Rapidly review the discharge to assess pilot, develop and test a model for patients who are suitable for further assessment or re-ablement outside of an acute setting.
- Rapidly review the current processes for the fast track, CHC decisions and placement.
- As a system, review the current referral process and use of the community capacity (stepdown beds) to ensure that it meets the needs of the patients and support the discharge to assess model of care.

Thank you for the invitation to come and review your system. We hope you find that the enclosed report is helpful and supports the potential improvements of some of your known challenges going forward. We are happy to provide guidance examples and case studies to support improvement initiatives as necessary.

Please do not hesitate to contact me if you wish to discuss or require any further clarity.

Yours faithfully

Colette Thompson
Improvement Manager
ECIST (South)

Cc
Richard Brownhill Senior Improvement Manager, ECIST (South)
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Vanessa Williams Improvement Manager ECIST (South)
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Emergency Care Intensive Support Team, (ECIST) System review of referral and discharge processes

Trust Board

7th March 2019

Background

The Wiltshire A&E Local Delivery Board invited the Emergency Care Intensive Support Team (ECIST) to review the following:

- Integrated discharge processes (including community, social care and SFT)
- Site management and operational reporting
- Referral process and pathways including social care
- Community teams, case management and transfer of cases

The visit took place over two days in November 2018, during which the visiting team observed the following:

- DTOC and Expert Panel meetings
- Site meetings
- Wards and Board rounds
- Ambulatory Emergency Care unit
- Discharge lounge

Meetings were held with the following groups of staff:

- Therapies lead and team
- Integrated Discharge Service and Social care team

Why is this important?

For patients who are seen and discharged from an A&E, the longer they have waited to be seen, the higher the chance they will die during the following 7 days (Guttmann et al, 2013).

The longer a patient spends in the Emergency Department (ED), the longer they stay in the hospital (Liew et al, 2003).

10 days in hospital leads to the equivalent of 10 years ageing in the muscles of people over 80 (Giles et al, 2004).

Once a hospital is over 90% bed occupancy it reaches a tipping point in its resilience (Forster et al, 2003).

Lowering levels of bed occupancy is associated with decreased in-hospital mortality and improved performance on the 4-hour target (Bowden et al, (2015).

Internal Actions

Action	Detail	Status	Completion Date
Embed the SAFER Care Bundle	To embed four main aspects of the SAFER Care bundle into Trust staff practice.	Work in progress	August 2019
Older People and Frailty Pathway	To improve the health for older people through strengths based working, prevention, early intervention and rapid reablement	Work in progress	March 2020
Service Function Reviews	To review identified service areas and operational meetings.	Work in progress	May 2019
Data, information and system access	To ensure our data sources, information systems and information that is reported on, is accurate, available in a timely manner and systems can support teams moving forward (across Acute and community services)	Work in progress	May 2019
End of Life Care	To review the existing systems in place for our CHC and Fast track patients being discharged from hospital on these pathways. To overall improve the quality and experience for patients, relatives and staff	Work in progress	March 2020

System Actions

Action	Detail	Status	Completion Date
Implementation of Trusted Assessor	There will be a trusted assessment and assessor between SFT and care homes	Work in progress	Trusted assessment partially implemented but no agreed date for Trusted Assessor
Demand and Capacity work, including Discharge to Assess	Demand and capacity assessment to be undertaken to ensure capacity meets demand across the health and social care system	Work in progress	Model available March 2019
System Frailty Pathway work	Develop a frail older people's pathway using the Silverbook, time standards with improvement/outcome measures to understand the effectiveness of the pathway	Work in progress	Programme scope to be available April 2019