

There's No Place Like Home

Improving Discharge Rates for No Criteria to Reside (NCTR) Patients

"Their way of working was pragmatic and grounded. Consortium24 were fearless in getting stuck in with a refreshing, grassroots approach."

– Executive Leads, Brighton & Sussex

Background

To many people, a hospital visit is a sign that something has gone wrong with their health. While many steps have been taken to improve individuals' experiences as patients, hospitals remain busy and unfamiliar environments.

Aside from hospital procedures necessary to stabilise conditions and kickstart recovery, the best place for people to recover from time in hospital is in the place they call home. Getting back to familiar environments, consistency and peace is vital for them to recover and regain as much independence as they can.

We were one of 7 firms selected by the Better Care Fund as part of their Support Programme to support discharge flow in healthcare systems across the UK. Particularly focusing on No Criteria to Reside (NCTR) discharges across Brighton and Sussex, our aim was to locate the root cause of delayed NCTR discharges – the 'blockage' in the pipe. Together with frontline colleagues from wards to finance to domiciliary care, we developed evidence-backed methods of shortening people's unnecessary stays in hospital, ensuring that they can return to the place they call home.

Mapping Out the Patient Journey

Over two visits to Brighton, we spent six days following the end-to-end patient journey from front-door admission to discharge from hospital to being settled back at home, specifically focusing on the Pathway One discharge flow through supported discharge scheme Home First. We spoke with frontline colleagues as they worked to take a detailed record of not only the patient journey but the IT systems, recorded data, and responsibility handover at each stage of the patient journey.

Through this mapping work, we saw that documentation had become fragmented over time, due to the nature of multiple trusts, teams and organisations working to support support of the same cohort of people. This simplified how information was recorded and shared, reducing the need to duplicate sensitive data while giving colleagues across the pathway greater clarity and consistency. For staff ranging from healthcare assistants to senior nurses, this step offered the potential to save valuable time on administrative tasks, allowing them to spend more time caring for and supporting individuals at home.

One Team with One Purpose

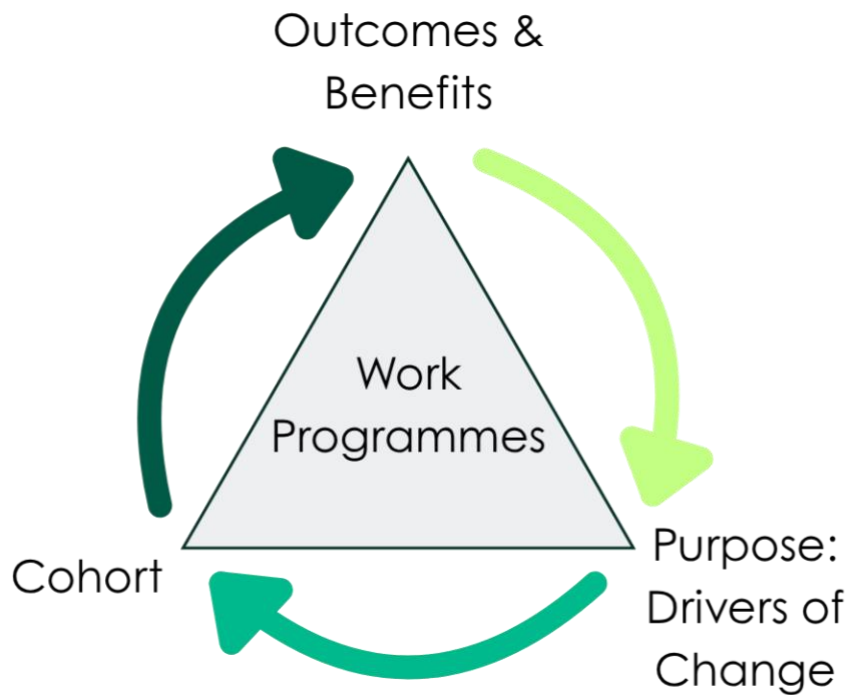
After these discovery visits, we brought together frontline colleagues from all seven functions supporting people discharged under Pathway One to reflect what they had shared with us.

These face-to-face workshops were the first time that many colleagues had met in person. This created one team with one common cohort: individuals leaving hospital and receiving some support while they get settled back at the place they call home.

The first milestone of the workshops was establishing a shared sense of purpose and, in turn, a shared sense of working as one team. This facilitated a co-designed 'one team with one purpose' model for Pathway One discharges across the system.

This model enables people to return home once they have reached NCTR in hospital, as safely and as early as possible, where they will receive the appropriate level and duration of support from community-based teams depending on their requirements. It features seven cornerstones underpinning its core objectives:

- An agreed purpose,
 - For one cohort,
 - Using one resource pool,
 - Building up a picture of information, and
 - Operating as one team.
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- To take the best actions in the most effective way that best support individuals as they leave hospital, and
 - To track changes in KPIs and outcomes, continually driving to improve outcomes.



This new co-designed model takes a 'one team with one purpose' attitude with a single unified dataset at its forefront.

*"We see now that we are one team, with a shared goal for our patients."
– Supervisor, Pathway One, Brighton and Hove*

Field Testing

With this newly co-designed operating model, we worked on site operating a 'test and learn' approach. Frontline colleagues from across the teams could start to get used to the new approach, and newly visible 'single version of the truth' of patients' records, while we observed outcomes and learned from frictions in the model.

Field testing confirmed that information availability and sharing as well as communications materially improved under this 'one team' approach, and showed improvements in flow and outcomes.

What we tested

Using assessments earlier in the process to:

- Improve understanding of patients' needs
- Reduce 'reassessment' time

The visibility of GP Connect and Discharge Summary in Home First to:

- Improve understanding of patients' needs
- Reduce 'reassessment' time

Placing increased focus on hospital 'green light' indicators (discharge summary, transport booked, TTO Meds ready, next of kin arrangement, family communication)

The impact

Richer insight from earlier assessment improves understanding and has potential to remove duplication

Material benefit of using Home First and hospital assessments reported by front-line colleagues, especially for MAR charts

Manual intervention helped 'catch' some missed indicators

Key Takeaways

- Using a 'hands-on' approach for system mapping

There is no substitute for a solid 'on the ground' workflow and bringing folks together when the work is so intrinsically tied with those carrying out the work, regardless of sector. Together, we gained complete clarity of roles and purposes, discharge flow, communication and communication breakdown, information sharing and blocking, and IT systems – much of which would have been inaccessible without speaking with them in person.

- Frontline colleagues have a seat at the table

It was clear how much colleagues from across the system valued co-creating the new Pathway One Discharge operating model; they did the work, the work was not 'done to them.' The joint ownership they felt over the model only supported their eagerness for closer collaboration with each other. Without this approach, the new model would have missed such rich insight that we only received from these colleagues' openness to change their day-to-day workflows to drastically change the impacts and outcomes of people leaving hospital.

- 'Test-and-learn' before delivering the final product

Observing how the co-designed model worked in real time, with colleagues picking up the phone after having data readily available for their care calls, was instrumental in presenting a final operating model that embeds seamlessly into teams' work.

*“We have known this for a long time, but Consortium24
has helped us expedite these changes.”*
– Senior Responsible Officer, Pathway One, Brighton and Hove

*Interested in how you can improve your team’s workflows? Get in touch with Managing Partner, Alex
Robertson, to see how we can work with you.*