Discharge case study
Northumberland Tyne and Wear NHS Foundation Trust

Improving Community and In Patient Transitions of Care in Adult Mental Health Services

Overview

Northumberland Tyne and Wear NHS Foundation Trust is a large Mental Health and Disability provider of inpatient and community services, providing local regional and national specialist services for adults, children and older persons.

In 2013 the Trust undertook a programme of work aimed at facilitating a safe and smooth transition between inpatients and community for adults of working age, suffering with acute mental health concerns. The team introduced a standardised discharge decision making process across all services based on individual patient need, an initiative that also helped to improve patient experience of care.

Elements of the service include:

- A standardised transition of care process.
- Introduction of the role of Community Liaison nurse.
- Integrated ward based discharge planning meetings.
- Improved joint decision making.
- Improved patient experience of care.
- New process algorithms and transitions checklist.
- Collaborative working between hospital and community care teams.

Background

In 2011/12 the Trust became alerted to a number of serious incidents and complaints that related to a lack of consistency and common approach to discharge and transfer arrangements for patients. The Trust is made up of a large number of inpatient and community teams and other provider organisations, all geographically dispersed, presenting logistical difficulties when patients under the care of community teams happened to be admitted to hospital outside their own locality.

The unplanned nature of some discharge planning and transition of patients from inpatients to community based care was considered to be unsafe. It also impacted on timeliness of discharge and length of stay. It was usual practice for the community based Care Coordinator who had oversight and co-ordination responsibility between
services and was familiar with the community setting, to be present at ward based meetings. However as meetings were often organised at short notice, and other patient needs took priority, community input varied hugely.

Due to the increasing number of incident reports and complaints received, the executive medical director championed the review of discharge processes and an improvement project was launched under his direct support, with guidance from clinical governance, under the remit of the Trust safety programme.

Understanding the problem

Between January and April 2013 a series of workshops were held involving multi-disciplinary ward and community based staff, who came together to examine the issues, identify the barriers to a standardised approach.

The teams used a variety of quality improvement tools to examine current pathways of care, and developed solutions to overcome some of the challenges faced. The work was led and championed by both inpatient and community senior managers and clinicians and staff were actively supported by the trust transformation team.

Solutions

From the workshops new processes were designed based on good practice already in place in one hospital site and local community teams. Updated guidance including role descriptors, process algorithms and a transitions checklist were developed to support implementation of the new way of working across all acute MH wards in the Trust.

The joint working group introduced the role of Community Liaison Nurses (CLN), and standardised the scheduling of ward based 72 hour meetings with consistent community involvement, where a planned approach to discharge enables community based plans to agreed, and services or support is put in place in preparation for the patient leaving hospital.

Impact and outcomes

The new process and guidance is now established practice across the Trust, and the CLN is now considered to be an essential role, supported by the trust corporate decision team, resulting in the following:

Patients

- Multi professional clinical decision making provides greater clarity around discharge planning for patients, carers and families.

- Patients and carers have greater involvement in the decision making process.
• Safer transition of care for patients from inpatient to community based care setting.

**Whole system**

• Community staff assurance that input to decision making is meaningful and relevant.

• A reduction in transition arrangements being identified as an issue in serious incident investigations.

• Consistent attendance at 72 hour and discharge planning meetings, evidenced through audit.

• Timely discharge, reducing the number of extended lengths of stay or delays.

• Case note audit December 2014 revealed 100% of patients discharged in the previous 3 months had a discharge planning meeting prior to discharge with joint review of care plan and risk assessment, improving the quality, relevance and accuracy of documentation and discharge certainty of arrangements.

• The dedicated function of Community Liaison nurses has been identified by all involved as positive and supportive to the patient journey.

The aim of the improvement was to improve clinical care and had no direct impact on cost.

**Top tips**

• Commit to working outside organisational boundaries, look at the whole patient and adopt a collaborative approach across services.

• Think creatively – consider redesigning and creating new roles as with the Community Liaison nurses.

• Think carefully about stakeholders and engage them from the start.

• Bring multi-disciplinary, multi-agency teams together to explore the issues and challenges faced, to gain a common understanding of the pathway and respective concerns before moving to solutions.

• Have someone taking a lead, championing and managing the project and able to keep pace and focus and make timely decisions.

• Don’t be afraid to go with a critical mass, you may not have everyone on board at the start.
Evaluation

The process was positively evaluated via audit 6 months post implementation. The quality of discharge planning remains an integral part of the annual records audit cycle, and the work is monitored via trust board and through the CCG.

Further quality improvements and spread

This improvement was based on 1 locality’s area of good practice and has been implemented across all adult mental health wards. It is now being implemented on the older people’s wards. There are plans in place to explore the role of the community crisis team discharge facilitators – nurses who focus short stay admission to ensure roles are not duplicated.

As other quality improvement initiative come on line, such as Principle Community Pathways and a new bed management service, the impact on Community and Inpatient Transitions of Care process is being assessed, and continuously improved.

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Themes

- Discharge Liaison Service
- Systems that involve patients in their care