

## REPORT TO THE PBC GOVERNANCE TO BE HELD ON 12 September 2009

<b>Enclosure:</b>					
<b>Subject:</b>	South East Staffordshire Consortium Discharge facilitation nurses at Good Hope Hospital				
<b>Lead Director:</b>	Sue Price				
<b>Lead Officer:</b>	Frances Sutherland				
<b>Recommendation:</b>	<b>For Approval</b>	<input checked="" type="checkbox"/>	<b>For Discussion</b>	<input type="checkbox"/>	<b>For Information</b>

### PURPOSE OF THE REPORT:

The South East Staffs consortium have undertaken a pilot to understand the patient pathways in Good Hope hospital. Recommendations from the pilot suggest that there are two roles that would be key in ensuring patients are returned to their own home as soon as possible. One role would be in the front of A&E and in the short stay medical unit. The other would be to ensure discharge occurs as soon as patients are fit to go home or to a community hospital. These roles would also reduce admissions, reduce some long stay admissions to short stay and reduce the number of excess bed days.

### IMPLICATIONS:

<b>Legal and/or Risk</b>	
<b>Standards for Better Health</b>	The service will provide: Clinical and cost effective care Accessible and responsive care
<b>Financial</b>	Invest to save project
<b>Training</b>	
<b>PBC</b>	PBC project
<b>Other</b>	

### RECOMMENDATIONS / ACTION REQUIRED:

--

## Service Provision Business Case

<b>TITLE OF PROPOSAL</b>	Discharge facilitator Nurses- South East Staffs
<b>ORGANISATION/ COMMISSIONING BODY</b>	South East Staffordshire Consortium
<b>LEAD NAME FOR PROPOSAL</b>	Frances Sutherland
<b>TELEPHONE</b>	07815 561767
<b>EMAIL</b>	Frances.sutherland@southstaffspct.nhs.uk

### Document Control

Document Version	Date of Revision	Summary of Revision

## Section 1: Compliance with the PCT Commissioning Framework

This business case complies with the following priority areas as outlined in the PCT Commissioning Framework:

<b>PCT Commissioning Framework Priority Areas:</b>  <i>PCT to complete PCT Commissioning Framework priorities as outlined in the PCT LDP and ISIP.</i>  <i>Full details of each of these areas are available from your PCT</i>	<b>This business case relates to the following</b> <i>(Proposer to tick as appropriate):</i>
<i>PCTS have specific targets on all of the following areas in line with national directives regarding achievement thereof, and practice are expected to work within these priorities as practice based commissioners. With regard to your specific service proposal, please tick all appropriate boxes served by your scheme.</i>	
1. National priorities	
1.1 Improving health of the population	
1.2 Supporting people with long term conditions	x
1.3 Access to services	X
1.4 Patient/user experience	X
1.5 Achieving financial balance	x
1.6 Implementing reform	
1.7 6 key service priorities:	
- health inequalities	
- cancer 31 and 62 day waits	
- 18 week wait	
- MRSA	
- Patient Choose & Book	
- Sexual health & access to GU medicine	
1.8 Links with Integrated Service Improvement Plan (ISIP) & Benefits Realisation Plan (BRP)?	
2. Local priorities	
Development of pre referral systems	
Care closer to Home	X

## Section 2: Outline of the Proposed Service Provision

<p><b>Introduction</b>  <i>Give a brief out line of the background (i.e. current service provision and demonstration of need for improvement. Include Health Needs Assessment)</i></p>	<p><b><u>Background:</u></b></p> <p>A project was proposed, and agreed by the South East Staffs consortia, as a consequence of the joint GP and ambulance investigations around Good Hope A&amp;E. The consortia employed a Nurse for a 6 month pilot scheme to investigate and enhance understanding of the pathways and process in Good Hope Hospital. Particularity focusing on the following;</p> <ul style="list-style-type: none"> <li>• Admissions to A &amp; E, Assessment Medical Unit (AMU) and AMU short stay (AMUSS)</li> <li>• Admissions to avoid breaching 4 hour wait</li> <li>• Admissions due to delays in arranging care packages</li> <li>• Identify patients who would benefit from earlier discharge</li> </ul> <p>Given the concerns raised from data and anecdotal evidence, an experienced nurse took up a facilitator role within Good Hope Hospital (GHH). The purpose of the role was to capture information specifically about South Staffordshire PCT patients in A&amp;E, AMU Assessment, AMU Short Stay, and the medical wards.</p> <p><b>Results of the pilot scheme:-</b></p> <p>During the pilot the nurse spent at least two weeks in each of the following areas collecting information and data on the pathways through the hospital system</p> <ul style="list-style-type: none"> <li>○ Accident and Emergency,</li> <li>○ AMU,</li> <li>○ AMU short stay</li> <li>○ Medical wards</li> </ul> <p><b>1) Front end A&amp;E/AMU/AMUSS:</b></p> <p>During pilot the facilitator avoided 3 A&amp;E Admissions in 2 weeks saving 13 bed days (If 3 admissions was average for 2 weeks and calculated at an average cost of non elective £2,400 then over one year could save approximately £187,000. If all these patients had only been short stay with an average tariff of £500 then the savings would have been £39K)</p> <p>Within the pilot the nurse also used community links to facilitate the early discharge of a further two patients, was actively involved in two patients attendances avoiding ward admissions and accelerated the discharge process for five patients reducing there inpatient stay from long to short stay. The average difference in tariff is approximately £600-£1200. These savings are difficult to quality but could range from £70K to £156K.</p> <p>The nurse signposted and supported discharges with OT, Physiotherapy and social services to prevent re -admissions and avoiding ward admissions and discussed cases with social services colleagues to facilitate the reinstatement of care packages (care packages are canceled if a patient stays in longer than 72 hours)</p> <p><b>2) Medical Wards</b></p> <p>In the first quarter of 2009/10, 186 patients were admitted and incurred excess bed</p>
--	--

	<p>days. The excess bed days alone cost commissioners £397.060. The average excess bed day per patient was 11 days at an average cost of £2135 per patient. These patients are not proactively discharged from the acute hospital. From a snapshot audit it is apparent that patients can be delayed when medically fit for discharge because of the processes that occur. Only 21% of patients are discharged when medically fit with no delays (8/38). The nurse would proactively manage these patients to ensure that assessments are undertaken on time, discharges to the home and to community hospitals are timely and appropriate. If 10% of those excess bed days were saved, that is 18 patients in each quarter, that would equate to £154K per year ( £38.K per quarter)</p>
<p><b>Outline of Proposal</b> <i>How does this link to PCT &amp; Local priorities?</i></p>	<p>The recommendations from the pilot suggest the development of two new roles to streamline patient flow through A&amp;E and the wards.</p> <p>1) A facilitator at the front end of Urgent Care within Good Hope – With a specific remit around admission avoidance;</p> <ul style="list-style-type: none"> <li>• Prevent avoidable emergency admissions</li> <li>• Facilitate early discharge by providing alternative pathways and staff better access to community teams</li> <li>• Liaise with South Staffordshire Social Services teams to fast track reinstatement of care packages where appropriate to prevent unnecessary admissions.</li> </ul> <p>2) A discharge liaison post to act at the back end of an acute admission to pull the patients out of the acute setting and signpost to the most appropriate setting for further rehabilitation and/ or assessments.</p> <ul style="list-style-type: none"> <li>• To work with the community hospitals to facilitate transfers of patients once the new criteria for the beds is established so that all SSPCT Patients who no longer require a consultant can be transferred.</li> <li>• Work with social services to identify when patients are fit for assessment.</li> <li>• Ongoing liaison with community teams to identify capacity and maximise discharges.</li> <li>• Identify a wider range of patients who could be managed in the community.</li> <li>• Work with Good Hope on education of community pathways</li> <li>• Be an advocate for SSPCT patients in Good Hope.</li> </ul> <p>These roles link to care closer to home, reduction in emergency bed days, increasing independence for older people and value for money.</p>
<p><b>Aims &amp; Objectives</b> <i>(Please expand on the brief outline that you gave in the Commissionin</i></p>	<p>The aim of these roles are</p> <p>1) To ensure patients who attend A&amp;E are reviewed and those who can be returned to their own home will be with support from local services. To ensure that evidence based locally developed pathways are followed and to inform commissioners when pathways are changed within the acute trust.</p> <p>2) To ensure patients who are medically fit are discharged as soon as possible to either their own home or to the community hospitals. That patients long stay patients are case managed to ensure a smooth discharge</p>

<i>g Proposal)</i>	
<b>Management of the Service</b> <i>(Explain how the service will be managed i.e. receiving referrals, appointments, outcomes and waiting list requirements)</i>	<p>The two nurses proposed would sit within the Rapid Response nursing team. This would ensure they are aware of the capacity within the team and pathways in the community.</p> <p>The nurses would be 'pulling' patients out of the acute trust and would be based in the hospital itself. The management of the hospital are supportive of this as it will improve patient flows. There are teams of nurses from BEN PCT who also undertake these roles. It is anticipated that the nurse in the front of A&amp;E will work five days a week within A&amp;E and AMU to turn patients around back into the community. Previous audits indicate that the busiest time for admissions from A&amp;E is between 11am and 7 pm Monday to Friday. It is anticipated that when Good Hope Hospital staff are used to working with the nurse they will begin to understand the pathways better and may use them out side of these hours. As the nurse will be part of the Rapid response team the cost of cover will be incorporated into the project to ensure there is cover for holidays sickness etc.</p> <p>The ward discharge facilitator will use the hospital IT system and be aware of all South Staffs patients in the hospitals. They will monitor all of the patients to ensure they are proactively managed through the hospital system.</p>
<b>Scope of the Proposed Service</b>	South East Staffs patients in Good Hope Hospital. Children under the age of 16 years are not included within the scope
<b>Clinical Effectiveness</b>	Ensuring patients are returned to their own home as soon as possible will help to maintain independence and reduce the risk of HAI

<b>What will be the benefits to Patients?</b> <i>(e.g. How will this link in to Choice/Choose &amp; Book?)</i>	<p>Returned to their own home sooner</p> <p>Increased chance of retaining independence</p> <p>Reduce risk of Hospital Acquired infections</p> <p>Assessments undertaken quicker then present</p>
<b>What will be the benefits for Clinicians/Staff?</b>	Ensuring patients cared for in a seamless pathway
<b>What will be the anticipated benefit area for the PCT</b> <i>(i.e Number of Reduced Admissions / Avoided Out Patient attendances)</i>	Reduced admissions and reduced excess bed days at Good Hope hospital

<b>Milestones &amp; Timescales</b>	<b>Milestone</b>	<b>Timescale</b>
	Appoint staff	3 months
	Agree base etc	1 month

<b>Initial Risks Associated with the Service Provision Proposal and Strategy for managing those risks (Countermeasure)</b>	<b>Risk</b>	<b>Countermeasure</b>
	Savings not achieved	Monitoring of caseload Development of evidence based pathways Close working with social care

## Section 3: Financial Implications

<b>Annual Expenses (Cost of New Service)</b> <i>List a breakdown of all expenses, remembering to add on-costs to staff costs</i>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>
<b>Capital Costs</b>			
Computers	1000		
Telephones	500		
<b>Staffing Costs, including backfill for clinicians running new service provision</b>			
2x WTE Band 6 nurses (plus 22% on costs and 52 weeks per year cover)	£83,111		
<b>Total staff costs (includes 22% on costs)</b>			
<b>Training supervision etc</b>			
<b>Equipment &amp; Materials</b>			
Patient information			
Stationary			
<b>Other Expenses</b>			
Travel	1000		
<b>Total Cost of New Service</b>	<b>£85,611</b>		
<b>Capital</b>	£1500		
<b>Anticipated Revenue</b>			

<b>Anticipated Financial Benefit to PBC Budgets</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>
Anticipated freed up resources achieved through avoided secondary care activity. <i>Please specify:</i> Average 1.5 admissions avoided per week at a cost of £500 (short stay tariff only) £39K Average 2.5 patients per week charged at short stay tariff with a saving of £600 per patient £78K 10% reduction in excess bed days £154K	£271K		

Less Cost of new Service Provision to users of the service	£85K		
Surplus to PBC Budgets	£186K		

<b>How much funding is being requested &amp; identification of purpose</b>	Invest to save project. Saving should be seen within 6 weeks of commencement of service
--	---

## Section 4: Corporate Governance

Please note that some contracting methods will entail certain liabilities, for example a Limited Company option under APMS. It is therefore essential specialist advice is taken to understand clinical/personal liability, medical indemnity etc.

<p><b>On which contracting basis do you intend this service provision to be based?</b> <i>e.g. LES, PMS, SPMS, APMS, PCT GPSI Commissioned Service, please explain.</i></p>	<p>Provider arm contract</p>
<p><b>Which National, NSF and PCT Targets will this service provision deliver against?</b></p>	<p>Care closer to home Reduction in Emergency bed days</p>
<p><b>Patient, Public &amp; Front-line Staff Involvement.</b> <i>Please describe how you have involved Patient, Public and front-line staff in this proposed development.</i></p>	<p>Local GPs, Rapid response staff, discharge facilitator undertaking pilot, district managers, Good Hope clinical and management staff, social services district manager.</p>

## Section 5: Quality & Corporate Assurance

Please note there is value in discussing your proposals early on with your PCT Clinical Governance Lead

<b>Clinical Governance Assurances</b>	
<b>Please provide details of how the intended provider location meets Health &amp; Safety and other Clinical Governance Assurance standards</b>	Based In Good Hope Hospital Part of Community contract
<b>Please Specify Audit arrangements ie, patient satisfaction surveys, reduction of hospital referrals &amp; admissions</b>	Reduction in hospital admissions Reduction in excess bed days Patient satisfaction
<b>What Quality Checks will be in place?</b>	
<b>What information will you supply to the PCT and with what regularity?</b>	Clinicians view for admissions avoided Numbers of patients whose discharge is facilitated within 24 hours rather than becoming a longer stay patient Number of excess bed days. Number of patients proactively discharged to either home or Community hospitals Data to be provided monthly
<b>Outline Contractual Arrangements (To be detailed in the Service Level Agreement)</b>	
<b>Proposed period of Contract</b>	In line with main PCT contract
<b>Proposed Notice Period</b>	In line with main PCT contract
<b>What Contract Review arrangements do you envisage?</b>	In line with main PCT contract

<b>How will Complaints be managed?</b>	Via PCT complaints systems
--	----------------------------

**To be Completed by PCT:**

<b>Comments received:</b>	<b>Date</b>
Practice Based Commissioning practice/consortia	
Clinical Governance Lead	
Executive Directors	
Professional Executive Committee	

<b>Outcome of Application</b>	<b>Name</b>	<b>Date</b>
Approved – on the basis of:		
Rejected - Reasons for Rejection:		
Passed for Payment:		