Report to: Health Overview & Scrutiny Panel

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Subject: Update on the Accountable Care System (ACS)

1. Purpose of Report

To Provide an update on the Accountable Care System (ACS) - specifically:

- The impact on Delayed Transfers of Care and Patients Medically Fit for Discharge
- The Integrated Discharge Service (IDS)
- Solent NHS Trust Community Services

2. Recommendation

That the Health Overview & Scrutiny Panel notes the content of this report

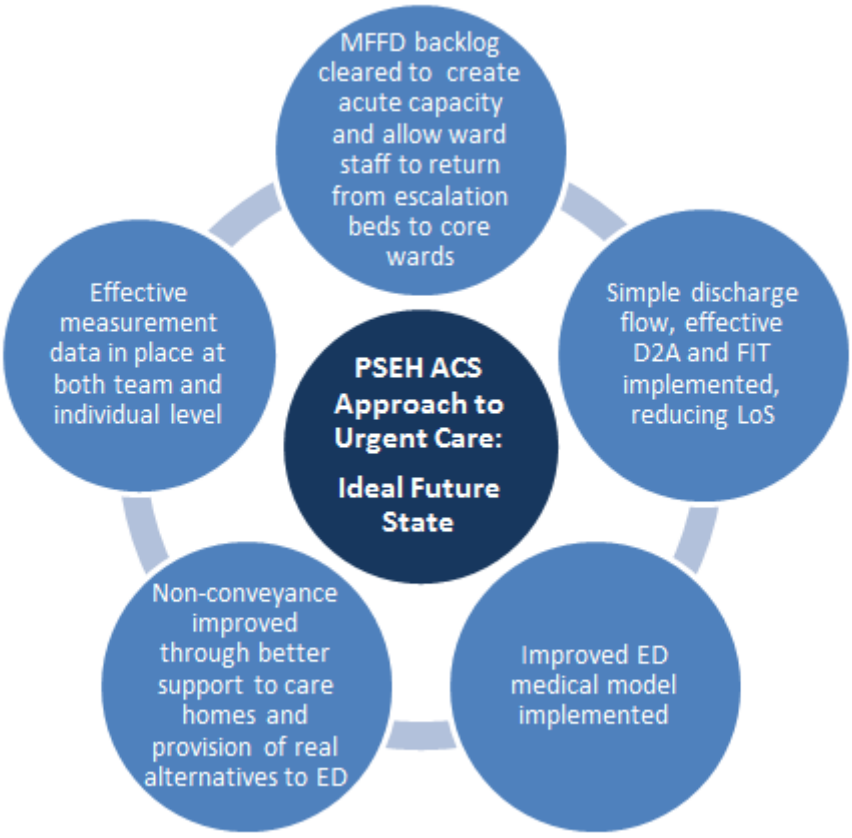
3. The impact on Delayed Transfers of Care and Patients Medically Fit for Discharge

3.1 In June 2017, an initiative to clear the backlog[1] of medically fit for discharge (MFFD) patients at Portsmouth Hospitals NHS Trust (PHT) as one element of the solution to achieve the ideal future state for PSEH urgent care services was agreed.

3.2 The below diagram demonstrates that there are several initiatives that needed to be implemented to achieve the future state. On 05 April 2017, the PSHE ACS Board agreed the first 3 priorities to achieve the ideal future state:

- Clear MFFD backlog-a one off initiative
- SAFER – simple discharge flow- requiring full implementation as 'business as usual'
- New medical model in the emergency department (ED)- requiring full implementation as 'business as usual'

[1] Throughout this report the term 'backlog' is used to describe the demand gap against current business as usual levels.



3.3 The delivery of these three programmes is crucial to achieving flow (particularly MFFD and SAFER) and quality in the emergency department. Our view is that clearance of the MFFD backlog will enable SAFER to be more successfully implemented.

3.4 In addition to the first 3 priority areas, there are other specific areas that will need to be addressed in time. Although these were not seen as the immediate priorities, their implementation is necessary to create the improvements required to be able to manage urgent care demand and flow effectively. Specifically these initiatives are:

- Full implementation of the frailty interface team and Integrated discharge service
- Reducing length of stay through the introduction of a dedicated Frailty Unit.
- Reduction in Care home conveyance to ED
- Reduction in Faller conveyance to ED

3.5 The number of patients at PHT who were declared medically fit for discharge, but who were still in hospital back in June 2017 – the "MFFD backlog[2]" was consistently around 250 patients. This represented over

[2] Taken from 0 days to longest stay medically fit

4000 bed days lost and contributed to clinical harm, likely to have long term impact on the re-ablement potential of individuals.

3.6 Although the IDS and discharge to assess (D2A) models have been in place since September 2016, they have struggled to deliver the expected outputs for various reasons, including:

- Other supporting systems had not been in place e.g. SAFER, Bedview, electronic reporting
- Continual increase in the number of referrals to IDS – due to rising patient complexity or lack of understanding of wards of the IDS role, lack of collaborative working between the wards and IDS – patients are referred with the expectation IDS will take over the discharge completely
- Resources in place are not maximised - inappropriate patients in pathway 2 beds because of hospital status
- The system is used to being in crisis

3.7 Instead of relentlessly focusing on the root cause of delays, there has been too much effort focusing of the problems that are demonstrably not the root cause and expending effort on initiatives that cannot possibly solve the issue.

3.8 Patients declared MFFD do not need to be in an acute bed, but they may require further support in the community. Patients who require further support can be discharged into one of 3 pathways:

- Pathway 1: home with support – for patients whose needs can safely be met at home and who are cognitively/physically safe between visits. Some of these patients will be End of Life (EoL)[3].
- Pathway 2: community rehab bed – for patients who are unable to return home and require further rehabilitation and reablement
- Pathway 3: complex assessment – for patients who are unable to return home, have complex needs and may need Continuing Health Care (CHC). Some of these patients may be EoL, if they are unable to return home to die.

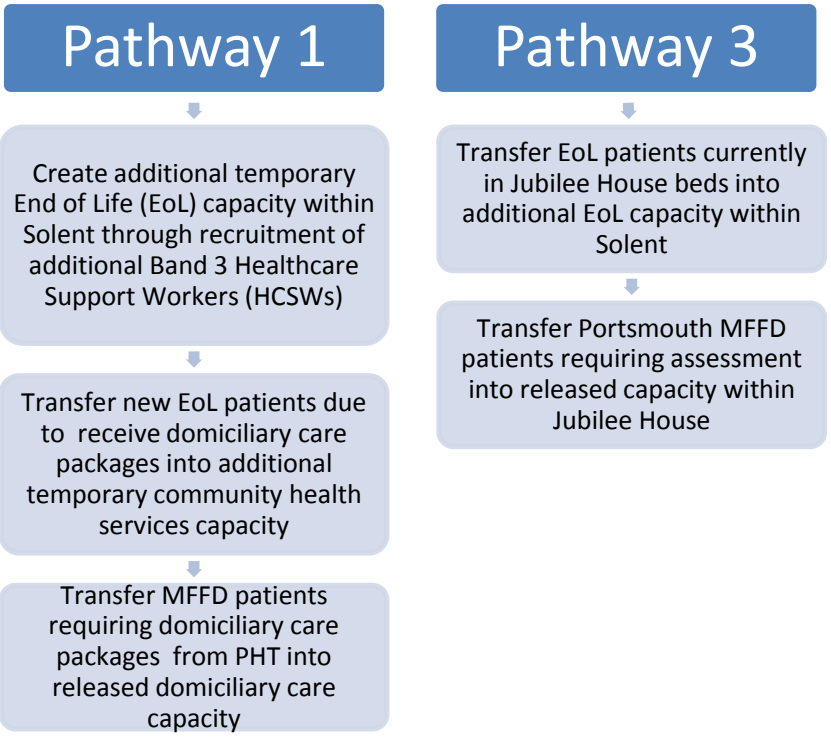
3.9 PHT have identified the optimum length of stay for any patient once medically fit should be no longer than 7 days. Our ambition is to aim for the D2A business case targets. Some MFFD patients at PHT were waiting significantly longer than this, caused by a number of potential reasons:

- Patient is awaiting assessment

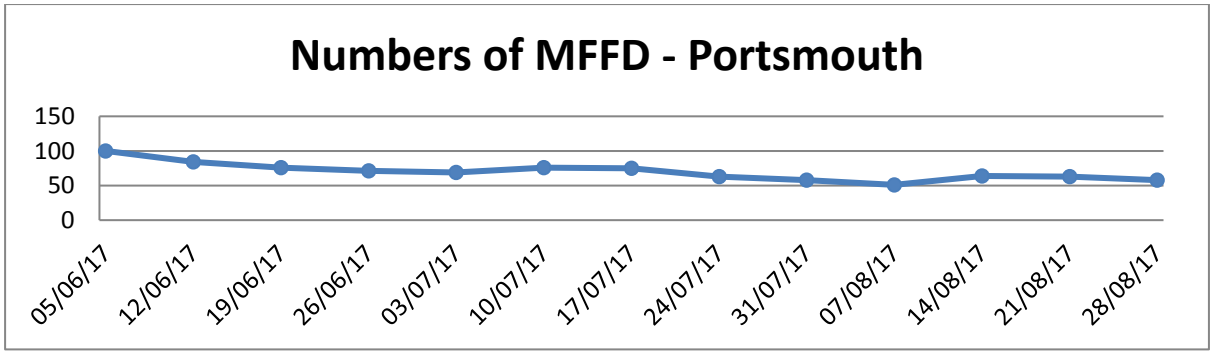
[3] Throughout this report EoL care is determined as patients with a life limiting illness who are in the last stages of life (4-6 weeks) or Fast Track Continuing Healthcare (NHS England – National Framework for Continuing Healthcare).

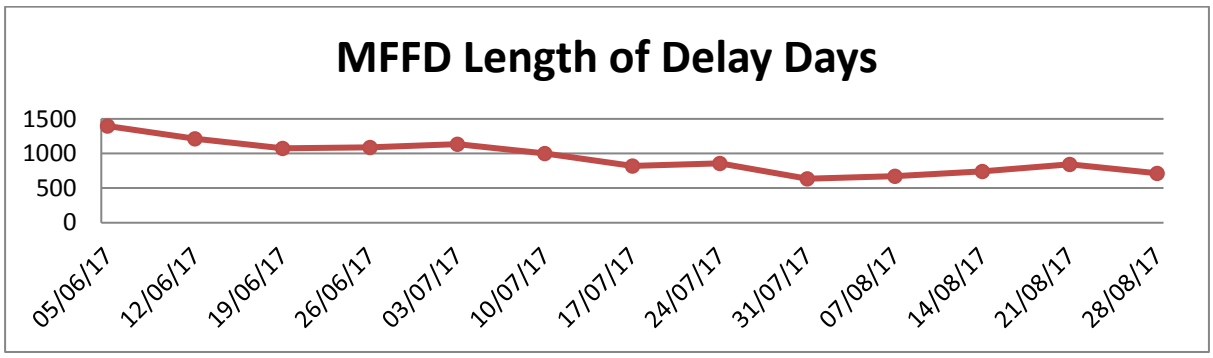
- Patient is awaiting an appropriate care package
- Patient is awaiting a community rehab or complex assessment bed to become available
- Patient is awaiting funding agreement
- Patient is awaiting equipment

3.10 The intention to clear the MFFD backlog at PHT to the agreed level of no one waiting more than 7 days for the Portsmouth system was to create temporary additional capacity outside of hospital (in both pathway 1 and pathway 3). This would be achieved by:



3.11 As can be seen from the below graph and accompanying evaluation presentation, the Portsmouth response to clearing the MFFD backlog has been successful in that it, along with other initiatives, has reduced the length of stay of patients. However, due to the other elements (Safer and New Medical Model) not yet being implemented, the desired outcome to close escalation beds within PHT and to be in a position now to decommission this End of Life service has not been realised.





3.12 The next steps for the additional temporary End of Life (EoL) capacity within Solent is to move resources to the community to prevent admissions to the PHT where possible along with ownership over cases and better interface with the 'front door' services of PHT to ensure patients do not stay in PHT any longer than is absolutely necessary.

4. The Integrated Discharge Service (IDS)

4.1 The Vision

To develop and implement an expert complex discharge team, that works in a seamless and integrated way across partner organisations both health and social care. The Integrated Discharge Service (IDS) will proactively 'pull' and case manage a range of patients with complex discharge needs and progress these patients safely to discharge via an appropriate pathway (usually Discharge to Assess – D2A.)

The model is focussed on the team providing a service to the wards of the Queen Alexandra Hospital (QAH) by providing expertise and advice in the safe and effective discharge of patients with complex discharge needs and acting as an expert to support discharge planning for the wards.

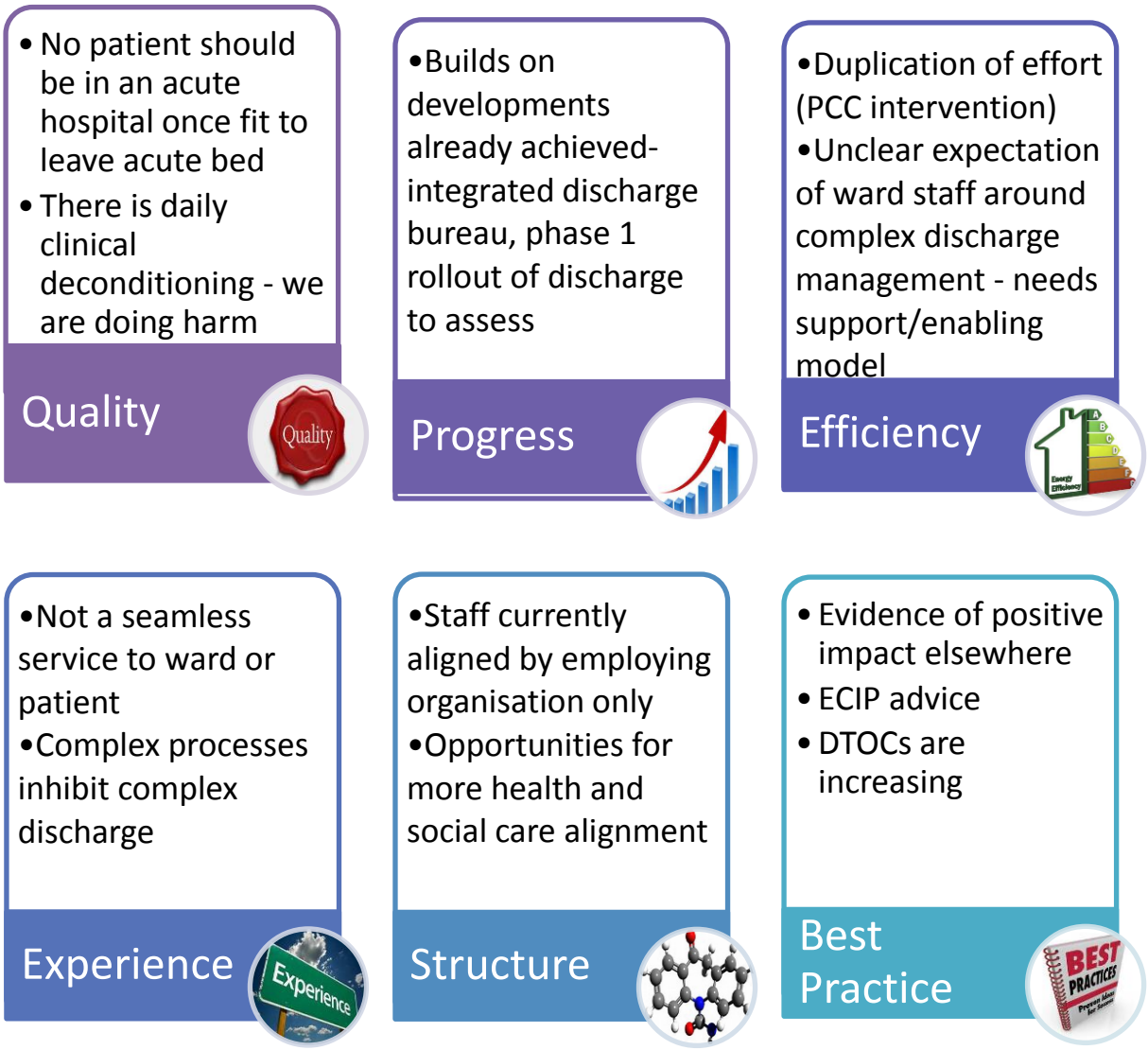
4.2 The Aims

- There is a need to provide a service to support the discharge or transfer of patients with complex needs as soon as they are medically stable to leave the acute hospital.
- There is a system cost benefit in reducing length of stay (saved bed days.)
- Early identification of patents with complex discharge planning needs is essential to ensure potential discharge issues are identified early in the patient pathway, and mitigate the risk of delayed discharge.
- To enable the effective use of discharge to assess pathways and available community capacity.
- To improve the quality of care and patient experience by providing high quality discharge options.
- To provide a consistent level of service, and reduce unnecessary duplication through the use of a trusted assessment model.

4.3 What difference does it make?

- Reduces LOS
- Reduces DTOCs
- Reduces MFFD figure
- We stop doing harm by enabling patients to leave hospital when they should
- Benefits to ED 4 hour target
- Happier staff – what we do adds value and we feel we are making a positive difference to people's lives
- Enables D2A to succeed
- Improves relationships with wards – mutual support and engagement

4.4 **Rationale to support the model**



5 Solent NHS Trust Community Services

The original case for Solent was to implement discharges for the EOL pathway, early indications in the pilot demonstrating that there was not the appropriate case load of patients within acute system to meet the EOL criteria in the business case.

Solent NHS Trust was responsive and developed contingency plans to ensure they could move patients to enable flow through the system.

This required a review of patients delayed in both QAH pathways and community beds. This also enabled the review of EOL cases within community nursing.

The presentation accompanying the report demonstrates flow was created throughout the system both at PHT and Community Services into PRRT. The teams

offering support to EOL care in community nursing from a health and social care perspective benefiting patients.

The ability to mobilise this project was reliant on current teams flexing their criteria and back filling with bank and agency whilst HCSW recruitment induction and training was ongoing.

Trajectories and targets to support the MFFD discharge has been challenging as highlighted within the report.

The key deliverable in this area is to focus on admission avoidance and turn around at the front door.

The original trajectory was based at the back log at that time, with continued increase of patients coming onto the MFFD further work is required to understand the DTOC and MFFD differential with a developing focus on patient safety and continued support in the pathway.

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