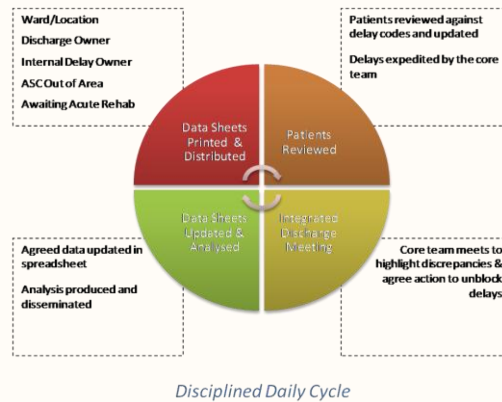
Working Across Boundaries For Patients

Whole System Capacity Through Integrated Discharge Management

The Task

Emotions were running high and nobody was thinking about the client / patient.

- Acute docs were sure the trust was failing because it was full of non-acute patients.
- Community teams believed patients needing long term care were 'dumped' in their beds.
- Social Workers were convinced their time was being wasted with blanket referrals.
- Intermediate Care believed they were holding social care clients at home.
- Continuing Care thought Social Care Commissioners were driving up residential care home costs.
- Social Care teams were worried about cost shunting.



Disciplined Daily Cycle

National Indicator 131 (delayed transfers of care) suggested the problem was tiny but relationships across the system were at an all time low and fines were escalating.

Organising With Purpose

Walking the system with clinicians confirmed that a significant population of people were *waiting* yet were not *recordable* as NI.131 delays.

It also confirmed that very many referrals to Social Care and Continuing Care did not result in Social or Continuing Care outcomes.

It was clear that the front line teams were paralysed by measures and retaliatory practices that had grown up over several years.

Over several evenings, a small team of executives from primary care, secondary care and adult social care agreed an eight point plan to change the way cross boundary care worked.

Central to this accord was the collective recognition that (i) recordable NI.131 delays represented a minority of the people waiting for appropriate care, and (ii) current practices were creating delay and cost for everyone.

The proposed solution was to create a single cross-organisation team with a single purpose – *get all patients to the right point of care fast.*

The plan was put to the Trust Boards and the Health and Social Care Overview and Scrutiny Committee.

Its implementation would be overseen by a Coordination Group with executive representation from each stakeholder.

Agreeing A Process

The 'integrated discharge team' met for the first time on a Monday and thereafter daily.

It included acute trust discharge co-ordinators, Adult Social Care workers, continuing care workers, and input from Therapies and Community Hospitals.

The first meetings were fraught as people struggled with sincerely held positions.

The situation was aggravated because no one had a complete picture of patients waiting; no two organisations' data agreed; and gathering this view was a laborious and frustrating task.

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But once a dependable view was available, the team could agree the principal pathways along which patients were being managed and assign ownership.

What became next however was that guidance offered to both Health and Social Care workers transferring care across boundaries is both ambiguous and contradictory.

Since these rules have funding and target implications, the team could not simply *agree*. It had to clarify process and ownership at every stage.

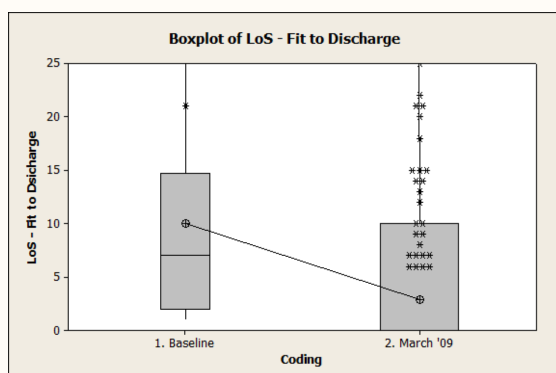
Notwithstanding these issues, it has been possible to:

- maintain a joint view of patients under care
- end the practice of blanket referrals to adult social care and continuing care;
- share wherever possible needs assessments minimising repetition for patients and staff;
- agree an objective basis for declaring NI.131 delays.

Discharge is now a team activity driven by results for patients not arguments.

Measuring Outcomes

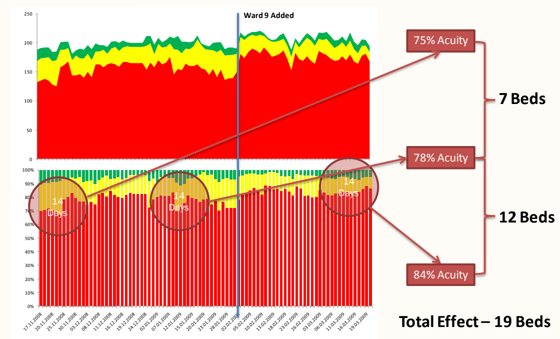
The Integrated Discharge Team reduced the average lead time from medically fit to discharge from an average 10 days to 3 days.



The percentage of acutely unwell patients in the hospital increased from 75% to 84% at one site, and at the second site from 66% to 76%.

This is the equivalent of liberating 39 beds previously occupied by *waiting* patients.

This allowed the Trust to close its escalation capacity in the face of extraordinary demand.



Step Increase in Acuity at Site 1

The Trust then felt able to waive fines so Adult Social Care could buy additional capacity.

There is no question that care is better for patients and that the integrated discharge team members' time is used more effectively.

Almost as a by product, NI.131 reportable delays have been reduced by nearly two thirds.

Why It Worked

The senior team created the space for their teams to focus on patients and supported them with resources as they processed the backlog of waiting patients in the system. They were confident that this was the right thing to do because the information produced by the team show exactly where the pinch points were.

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