



Transfer of Care Hub: Discharge Story

January to December 2023

Introduction

WUTH are committed to a journey of flow continuous improvement. The Hospital Wide Flow programme launched in April 2023, is aimed to support in treating the **right patient, in the right place, at the right time**. This programme of work focusses upon improving internal processes and working with system partners to ensure a joined-up approach to safe, timely patient discharge.

Significant sustained reduction in the number of non-criteria to reside (NCTR) patients residing in acute hospital beds is multifactorial. The establishment of the Transfer of Care Hub has been the primary driver to this achievement. Our WUTH discharge story is outlined within this document:

- Hospital Wide Flow Scope and Governance
- Transfer of Care Hub
- Outcomes
- System Partner Feedback
- Summary and Benefits

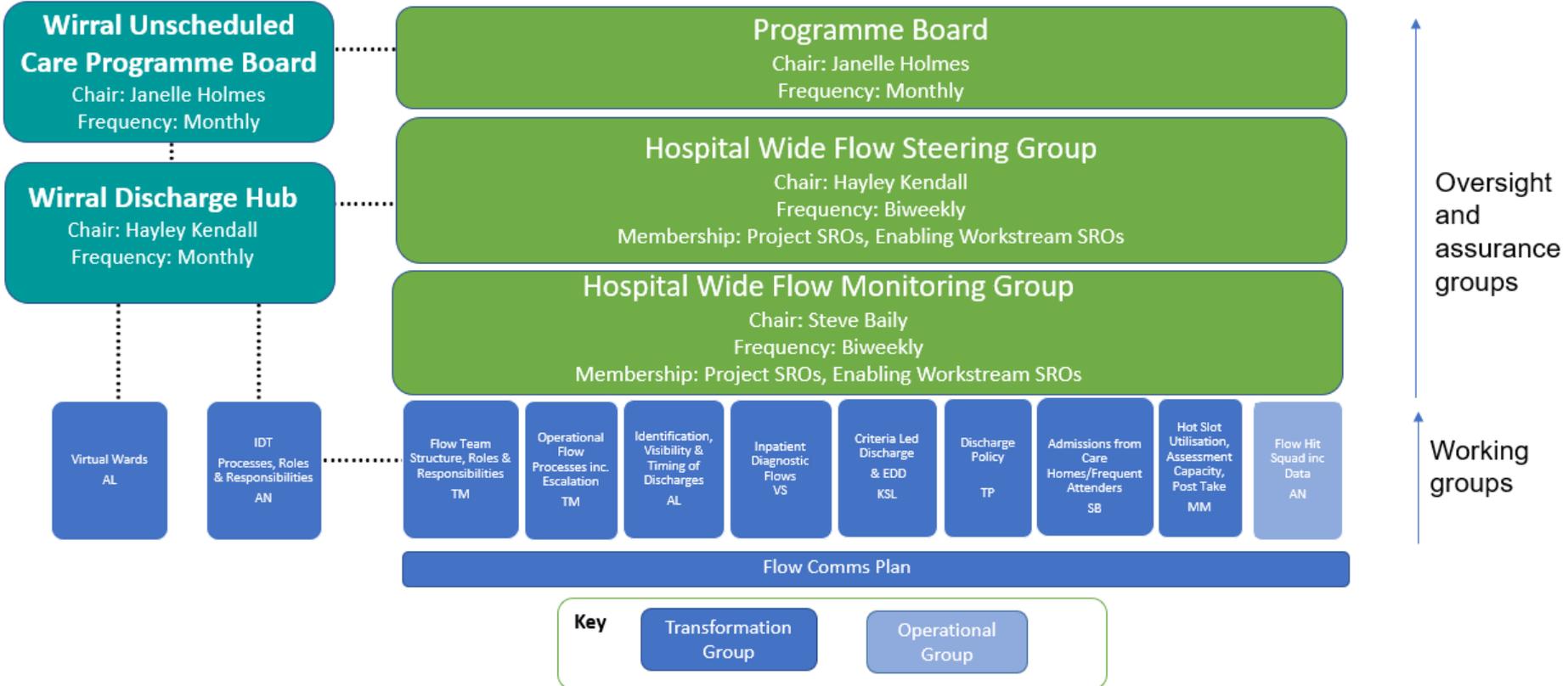
**Hayley Kendall,
Chief Operating Officer**

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Background

Hospital Wide Flow Programme Scope and Governance Structure
Launched April 2023

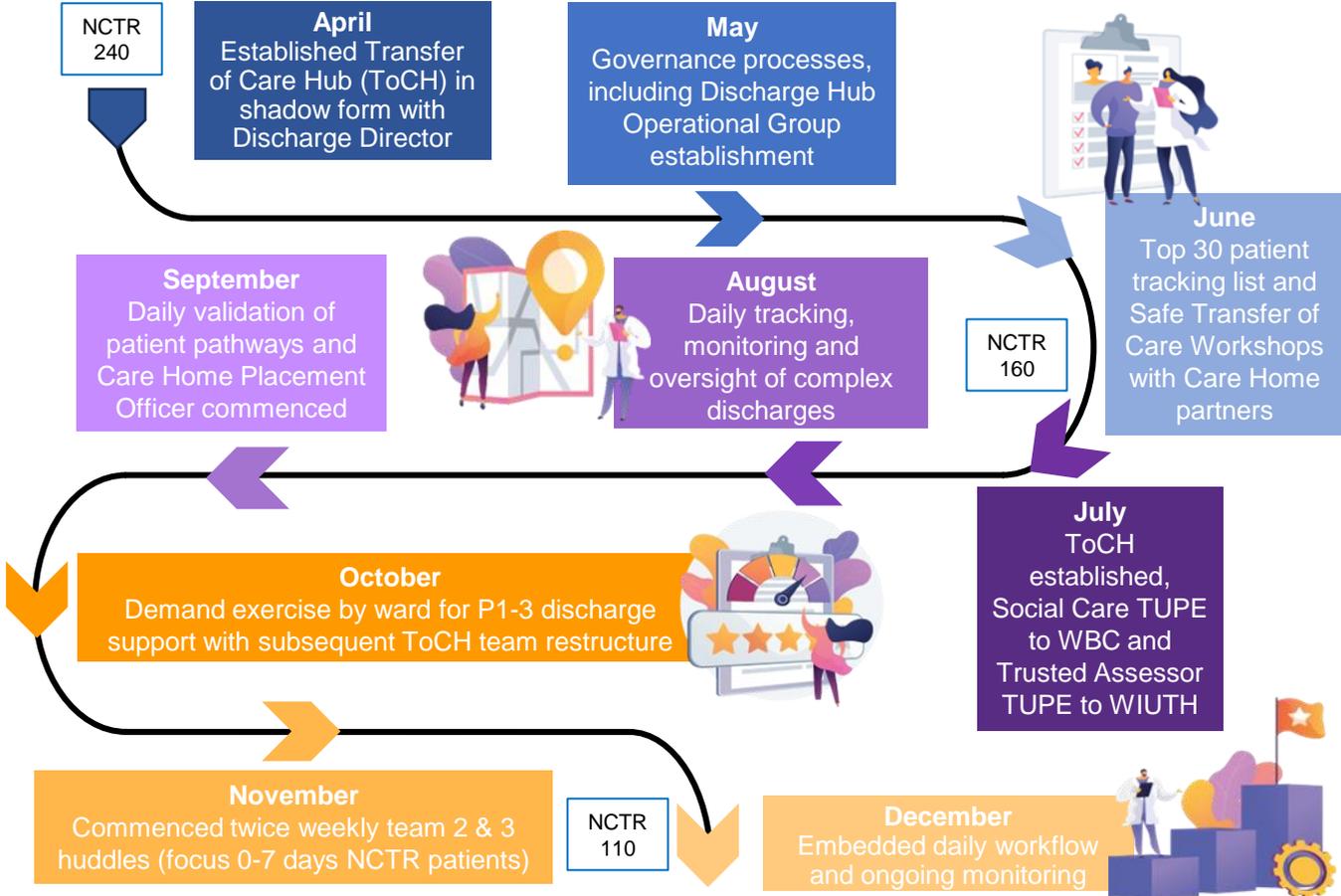




Transfer of Care Hub

Transfer of Care Hub

Timeline Overview of Improvement, 2023/24



Enablers

- Leadership within ToCH
- Enhanced system oversight and collaboration
- Robust processes for patient tracking

Key: Q1 Q2 Q3

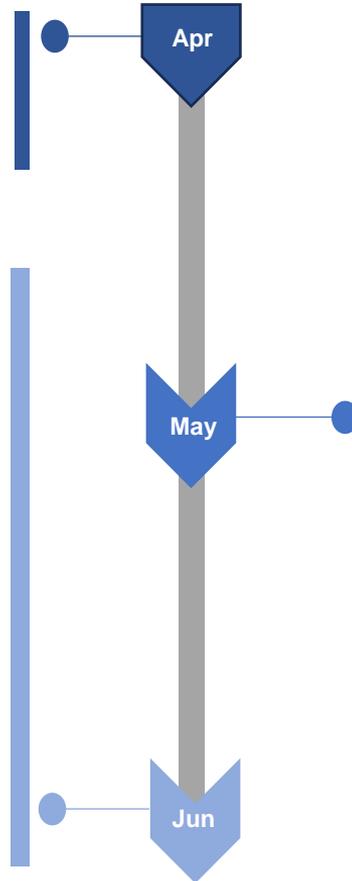
Transfer of Care Hub

Deep Dive into Timeline of Improvement, Q1 2023/24

- **Shadow Hub took ownership of the Top 30 progress chasing and discharge tracking**

- Escalation process for Domiciliary Care circulating > 24 hours agreed
- Established Hub transition 9-week plan

- Social work team commenced using 3 conversation model (reduced reliance on assessment paperwork)
- Commenced twice weekly Hub 'Top 30' review meetings (Tuesday/Thursday)
- Teams Top 30 tracking list
- Inaugural WUTH/ Care Homes Safe Transfer of Care workshops commenced
- Commenced dialogue with Wirral Housing Options on homeless pathway
- Discharge Cell meeting discussion now consider the top delays in WUTH; Home First & CICC
- Standard Operating Procedure for Wirral Discharge (ToCH) being drafted with key partners
- Ensured access to Teams; NHS Mail; Cerner for those TUPE who require it (supported by DPIA)
- Hub Director joined Care Market oversight group meeting



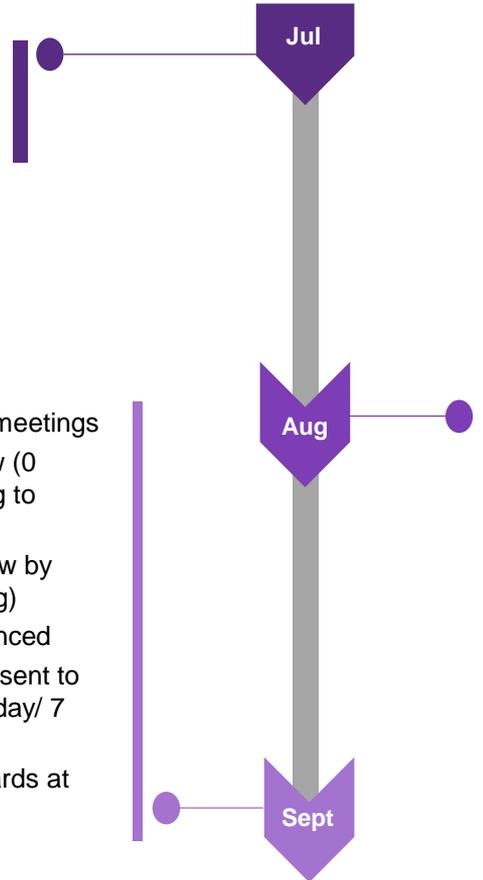
- Shadow Hub took ownership of the Top 30 reporting
- Commenced development of weekly no C2R & Discharge data pack
- Hub Team Leads meetings established
- Scope key daily workflow processes to enable timely discharge
- Discharge Hub Operational Group established (Chair Deputy COO)
- Discharge Trackers attend afternoon ward huddles
- Weekly whole Hub Team catch ups commenced
- Introduced SToC document concept (remove N2A/Ds)
- Commenced Professionals meetings for very complex discharges
- Commenced point prevalence meetings to expedite P1/2 discharges

Transfer of Care Hub

Deep Dive into Timeline of Improvement, Q2, 2023/24

- **ToCH established**
- Social Care Team TUPE to WBC
- Trusted Assessor TUPE to WUTH

- Established weekly ToCH team leads meetings
- Commenced daily validation of the new (0 days) no C2R patients and sign posting to pathways
- Hub leads modelled daily discharge flow by pathway required (reducing the backlog)
- Care Home Placement Officer commenced
- Complex discharge Checklist initiated: sent to Wards, Flow Team, DHC four times a day/ 7 days a week
- Collaborated with intermediate care wards at CBH to improve model of transfer

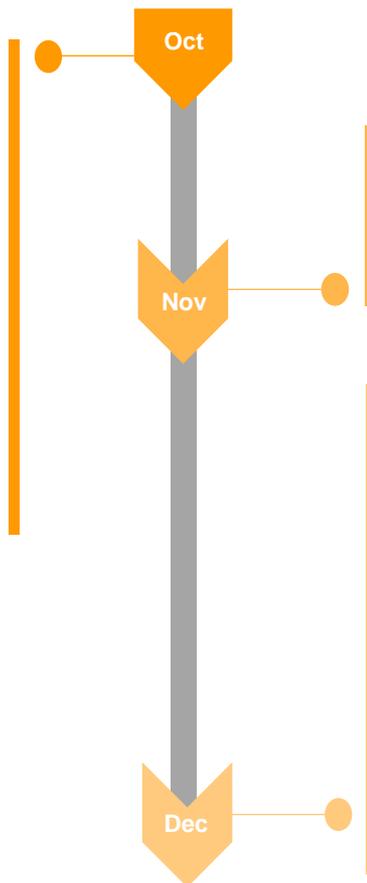


- Engaged Organisational Development team to support Team Leads development
- Business Support Manager commenced in role
- Discharge list: to track daily complex discharges, delay and cancellations, wait list for D2A, HomeFirst, Age UK activity, out of area patients and community readmissions
- Tracker for weekly discharge outcomes, so monitor actual discharges by pathway & by service
- Hub Daily workflow tracker to support command meetings

Transfer of Care Hub

Deep Dive into Timeline of Improvement, Q3, 2023/24

- Hub Team Leads Development Day
- Undertook demand exercise by ward for P1-3 discharge support to understand Hub structure required
- Established Hub Teams 1, 2, 3 supporting agreed wards
- Major Hub 'dump the junk' exercise over four weeks
- Created space to store incontinence products to use when discharging patients to Care Homes
- First Domiciliary Care WUTH event
- Hub monthly Quality Board established and first meeting
- Daily Team 1-3 no C2R list circulated within Hub
- Project group established to focus on complex discharge pathways including Delirium, Non-weight-bearing, Bariatric and Homelessness



- ToCH teams moved to co-locate as 'Teams'
- WBC Hub service manager appointed on secondment basis
- Commenced twice weekly team 2&3 huddles (focus 0-7 days no C2R patients)
- Scoped hub refurbishment (co-locate Nurse & professional leads, Trusted Assessors & Care Home Placement Officer)
- Team huddles commenced Tuesdays and Thursdays to review and validate no C2R patients 0-7 days
- TTH tracker visibility within ToCH
- TV screens located for Team 'command' working, computers, keyboards/mouse ordered
- Age UK SPA 'go live' 4/12 to give enhanced support for people going home and link wider VCSEF organisations
- Embedded daily workflow and ongoing monitoring
- Sent Questionnaire to Care Homes to ascertain feedback on improvements
- National Pilot site for adopting the new NCTR coding model with DHSC.

Transfer of Care Hub

Summary and Next Steps

- WUTH have proactively undertaken a significant amount of work in the first three quarters of 2023/24 to ensure the **right patient, is treated in the right place, at the right time.**
- This has included: the establishment of the ToCH, embedded leadership, refinement of processes to ensure robust patient oversight and tracking, commitment to collaborative and partnership working.
- Outcomes are reflected in Section 3.
- WUTH ambition is to continue this work to further drive down the number of NCTR patients residing in acute hospital beds and reduce the length of stay for this patient group further.
- Therefore, an overview of ongoing work is outlined to the right.



Q4

- NCTR and status capture (via Cerner)
- Safe Transfer of Care document – agreed at CDDA 18/1/24 as priority
- Therapists joining twice weekly Team 2 and 3 huddles. Team 1 huddles to commence 22/1/24
- B6 Discharge Coordinators/Social Work Development Programme
- Commenced workflow admin development (embed workflow and reporting responsibilities)
- Age UK target wards 21, 22 and 31
- Establish Care Home discharge ‘wellness’ calls
- Maximise Age UK going home service for HomeFirst discharges
- MCA training for Discharge Coordinators
- SNOPSs to collocate with Hub Team - complete
- Delirium pathway workshop – recovery in community
- Bariatric pathway through acute and rehabilitation
- Second Trusted Assessor and WCB Professional Lead due to commence in March 2024
- Department of Health and Social Care visit March 2024



NHS

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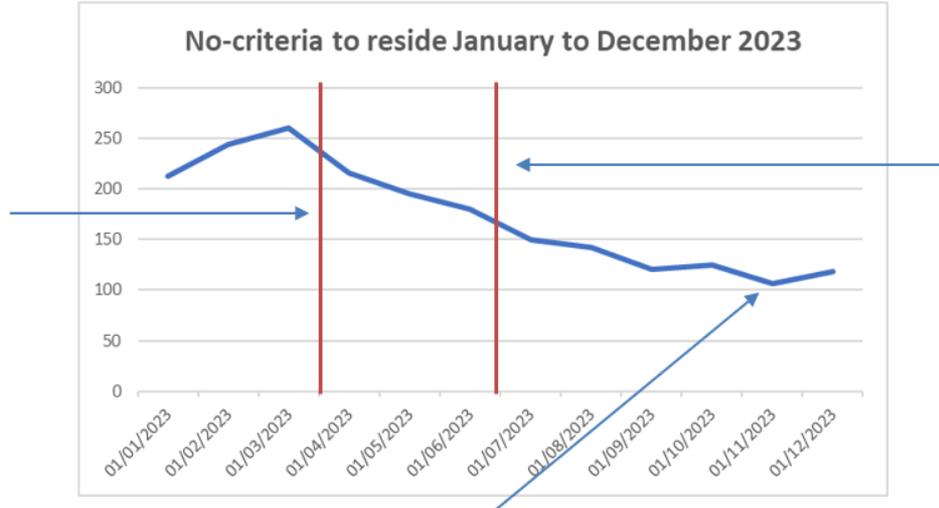
Outcomes

together
we will

...deliver the best quality and safest
care to the communities we serve

NCTR Position

- WUTH established Transfer of Care Hub in shadow form with Discharge Director.
- Executive Discharge Cell commenced.
- Focus on improved pathways and processes and escalations.
- Visibility of data and where delays were occurring.



100 no-criteria to reside patients achieved from 260 at its highest point

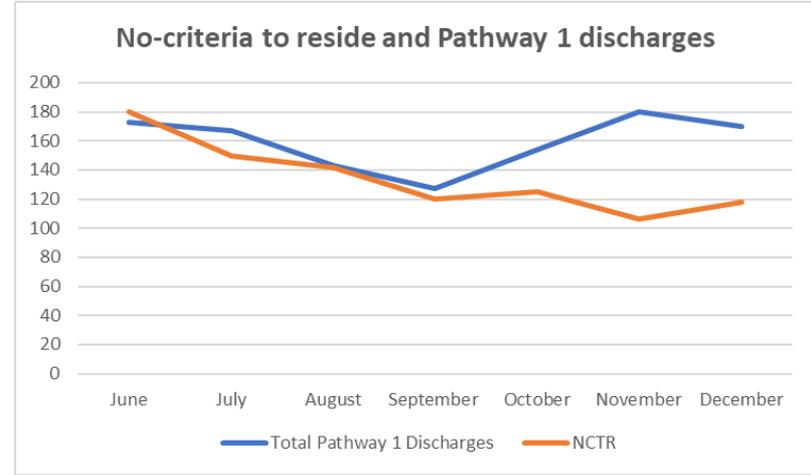
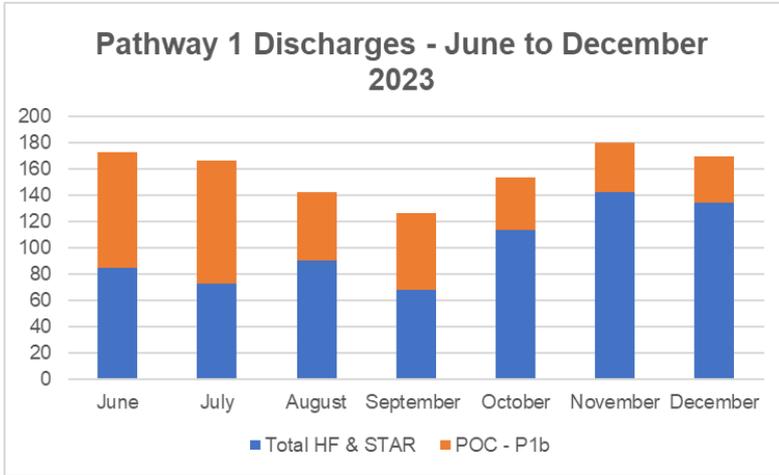
- Formal establishment of the Transfer of Care Hub at WUTH.
- Social workers transfer back to LA and come under single WUTH leadership structure in collaboration with LA.
- New reporting arrangements introduced.
- Reduced transactional hand offs between organisations.

Pathway 1 Discharges

		June	July	August	September	October	November	December
		full month						
Discharge Service								
Home First	P1a	55	33	42	50	100	141	118
Homefirst - Hybrid	P1a	*	*	*	*	*	*	17
STAR	P1a	30	23	18	11	14	2	0
STAR HomeFirst HCA	P1a	0	17	31	7	0	0	0
Total HF & STAR		85	73	91	68	114	143	135
POC	P1b	88	94	52	59	40	37	35
Overall P1 total		173	167	143	127	154	180	170

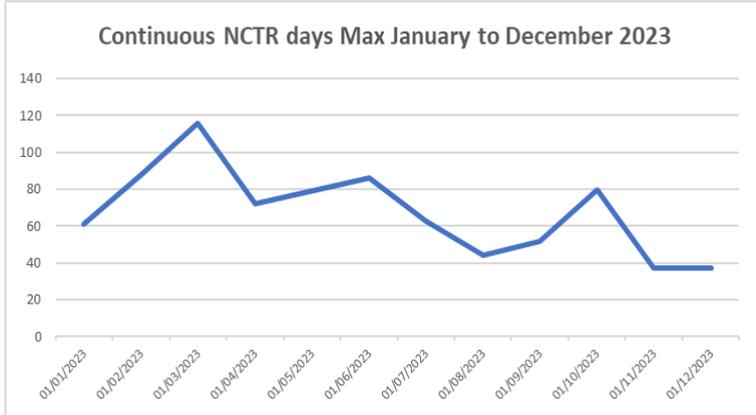
- Home First has had a significant impact on capacity to reduce the non-criteria to reside position.
- This has been offset by the reduced numbers of packages of care, so the net pathway 1 discharge volumes have not changed

Pathway 1 Discharges

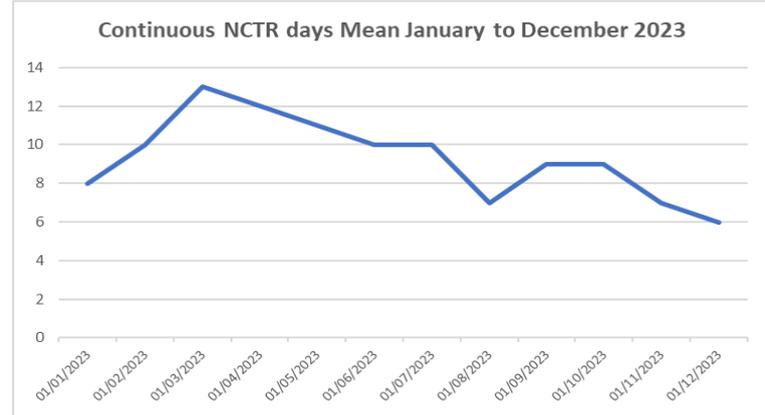


- In summary the number of pathway 1 discharges from WUTH have not changed over the period.
- There has been a shift from packages of care to Home First, this has led to surplus capacity in the domiciliary care market.
- Utilising the data it seems that the streamlining of processes has had the largest impact in reducing the number of beds occupied by patients that do not have a criteria to reside, in addition to reducing the length of stay for patients with no criteria to reside.

NCTR - Length of time to discharge



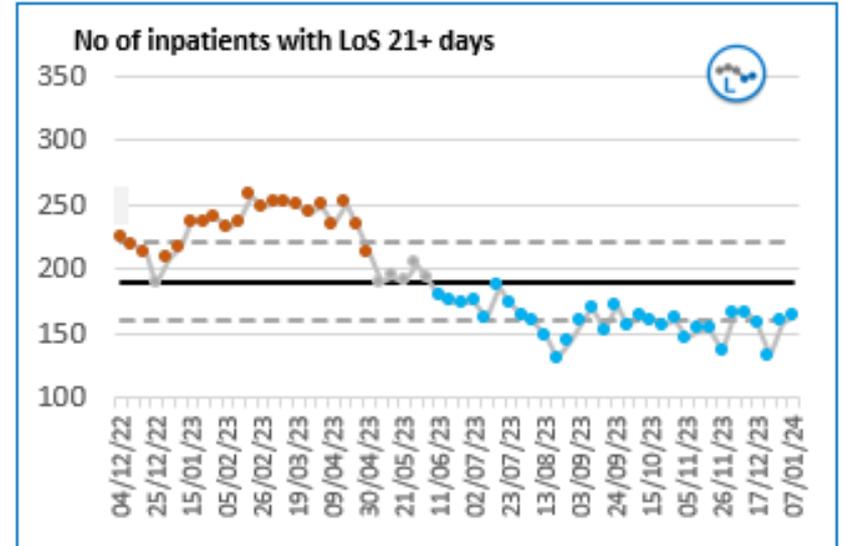
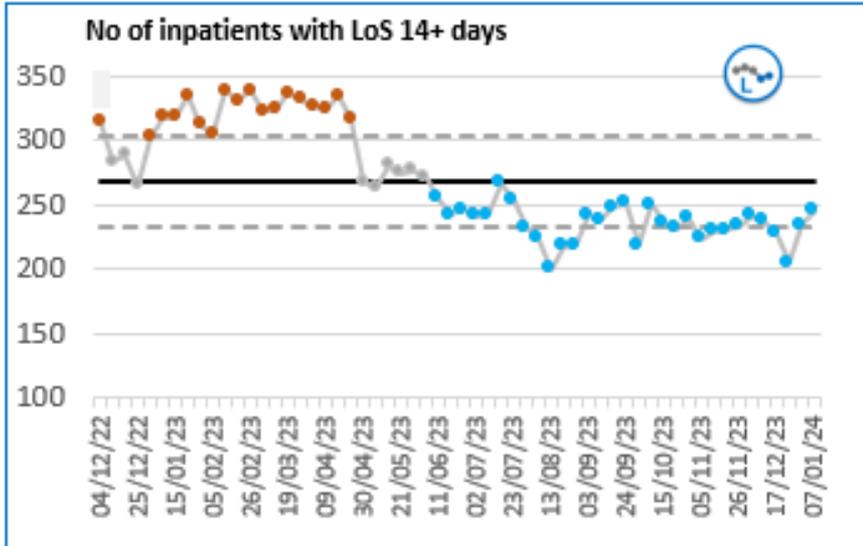
Maximum continuous NCTR –
Reduced from 116 to 37 days



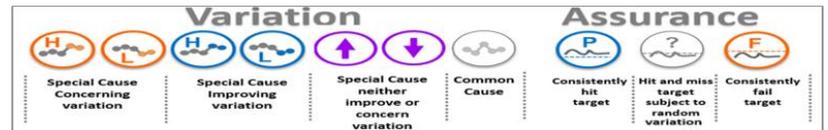
Continuous NCTR mean –
Reduced from 13 days to 6 days

- Demonstrated a reduction in length of stay for patients from the point of meeting NCTR.

Long LoS Hospital Wide



14+ & 21+ day LOS charts illustrate the sustained nature of the reduction over the last 12 months



Performance compared with other C&M Places

Daily Percentage of ALL Beds Occupied by Non-Criteria to Reside Patients Not Discharged

Latest Date: 04 February 2024

	Trust	Trajectory	Current	PP Var
1	Wirral	24%	16.1%	-8%
2	East Cheshire	26%	18.0%	-8%
3	Countess of Chester	18%	18.1%	0%
4	Mersey and West Lancs	20%	18.7%	-2%
5	LUHFT	26%	24.6%	-1%
6	Mid Cheshire	16%	25.0%	9%
7	Warrington & Halton	25%	27.5%	3%
	Total	23%	21.5%	-1%

Provider	Trajectory	Current	Var
Countess of Chester	18%	18.1%	0%
East Cheshire	26%	18.0%	-8%
LUHFT	26%	24.6%	-1%
Mersey and West Lancs	20%	18.7%	-2%
Mid Cheshire	16%	25.0%	9%
Warrington & Halton	25%	27.5%	3%
Wirral	24%	16.1%	-8%
Total	23%	21.5%	-1%

Discharge SITREP: 04/02/2024

Please note: The old 10% target has been replaced by trajectories from the individual Provider Operational plans



System Partner Feedback

System Partner Feedback

ToCH Quality Board

- The ToCH launched monthly Quality Board in October 2023 to ensure patient stories, system partner feedback and incidents are monitored and actioned to ensure the highest standard of care and safe transfer for patients.

Safe Transfer of Care Feedback Questionnaire

- A series of Safe Transfer of Care workshops have been undertaken hosted by the Local Authority and attended by WUTH, Care Home partners, Domiciliary Care and Community Pharmacy. The purpose of the workshops was to build working relationships between the providers, understand each other's requirements and identify areas for improvement.
- Following a number of actions being undertaken to enhance the transfer of patients out of hospital, WUTH actively sought system partner feedback via questionnaire circulated by the Local Authority. Feedback will be used to highlight further areas of improvement.
- The questionnaire was circulated in December 2023 for initially a two weeks period and then extended for a further two weeks in January 2024 to maximise the number of responses.
- 6 Care Home and Domiciliary providers returned completed questionnaires.



Safe Transfer of Care
Feedback Questions

Overview of Questionnaire Results

- 66.7% reported improved communication between WUTH and their service (remaining 2 selected neither agree or disagree).
- 100% of respondents value the role of the Trusted Assessor.
- 66.7% reported the quality of information about patients being discharged from hospital has improved.
- 66.7% confirmed that they know how and who to contact at the hospital if they have any queries (remaining 2 selected neither agree or disagree).
- Additional comments provided include:

“The communication has improved and the quality of discharges”

“Discharge information has improved and the quality of the service”

“The Trusted Assessor is very valued by Elderholme and makes Transfers quicker and communicates well”

“I am aware that the Care Home Placement Officer is ensuring the right referrals are being placed”



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Summary and Benefits



...deliver the best quality and safest
care to the communities we serve

Summary and Benefits

- Significant progress has been made in reducing the NCTR position at WUTH.
- There has been no change in the volume of Pathway 1 discharges from WUTH.
- The Transfer of Care Hub has been instrumental in achieving these statistical improvements.
- The length of time patients are waiting from discharge ready to actual discharge has significantly reduced and maps with the transactional improvements in the Transfer of Care Hub and other improvement programmes from our Wirral partners.
- The Home First service has been considerable in supporting the improved NCTR position and has been a great success as well as significant improvements in the care market sufficiency project.
- The above has been offset by a reduction in the number of Pathway 1 discharges to a package of care.
- To improve the performance further we need to maximise the package of care discharges to achieve the next stretch target for NCTR.

Quality Benefits	
Patient	<ul style="list-style-type: none"> • Significant and sustained reduction in the number of NCTR patients residing in acute hospital beds and for reduced bed days, resulting in patients being cared for in the most appropriate setting. • Acutely unwell patients being treated in the most appropriate setting due to increased access to hospital beds. • Safe transfer of care.
System	<ul style="list-style-type: none"> • M3 escalation ward sustained closure. • Appropriate allocation of resource to care for patients. • Collaboration and partnership working.