Discharge Case Study
University Hospitals Birmingham NHS Foundation Trust

Queen Elizabeth Hospital Birmingham introduces a Complex Discharge Team

Overview

Queen Elizabeth Hospital Birmingham has 1,400 inpatient beds, 32 operating theatres and a 100-bed critical care unit, the largest co-located critical care unit in the world. QEHB is host to the Royal Centre for Defence Medicine (RCDM) and is world-renowned for its pioneering surgical techniques in the management of ballistic and blast injuries.

QEHB has been designated both a Level 1 trauma centre and host of the UK's first and only National Institute for Health Research (NIHR) Centre for Surgical Reconstruction and Microbiology.

In order to improve the efficiency, capacity and flow of patients through the whole hospital system, a team put their efforts into improving processes for patients for whom discharge was considered to be complex.

At a Glance:

- Improve the quality of patient care and discharge.
- Enhance communications relating to discharge.
- Improve collaborative working practices as social services and complex discharge nurses work to ensure minimal delays in discharge planning and transfer of care
- Streamline the management of patients referred for further social or health assessment at discharge.
- Improve efficiency, demand, capacity and flow across patient pathway

Background

Focus had traditionally been on the 'front' door pathway, elective and emergency admissions with very little work carried out to improve process and pathways around patient complex discharges.

To improve efficiency of the front door flow it was vital that discharge became a focus within the Trust. Scoping was carried out in September 2014 and a 'task and finish' group was formed to look at systems and processes from referral and assessment through to discharge for health and social care

Findings indicated:

- Delays in assessment by discharge liaison nurses due to size of team, number and appropriateness of referrals

- The referral process to social care using the section 2 and 5 process required improvement specifically related to the timing of the referral and allocation of a case worker

To address the issues raised the health and social care team joined forces and formed a complex discharge team, working together to redesign and improve the referral and assessment process for patients with ongoing care needs.

Solutions

A pilot was launched in June 2015 bringing together social and health care workers into one team introducing changes to the process that included:

- Co-location of social and healthcare workers in a discharge hub.
- A single transfer of care referral (TOC) form for both social and health assessment which included the CHC checklist and Section 2 referral.
- TOC form to be submitted 72 hours prior to patient being medically fit for discharge.
- Triage of referrals received into the discharge hub identifying assessment type as 'social', 'health' or 'both'.
- All 'social care' assessments undergo a further triage for allocation; 'standard' assessments allocated to and a care facilitator and 'complex' assessments allocated to a social worker.
- Combined assessments where patients require assessment by both a social and health worker.
- Development of a discharge hub management system (DHMS) to track pathways against all referrals made into the discharge hub.
- Daily board rounds with representation from health and social services; patients with an active TOC are discussed the senior practitioner for delivery for enhanced assessment bed (EAB) 3 times a week.
- Daily tracking with out of Birmingham local authorities re. case management of their patients within the QEHB, which equates to approximately 20% of patients on the DHMS system at any one time.
- Development of an executive director discharge board who have the ability to meet weekly to discuss any complex discharge delays or concerns.
- Recruitment of a further 3 complex discharge nurses to the pre-existing team.
- Demand and capacity modelling identified a shortfall in social work capacity. This has been addressed on an interim basis.

Impact and Outcomes

- Since introduction in June 2015 the team has seen a 58% reduction in delays to transfer of care (DTOC) this equates to 5,086 delayed beds days for 6 months up to November 2015 in comparison with 12,279 delayed bed days for the same period in 2014.
- Reduction from a wait to be seen by the Complex Discharge Nursing team from 14-21 days down to 2 days.

- A clear understanding of the demand, the number of referrals, discharges, rejection of referrals per week to the team which in turn allows and supports further work force planning.
- Timely allocation of case worker (health and social) to patient for assessment.

Patients

- Timely, safe and appropriate discharges to the most appropriate location.
- A coordinated approach from both social and health in the assessment process for complex discharges

Whole System

- Improved working relationship with complex social and health care workers and inpatient clinical ward teams
- DHMS – allows a clear understanding of true demand on this team especially supporting daily case management allocation and the patient pathway.

Further Quality Improvement and Spread

- The next 6 months will focus on the review and evaluation of new processes
- A regional launch in conjunction with Acute Trusts and CCG of the newly approved 'Bed Utilisation Policy' in November 2015.
- Further scoping around the 'Flow' coordinators role and need within a complex discharge team
- Ongoing work with Birmingham city council regarding work force requirement for a hospital team using the data available from the DHMS.
- Explore potential to replicate this approach at a system wide level for spread and adoption by other settings

Top Tips

- Work in conjunction with the local authority or key partners
- As soon as possible understand demand of the number of referrals made to the team and track detail weekly relating to this. Data vital for work force planning
- Engage and communicate with clinical and social care workers as early as possible
- Secure executive support for your change principles and ideas so they become a reality

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Themes

- Discharge Liaison Service
- **Policies and systems that link health and Social Care**
- Systems that ensure provision of high quality information