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Combined Patient Flow Review Projects

September 2015

Barnsley NHS Foundation Trust and
NHS Barnsley CCG

Results and Action Recommendations

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Project Objectives

All patients in acute care beds were reviewed against Medworxx Utilisation Management Clinical admission/continued stay/discharge criteria.

Focus: Could an *alternative level of care (ALC)* setting have met the patients' needs?

Focus: Which ALC care setting might have prevented the admission or reduced the patient's length of stay? Are such ALC beds or home care capabilities in existence, available?

Focus: Assess the efficacy and efficiency of current admission avoidance, in-patient care coordination and discharge planning programmes

Focus: What strategic change is required to develop a smooth patient journey and "vertically integrated" care network?"

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Summary Findings

- Small number of ‘Avoidable Admissions’ patients at BHNFT
- No ‘Avoidable Admissions’ in Community Hospitals or Intermediate Care Beds
- 30% patients at BHNFT - ‘Ready for Discharge’
- No ‘Ready for Discharge’ patients at Kendray Hospital but some at Mount Vernon and in IC Beds

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Recommended Actions

Barnsley NHS Foundation Trust, Barnsley CCG and Community Services

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Critical Element - NOW

I. Take these **IMMEDIATE ACTIONS** whilst following through on 3 Critical Elements

a) Strengthen and improve the Step-up Care schemes

b) Fully develop and implement the Virtual Ward programme

c) Broaden the access criteria to Intermediate Care Rehabilitation Beds to accept patients with underlying medical conditions

d) Increase the number of Sub-acute Care beds at Mt Vernon and Kendray CH to at least 10 beds

e) Shorten the length of stay and home visits @ each LOC

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Critical Element Number One

1. Initiate an Organisational Development (OD) Programme to engage systemic, community-wide culture change to support
   a) Reduced length of stay in acute and community hospitals
   b) Reduced home visits of nursing and therapy
   c) Accountability for over-use or under-use of health care resources

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Critical Element Number Two

2. Implement the UM Infrastructure
   a) Community-wide UM Steering Group
   b) Agree clinical, evidence based admission and discharge CUR criteria for each level of care, criteria that are adhered to *(NHS England CUR CQUIN Standard ...a standard that supports the use of Medworxx UMS)*
   c) Review every patient, every day (Case Manager review and at Bullet Rounds)
   d) Establish EDD programme for every patient in acute and step-down care including home visits, an EDD based on the clinical condition of each patient factored by tariff

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Critical Element Number Two

2. Implement the UM Infrastructure
   d. Example: EDD based on the clinical condition a patient with COPD w/o intubation, with co-morbid condition(s) using Medworxx UMS criteria
      1. Clinical Condition for Discharge:
         a) Values normal or can be managed in community;
      2. PBR Tariff: £2,718 = pays for 5 days of acute care
      3. EDD: Target: Day 3 or 4
      4. Plan for Discharge documented within 24 hours of admission: 78 year old patient w/Type 2 Diabetes and Heart Failure. Plan for discharge home with Hospital at Home support. Refer to H@H Team now for assessment and discharge planning

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Critical Element Number Two (cont.)

2. Implement UM Infrastructure (cont.)

d) 'Pull' system for step-down care access

e) Refer LTC management candidates at every access point (clinic, A&E, wards, etc.) to the LTC Management Team

f) Transfer hospice and respite care candidates before or early in the acute or community hospital stay to the most appropriate care setting

g) Determine the appropriate staffing level and shift cover for the Case Managers and members of the Admission Avoidance Teams (RRT, H@H, Frailty Team, etc.)

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Critical Element Number Three

3. Take Action(s) based on UM Data and UM Review Findings

a) Quantify the needed amount of step-down beds and community services using Medworxx UMS and other data sources

b) Monitor UM Performance by Speciality/Service Line; Clinical Directorate; Ward, etc. holding each party accountable for over-utilisation or under-utilisation

c) Overcome patient flow barriers

d) Community-wide UM Steering Group will report monthly on UM actions to their respective Boards

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Levels of Care: The Vision

Level of Care	Care Capabilities	Staff	Diagnostics	LOS Range Target LOS
1.Acute care	•Clinical observation /intervention •Medication management •Oxygen, IVs, monitors • ICU/CCU/HDU •Theatre	•Consultants, SHOs, etc 24/7 •Nurses providing skilled care every 4 hours •Therapists and other AHP	•Yes, on-site •24/7 access	•Range: 1-7 days or visits •Target: 5 days or visits
2.Complex Continuing Care *(aka Virtual Ward)* Can be provided in 24 hr facility or by Hospital @ Home	•Clinical observation •Medication management •Oxygen, IVs	•GP or Consultant, daily rounds •Nurses provide skilled care every 6 hours •Patient too ill for PT/OT	•Yes, either on-site or accessible on demand 24/7	•Range: 5-15 days or visits •Target: 10 days or visits
3. Rehabilitative Care (high intensity) Can be provided in 24 hr facility or Hospital @ Home service	•Clinical observation •Medication monitoring •Pt motivated to participate in aggressive therapy	•GP or Consultant, rounds every 48 hours •Nurse provide skilled care every 8 hr •P/O/S TH up to 3hr per day/6d/wk	•Not available on site •Pt or specimen transported to site for diagnostics	•Range: 5-30 days or visits •Target: 15 days or visits
4.Therapist led rehabilitation care (slow stream) Can be provided in bedded facility or through home based	•Patient must be motivated and able to participate in slow stream therapy programme	•Physical/occupational/ speech therapy 1 hr per day, up to 4 days per week •Low nurse cover	•Not available on site •Pt or specimen transported to site for diagnostics	•Range: 4-45 days or visits •Target: 20 days or visits