UPDATE BRIEFING ON INTEGRATED DISCHARGE PILOT

Date: 30.08.17

This paper is to update the A&E Delivery Board about the Integrated Discharge Pilot which has been in operation since 1st August 2017, with the aim of assessing the impact of the model in practice. In view of the impending winter pressures, it was agreed that the pilot should continue until 31.03.18.

The Board will recall that the pilot was set up to focus on delivering a streamlined, effective and efficient discharge process for patients in SUFHT and is based on bringing together all those who have been involved in discharge into one cohesive *"integrated"* team. The team is working to the recommendations of the Task and Finish Group, which were agreed by all partners.

These recommendations follow the *LGA, High Impact Change Model.* An assessment of the system's position against the model is currently being undertaken in the Discharge Management Forum and the findings will inform the refinement of the project. The timescale for completion of this audit is not yet confirmed, but the plan is that it will allow the team/service to be able to evidence compliance with the "established" level during the pilot phase with continuing work being aimed at achievement of "mature" and "exemplary".

Baseline Data: The Group is sought support from the system to undertake a swift evaluation to be carried out of each element of discharge detailed to establish a baseline, against which there can then be measurement of progress/improvement over the pilot period. This evaluation should include:

1. The percentage of rehab assessments undertaken within 48 hours of admission
2. The percentage of social care assessments that have started within 48 hours of admission
3. The percentage of TTA`s planned in advance
4. The percentage of patients home for lunch (National target is 33%)

Update: It is unfortunate that the baseline assessment has not been undertaken. However, the self-audit detailed above should [provide similar information to use and a firm timescale for completion is required. In the meantime, the 4 measurements above will fulfil the requirements of the joint CQUIN for SUFHT and EPUT.

Other recommendations made by the Group are being progressed within other committees and reports will be provided by them. These include CHC, PTS, Red Bag scheme).

The Task and Finish Group agreed that during the service should be led by one representative of each of the 4 organisations involved in the design work. The representatives have been identified and each organisation thus provides the team leader for one of each of the 6 zones. In

addition, the current Community bed flow coordinator remains supernumerary to this process and liaises with all teams, supporting where necessary/relevant.

Fundamental to the pilot implementation will be the actions identified thus far by the Group during the planning/design phase:

- Zoning of teams to be implemented and completed by August 2017.
- Teams to work together to organise discharge as per the process to provide consistency and streamlining across the relevant zones. Deal with all aspects of discharge coordination, thereby reducing workload for ward staff.
- Daily MDTs to be held and recorded on white boards
- Inclusion of the voluntary sector in the teams.

It was also agreed that the team leads would work together by meeting once a week to discuss progress and issues, agreeing between themselves how challenges should be resolved; they would also evaluate the daily data to ensure that the project is making progress. The pilot is therefore the second part of the design and modelling process. The first such meeting took place on Wednesday 2nd August, which was well-attended and where an "action log" was commenced to record progress week on week.

However, it is unfortunate that SUFHT cancelled the next 2 meetings at short notice, due to internal hospital pressures. It has also become apparent that Wednesday mornings are no longer convenient for the hospital. Since EPUT colleagues were already in the hospital when notice of the cancellation came through on 9th & 16th August they discussed issues from their perspective and the action log was updated accordingly. This is not ideal.

In view of this, it was decided to defer any meetings until the first week in September, when individuals will have returned from annual leave. A decision will thus be reached next week as to how best to achieve the meeting – one of the fundamental tenets of embedding a cohesive approach and dealing with issues in "real time".

The action log from the meetings has been appended to this briefing for information.

Funding for pilot:

The Task and Finish Group made 2 recommendations about funding for the pilot: 1. For the shortfall in DCO posts and 2. For the EPUT staff member. Neither has yet to be agreed.

However, discussions relating to the latter have been on-going since November 2016, with agreement in April 2017 that the Band 6 vacancy in SPoR could be utilised for the purpose of backfill for some of the community role.

The request in this regard was: Full funding for the 1wte Community bed flow coordinator; Band 7 RN to provide cover; 0.5wte admin clerical support. It was acknowledged that this requirement will increase if it is decided that 7 day working is needed. The expectation seems to be that EPUT can progress discussions about funding decisions. This is not possible and a system resolution needs to be identified. In the meantime, the individual continues to work almost solely within the hospital supporting discharge. An urgent discussion is therefore needed.

Integrated Discharge Team - Action Log 10th August 2017

Lead Key					
Name	**Initials**	**Name**	**Initials**	**Name**	**Initials**
Kellie-Jo Hill Discharge Co-ordinator SUHFT	KJH	Charmaine Duce Discharge Co-ordinator SUHFT	CD	Tina Broderick Head of Intermed Care EPUT	TB
Penny Renham Senior Occupational Therapist - SUHFT	PR	Karen Bayliss Care Co-ordination CPR EPUT	FBA	Flora Baafuo-Awuah – Complex Care Co SOS EPUT	FBA
Michelle Reeve Essex County Council Representative	MR				

RAG Rating Key	
Outstanding action	
New action/required next meeting	
Future action	
Action completed/closed	

Action	Lead	Deadline (mm/yy)	Outcome	Status Comp/ Open	RAG Rating
Action Point 1 - Purpose of meeting – 03.08.17 Local discussion conferring purpose of meeting was to discuss immediate operational issues and support each other in the support of timely patient discharge. There was recognition that this meeting will evolve over the next 2-3 months.	KJH/ TB	04.08.17	Action Log to be established to log and monitor progress/issues ***Action log commenced 02.08.17***		
Action point 2 – ESD/Delayed discharges – 03.08.17 Some confusion identified in the reporting of DD information from both Stroke wards following the introduction of ESD. TB already met with Bev Bambury (Discharge Co-ordinator	KJH/TB	Ongoing Update to meeting 13.09.17	KJH to link with Bev Bambury to confirm delayed discharges on these two wards. ***Agreed and ongoing 07.8.17***		

Action	Lead	Deadline (mm/yy)	Outcome	Status Comp/ Open	RAG Rating
– SUHFTl) and Carolyne Dawson – (ESD Co-ordinator - EPUT) close communication required between these 2 individuals to allow Discharge Team to collate accurate delayed discharge information on Paglesham and Benfleet Wards.			TB to meet again with Bev Bambury and Carolyne Dawson in early September to review progress		
Action Point 3 – CPR CHC Discharge Pilot – 03.08.17 The group discussed the above pilot and the teething problems in relation to current timescales being experienced. Differences in Southend also discussed briefly so the whole group had an understanding	KJH/MR	Ongoing	KJH to liaise with Sandra Steeples (Discharge Manager- SUHFT) who is preparing information giving examples of issues to share with the lead commissioner. MR linking with Jo Allen (Social Care Manager - Essex County Council) to ensure Social Care perspective is captured and can be shared at the high level evaluation meetings		
Action Point 4 – Care Co-ordination – 03.08.17 KB discussed benefits of involving Care Co-ordination with many of our complex patients. She explained that previous discussions with James Currell (General Manager for Acute Medicine SUHFT) had suggested putting a 'flag' on Medway to alert staff of patients that Care Co-ordination services are already involved with. All agreed an increased communication between the hospital and care co-ordination could only benefit patient	KJH/KB	To be agreed at next meeting	KJH to enquire about progress regarding 'flags' for this patient group and how this would need to be implemented. – 10.8.17 This chased by KB and waiting outcome. KB to provide a batch of updated leaflet for the team for insertion into Discharge Booklet. These same leaflets also to be supplied to Essex Social Care staff in the hospital. ***Completed 10.8.17- with Discharge Team***		

Action	Lead	Deadline (mm/yy)	Outcome	Status Comp/ Open	RAG Rating
care with examples discussed. KB also offered Care Co as a potential support mechanism at weekends if usual services could not support in the short term (CPR only at this stage)			KB to provide KJH with contact details for weekends ***<u>Completed 10.8.17- With Discharge Team</u> Please remember medication cannot be administered via this service. Also BH staffing reflects weekend not weekday numbers.***		
<u>Action Point 5 – Lack of support from Essex Social Care Duty Team – 03.08.17</u> Recent experience discussed, confirming there appears to be no ability for the duty team to organise community support for patients in the community out of hours and they are advising patients/families to attend the hospital instead as a way of accessing services.	MR	To be agreed at next meeting	MR has escalated this problem to senior staff - feedback to be given as available		
<u>Action Point 6 – Intermediate Care Capacity at weekends 03.08.17</u> CD identified that having the regular conference calls on a daily basis now ceased there is no way of the discharge team know the community capacity at weekends to support discharge	TB	04.08.17	TB to request that SPOR recommences the Friday email giving current capacity within Intermediate Care and forward to the Discharge Team - to commence Friday 04.08.17. TB to inform Phil Read - (Associate Director of System Resilience) of this plan to gain support and ensure an alternative process is not required. ***Action completed 02.08.17 to commence 04.08.17 and supported by Phil Read as an interim solution.***		

Action Point 7 – SLT altered diets 10.08.17 TB identified as a result of an excellent SLT service in the hospital the number of swallowing assessments appears to have risen dramatically and as a result and increasing number of people appear to be being discharged on altered diets. While this is not a problem in the first instance the issue is the lack of provision in the community to review these patients and safely manage them back to a normal diet where possible.	TB	17.08.17	TB to raise this with Director and identify way forward in relation to commissioners. KB to share with FBA and be aware for Care Co patient group		
Action Point 8 – Recent Care Co Data related to Re-admissions 10.08.17 KB explained that having recently received data regarding multiple admissions, it became apparent some of this information did not show a number of different patient admissions but an admission with a number of different internal ward moves within one admission. The concern being this may be skewing data analysis	KB	To be identified at next meeting	KB to meet with Pam Sabine and Jo Thomas to review and identify way forward **Update: 25.08.17:** Meeting with Jo Thomas has resulted in agreement about requirements for information. To commence week beginning 28.08.17		
Action Point 9 – New 'Light Touch' Reablement Service in CPR 10.08.17 KB voiced concerned that having launched this service recently Care Co had attempted to use it for admission avoidance but unfortunately there was no capacity	MR	To be identified at next meeting	For further discussion to increase understanding of availability of this team and alternatives when not available at next meeting.		