Report to:	**ADULT SOCIAL CARE AND HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	Dr Jim Gardner, Medical Director and Joanne Bark, Deputy Director of Operations for Unscheduled Care, BTH
Date of Meeting:	Thursday 17 September 2020

WHOLE SYSTEMS TRANSFERS OF CARE SCRUTINY REPORT

1.0 Purpose of the report:

1.1 The purpose of this report is to update the Committee on the outstanding recommendations from the initial review which consisted of the following:

- Impact of delayed prescriptions as part of the discharge process
- Review and improve the discharge pathways
- Update on the exploration of subsidised parking.

2.0 Recommendation(s):

2.1 The Committee is asked to sign off the implementation of the recommendations of the review, if it so agrees that they have been sufficiently completed and to determine what future review of this subject matter is required.

3.0 Reasons for recommendation(s):

3.1 To ensure that the Committee is apprised of the progress with regards to implementation of the recommendations and the impacts.

3.2 Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.3 Is the recommendation in accordance with the Council's approved budget? N/A

4.0 Other alternative options to be considered:

4.1 Not applicable

5.0 Council priority:

5.1 The relevant Council priority is

- Communities: Creating stronger communities and increasing resilience.

6.0 Pharmacy Provision - Exploring the impact of delayed prescriptions as part of the discharge process and identify a course of action to address those delays

Patients often believe that the delays experienced waiting for medications to arrive on the ward which then permits them to be discharged is due to challenges within the pharmacy department. Previously this was the case on many wards however a number of actions have been taken in order to improve the response we expect for our patients.

- There has been an introduction of ward based teams on 12 wards within the medical division who operate a Pharmacy led discharge process. This team support a more stream lined process, carrying out many actions which would have previously waited for already busy junior doctors to complete.
- There are three satellite pharmacies in addition to the main dispensary which ward based teams operate from and operate a dispensing for discharge system whereby there is a preparation for discharge at the beginning of the patients journey.
- The Pharmacy department monitor the turnaround time of discharges through the dispensary on the ward tracker. The average turnaround time for discharges through the dispensary in July 2020 was 69 minutes. (Receipt in Pharmacy to final check), compared to 89 minutes in July 2019.
- Omnicell is in place in some areas such as the Emergency Department, it offers innovative medication management products and medical supply inventory systems that enable us to better serve patients. This includes distributing medications across the hospital and post-acute care to supporting medication adherence for patients at home. The system is being explored to determine whether it will benefit the patients' journey and safety within the Acute Trust.

The table below shows the departmental Key Performance Indicators (KPIs) on dispensary turnaround time of discharges. There has been steady improvement since March 2020:

Workstream		Annual Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Average Discharge Turnaround Time DISPENSARY(arrival in pharmacy to completion) Target 60 minutes	AB	R > 80mins A 71-80 mins G 0-70 mins	89	90	88	86	86	91	92	89	84	83	83	80	66	80	66	69
DISPENSARY discharge TAT - % of prescriptions completed within target time of 60 minutes	AB		38.48%	35.97%	40.29%	35.20%	56.26%	59.67%	51.85%	57.62	59.89	59.96	59.81	58	71.50%	65.72%	60.57%	52.31%
Number of transactions via dispensary terminals	AB		20027	20854	18763	19893	19642	20114	21219	21876	21731	23584	20735	19646	16823	18284	19684	

It is acknowledged that delays do occur when there are errors or queries on discharge letters and the teams await prescribers to clarify. We have previously audited this (excluding the wards with pharmacy led team) and identified approximately 40% of discharges written contained one or more errors. In light of this finding several improvements have been put in place. There are a few areas within the Trust without a one stop system, ward based teams or a satellite pharmacy, notably women's and children, inevitably discharges may be delayed here, however, priority is given to discharges wherever possible through the main dispensary.

The Trust is looking to implement a Pharmacy led discharge service across further wards to assist with discharge. The aims of the service are to:

- Reduce the time between identifying patient fit for discharge and completion of the discharge prescription.
- Reduce the time spent clarifying prescriptions.
- Reduce the pharmacy processing time.
- A timely planned service leading to a reduction in the likelihood of patients discharges being delayed or occurring late in the day which causes transport issues.
- Less stress for all. (Patient, Nurses, Medical Staff and Pharmacists).

Data below shows turnaround times from our Pharmacy-Led Discharge Service. The team is funded to carry out this service in most areas of Unscheduled Care with the exception of wards 2, 6, 24, C and 1. The KPI's below show that the majority of discharges processed by the team are complete in just over two hours. This is two hours from the time the doctor gives the go ahead to discharge to medicines being returned back to the ward:

	Target	2019 Average	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Average time taken between Doctor Communicates Intention to Discharge and Discharge Written (hh:m)	G < 00:30 A < 00:45	00:38	00:39	00:35	00:37	00:42	00:41
Average time taken between Discharge Written and Returned to Wards (hh:m)	G < 01:30 A < 01:45	01:30	01:30	01:35	01:34	01:28	01:32
Average of Time between Clinically checked and Accuracy checked (hh:m)	G < 00:45 A <01:00	00:44	00:44	00:49	00:49	00:58	00:53
Average of Time from Doctor informs of intention to Discharge to Medicines returned to Ward (hh:m) *	G - <2hrs A <2.5hrs	02:05	02:08	02:10	02:11	02:10	02:12
Average of Time from Doctor informs of intention to discharge to patient discharged (hh:m) **	G - <4hrs A <4.5hrs	04:13	04:35	04:29	04:32	05:10	05:00
%age completed in advance	G > 25% A> 20%	32.03%	34.42%	37.34%	30.65%	29.63%	38.44%
Number completed by pharmacist		6320	520	482	558	324	333

We have recently started to trial using pharmacists as part of a multi-disciplinary team who focus on discharges at weekends in order to reduce the delays which have been identified. There is further work and investment required. Once we adopt an Electronic prescribing and medicines administration system (EPMA) this will massively

reduce delays and improve the number of errors. The EPMA project is due to be initiated in September 2020 and roles have been recruited to. We are currently working on a proposed 'Go Live' date of Apr/May 2021 giving 8 months from initiation to 'Go Live'. Roll out across Cardiac, Medicine and Surgery will take roughly 12 months.

7.0 Review and improve discharge pathways

7.1 Background

This year has seen some extreme challenges in discharge processes and a 'whole system' change that was a direct result of the COVID-19 emergency. To that end our Health Economy worked collaboratively in March and developed a response to the National Guidance "Hospital Discharge Service: Policy and Operating Model". https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model

One positive highlighted as a result of the ongoing COVID-19 crisis is that it has demonstrated what is possible in terms of rapid and safe discharges and (importantly) admission avoidance.

Part of this is working with partner organisations to improve the management of patients that are identified as 'medically optimised' (the point at which care and assessment for a patient can be safely continued in a non-acute setting). We now have a daily Multi-Disciplinary Team (MDT) conference call where each patient that no longer requires an inpatient acute bed is discussed and progressed to a discharge outcome.

7.2 Single Point of Discharge and Home First Service

Single Point of Discharge (SPoD) was launched in December 2019 and is a joint health and social care venture. Experienced professionals manage referrals into the most appropriate community service to support an individual's needs upon their discharge from hospital.

Home First (HF) service has been operating since October 2018, facilitating people who are medically optimised to leave the hospital and return home. They can then be assessed in their own environment for continued support from community services or longer term social care needs.

Both initiatives are congruent with the NHS Long Term Plan of maximising collaborative working between health and social care professionals and supporting people to manage their health and well-being in the community, as independently as possible. This is also echoed in the Trust 'Partnerships', 'Collaboration' and 'Efficiency' work programmes, which focus on developing new and integrated models of care to

support reduced lengths of stay and delivery of affordable, high-quality care.

The SPoD service is based at Blackpool Stadium and covers 7 days a week, between the hours of 8:30 – 17:00. The Rehabilitation Coordinator roles have been absorbed into this team and there is therefore currently no consistent acute hospital presence.

The Home First team is based at Blackpool Victoria Hospital and covers 5 days a week, between the hours of 8:00 – 16:00.

To date these services have been functioning as separate services, albeit with regular referrals from SPoD into HF and close liaison regarding patient care.
In the absence of additional resource, the SPoD team was created utilising established staff from other services, on a pilot basis.

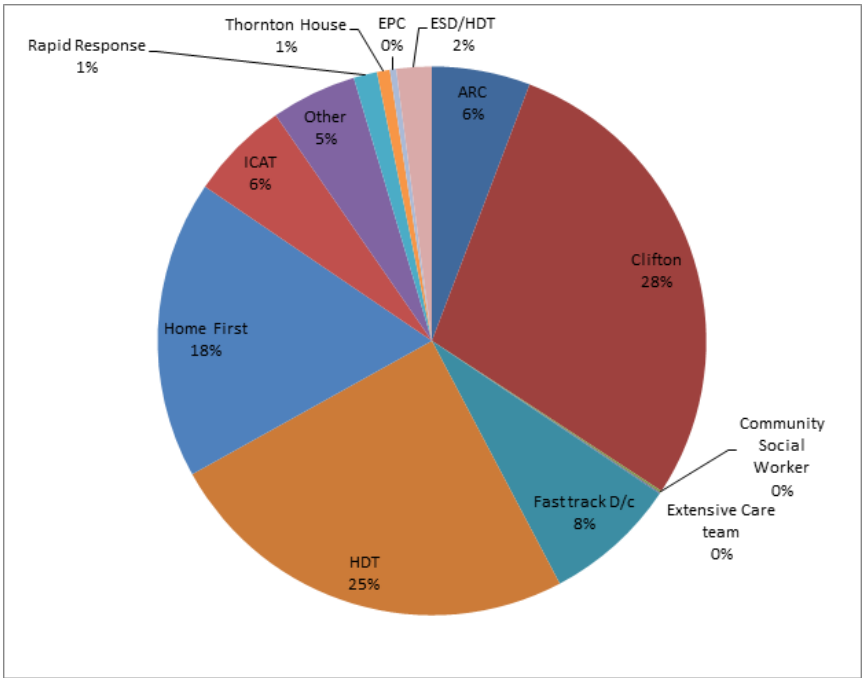
The service objectives are:

- To provide a single access route into community health and social care services
- To co-ordinate and progress discharge plans to facilitate the timely transition of patients out of hospital
- To reduce delayed transfers of care by matching patients to available social and community care
- To contribute towards improved flow through the hospital and reduced lengths of stay
- To reduce avoidable re-admissions into the acute hospital
- To deliver the right care, at the right time and in the right place to best meet the needs of our patients.

In response to the Covid-19 pandemic, access to SPoD was widened from the pilot wards to the entire BVH ward footprint and a progressive increase in the number of referrals has been seen, with 474 referrals in June and 519 in July.

Modelling completed by the business intelligence team demonstrates a referral trajectory of 20-25 per day on weekdays and 5-10 per day on weekends; 110-145 per week in total. Further communications are planned in order to support complex discharge planning referrals at a weekend. This level of referral is on average in the region of 20% of all of hospital discharges that take place.

The total distribution of discharge pathways for March-July 2020 is as follows:



Home First are completing an average of 63 visits per month and an average there are a further 12 slots that could be utilised; capacity of 75 visits per month/ ~18 per week. It should be acknowledged that the Home First capacity has been affected by a persistent qualified therapist vacancy, the service has continued to try to recruit. These visits are for patients who require assessment in their own home in order to determine exactly what package of care, rehabilitation is required in order to support them safely in the home environment. This reduces the level of care that is often put in place in the ignorance of how independent patient can be where returning to a more familiar area.

The slots that are not utilised are due to:

a) medical deterioration of the patient therefore cancellations– 5.4%

b) the patient not being ready to depart the ward at the scheduled time of the visit and an inability to substitute another patient – 1.1%

Less than 2% of patients return to hospital following their assessment. In order to respond to requests for Home First on the day of referral we need to increase the capacity of the team and plan across winter 2020/21 to increase capacity to 50 visits per week. In order to make the posts more attractive the staff required to support rehabilitation, single point of discharge and home first will become one service and will rotate - recruitment is underway for this service.

7.3 Embedding a 'Discharge to Assess pathway' (D2A)

The D2A (Discharge to assess) model enables patients who are medically fit for discharge the opportunity to be discharged earlier from the acute inpatient wards by organising their assessments in the community. Patients on the D2A pathway are assessed and discharged faster and are as a result, at less risk of developing complications or becoming more debilitated following an acute admission to hospital. For frail and elderly patients, it is well documented that this can include the loss of mobility, dexterity and cognitive function, all of which decline rapidly following admission to hospital, along with increased risk of falls and infection.

This is now a well-established pathway but has been suspended as part of the National response to Covid-19. As a result the outreach element of the process undertaken by the Hospital Discharge Teams is now held with the CHC (Continuing Health Care) Teams based within the CCG (Clinical Commissioning Groups). In effect this has released a significant Specialist Nursing resource which is supporting the Trust in managing Complex Discharges. As of 14/08/20 a total of 347 patients have been discharged on this pathway since April 2020.

Recent National guidelines released on the 19th August 2020 require the CHC process to recommence from 1st September 2020. The preferred option would be for the decision support tool element to be recommissioned from another resource rather than resort back to` Hospital Discharge Team (HDT) completing out-of-hospital assessments. This is currently being evaluated as part of the Health economy Winter Planning.

7.4 Winter pilot of a non-weight bearing pathway (NWBP)

Following a pilot utilisation of 'Block provided' Nursing Home beds this service has resorted to an agreed pathway at Clifton Orthopaedic Beds. This is for those patients that cannot go back to their own home and will require some further assessment and rehabilitation at the end of their Non-weight bearing period. This has been a success and provided an improved experience resulting in a greatly reduced length of stay in an acute setting.

7.5 Discharge facilitation

Discharge facilitators have remained a part of the Hospital Discharge Team albeit in a limited capacity again due to lack of recruitment. Currently 5.3 WTE posts are in place which is being expanded to 8 WTE to ensure there are 2 medical wards per facilitator. The primary role is supporting wards with management of 'Medically Optimised' patient pathways and is now an established, essential, role within the Trust. Furthermore as part of the COVID-19 response they are able to support the wards with pathway 0 (simple discharges) patients in terms of progressing plans for

discharge. The wards continue to be supported on a daily basis by the patient flow team who have a number of developed dashboards available to them in order to assist with visibility of each patient pathway and progress made.

7.6 Long stay reviews

Extended LoS (Length of Stay) - Super stranded 21days +

Prior to the COVID 19 pandemic the organisation was tasked with reducing the number of super stranded patients (Los 21+ days) by 40% by the 1st March 2020 and maintain the position until the 31st March 2020. In addition to this the organisation was asked to introduce local targets to reduce LoS for patients with a <7 and <14 day LoS.

Table 1 shows the overall position in terms of 21 day stays and includes Clifton Hospital (Community Rehabilitation Bed) whose pathways tend to exceed 21 days as part of a rehabilitation journey.

TABLE 1

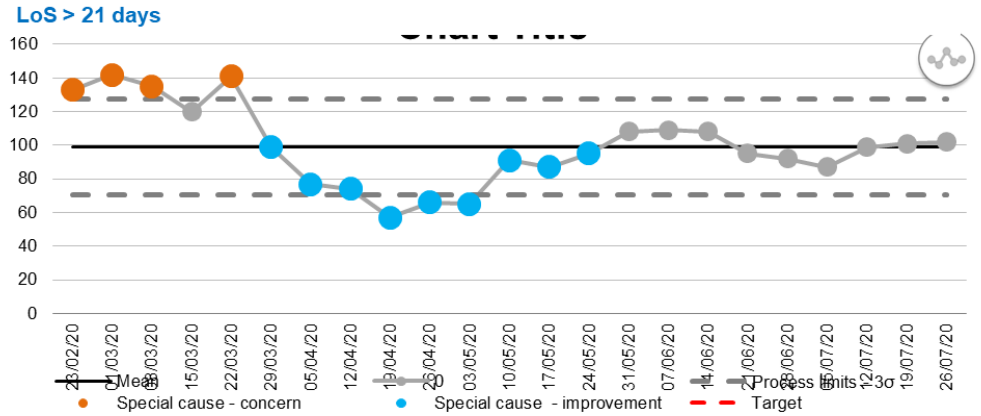


TABLE 2

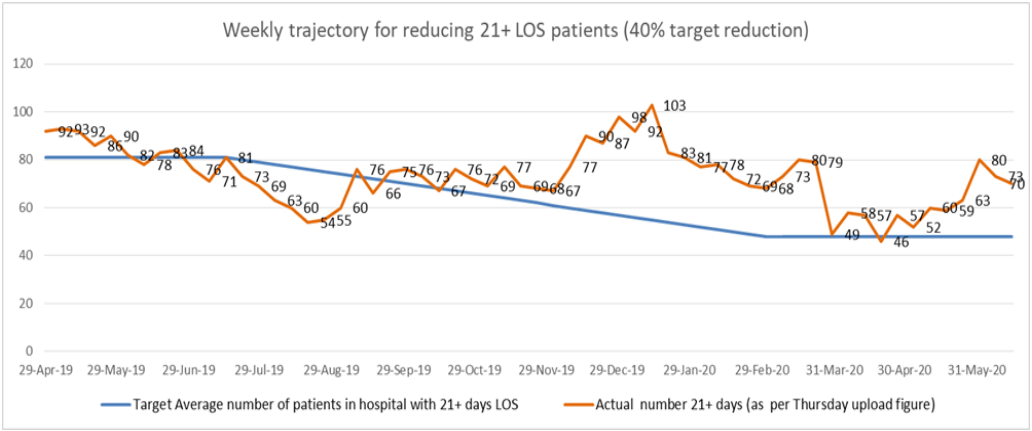


Table 2 demonstrates that prior to COVID 19 the Trust reduced the number of super

stranded patients in line with the trajectory until November 2019 and in line with seasonal activity and associated bed pressures the LoS increased to over 100 patients in January 2020.

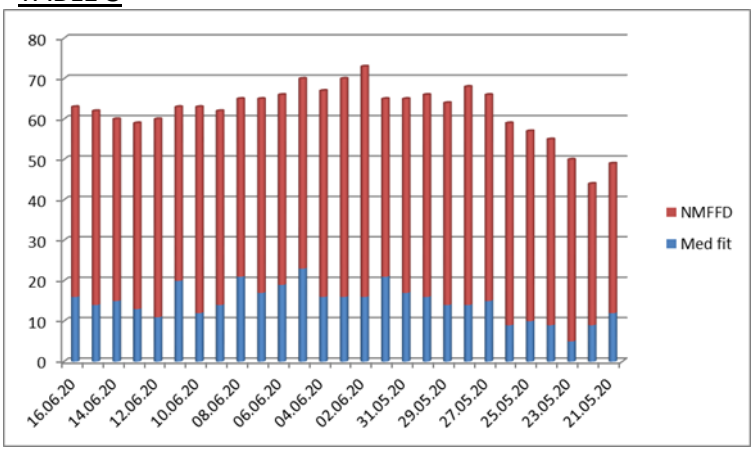
The most significant decrease in LoS for this group of patients was in March 2020 and attributed to the COVID pandemic and the focussed efforts of the organisation to discharge patients in order to prepare for a COVID surge.

Since week ending 26th April there has been an increase in the LoS in all patient groups yet the DTOC (Delayed Transfer of Care), home first and discharges to rehabilitation have remained relatively static, resulting in an associated increase in bed occupancy from 69.1% to 84% respectively.

Data (Table 3 below) suggests from the 21 Day ELoS (Extended Length of Stay) SITREP data that 70% - 80% of long stay patients are not identified as medically fit and have ongoing medical needs that are been treated in an acute hospital bed. This is challenged daily.

To ensure those patients are managed safely and appropriately various improvement workstreams have been set up to ensure in-patient processes are optimised and delays removed from the pathways. These include a daily clinical review of those patients with extended length of stay but are not medically optimised for discharge and a daily Multi-disciplinary (including Social Care managers and Clifton Management) conference meeting for those patients that are medically optimised.

TABLE 3

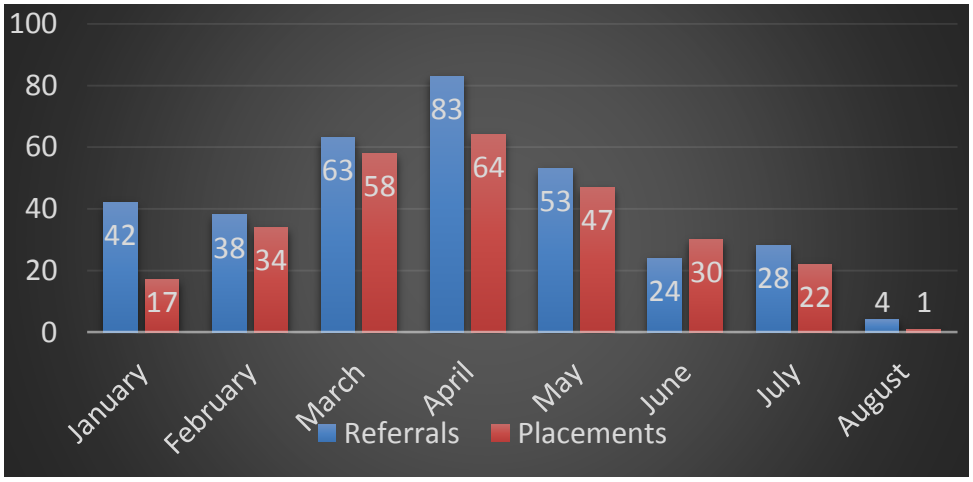


Carehome Select (CHS) have been commissioned to support the Trust with a care home finding service and commenced on an initial 12-month contract from 6th January 2020.

Their service was to support up to 30 patients per month but due to the COVID19 emergency this was increased to ensure placement were sourced in large numbers,

quickly and safely. The table below demonstrates the successful placements (red).

CHS provide a 7 day service that is quick to respond and provides additional aftercare support to patients and their families after placement has occurred.
CHS placement times are under 5 days (average) compared to 18 days national average and so provide a significant bed day saving. Analysis of this is currently underway with Commissioner partners to evaluate the 'return on investment' profile for future commissioning.



7.7 **<u>Exploration of subsidised parking</u>**

As part of the arrangements as a result of CoVid-19 the Trust agreed to remove parking charges for staff and patients. At this point there is no intention to reinstate any changes in the immediate future. Further guidance is awaited nationally. If charges are reinstated we will progress the work planned to reimburse patients who are re-directed or have to wait longer periods of time due to delays in departments.

7.8 **Impact Analysis of Review**

The Council's Corporate Delivery Unit was asked to undertake a brief impact analysis of the review. The findings of this analysis can be found at Appendix X(a). **Please note that this was compiled by council officers and not the NHS representatives in attendance.**

Does the information submitted include any exempt information? No

8.0 List of Appendices

8.1 Appendix 8(a): Impact Analysis of Scrutiny Review

9.0 Legal considerations

9.1 Not applicable

10.0 Human resources considerations

10.1 Not applicable

11.0 Equalities considerations

11.1 Not applicable

12.0 Financial considerations

12.1 No additional comments outside of the above.

13.0 Risk management considerations

13.1 Not applicable

14.0 Ethical considerations

14.1 Not applicable

15.0 Internal/external consultation undertaken

15.1 Not applicable

16.0 Background papers

16.1 Not applicable