South Tees Hospitals NHS
NHS Foundation Trust

APPENDIX 1

Report for Middlesbrough Council Overview and Scrutiny Board:

HOSPITAL DISCHARGE

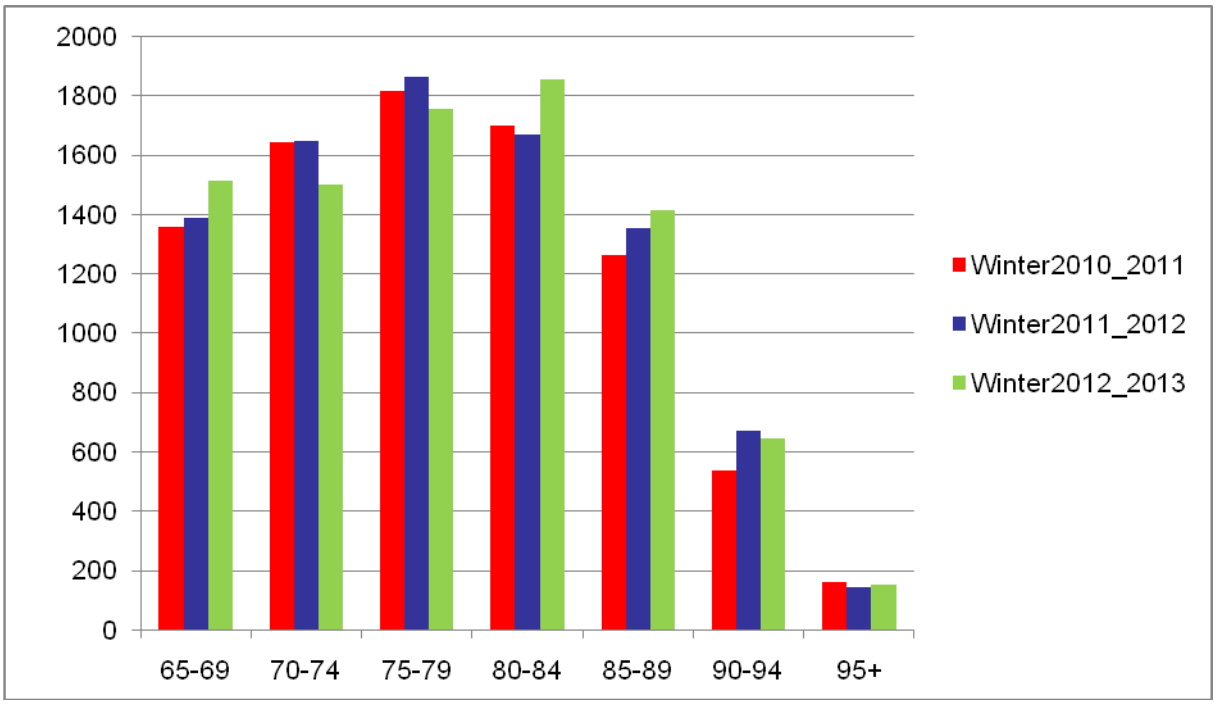
1. Introduction

The purpose of this paper is to provide the members of the Overview and Scrutiny Board, the Health Scrutiny Panel and the Social Care and Adult Services Scrutiny Panel with an overview of current hospital discharge processes, a summary of the main reasons for delays to hospital discharge and an outline of the measures that have already been and could in the future be implemented in order to reduce delayed discharges.

2. Background

As the demographic profile of the population changes, with an increasing number of older people, the demographic profile of hospital patients reflects this position. As a consequence 1 in 4 patients admitted to hospital is over the age of 75 years. The graph below outlines the number of older patients admitted as emergencies to JCUH over the past three winters, which shows a steady change in the age profile, with the largest cohort of patients now being over the age of 80.The impact of these demographic changes means that an increasing number of patients require a range of support services on discharge from hospital.

TABLE 1: Number of unplanned admissions to JCUH of patients over 65 years of age.



3. Overview of Hospital Discharge

The timely discharge of patients with complex needs, following a period of acute illness requires all statutory agencies to work together in close partnership. The key legislation around hospital discharge is the Community Care Act (2003). The Act places duties upon both the NHS and local authorities with social care responsibilities, regarding the discharge of patients from hospital. In addition, if a patient potentially requires a commissioned service, assessments required as part of the Continuing Healthcare Care Framework (DoH 2012) must also be undertaken. These assessments are primarily the responsibility of CCGs as health commissioners, in conjunction with healthcare providers and social care.

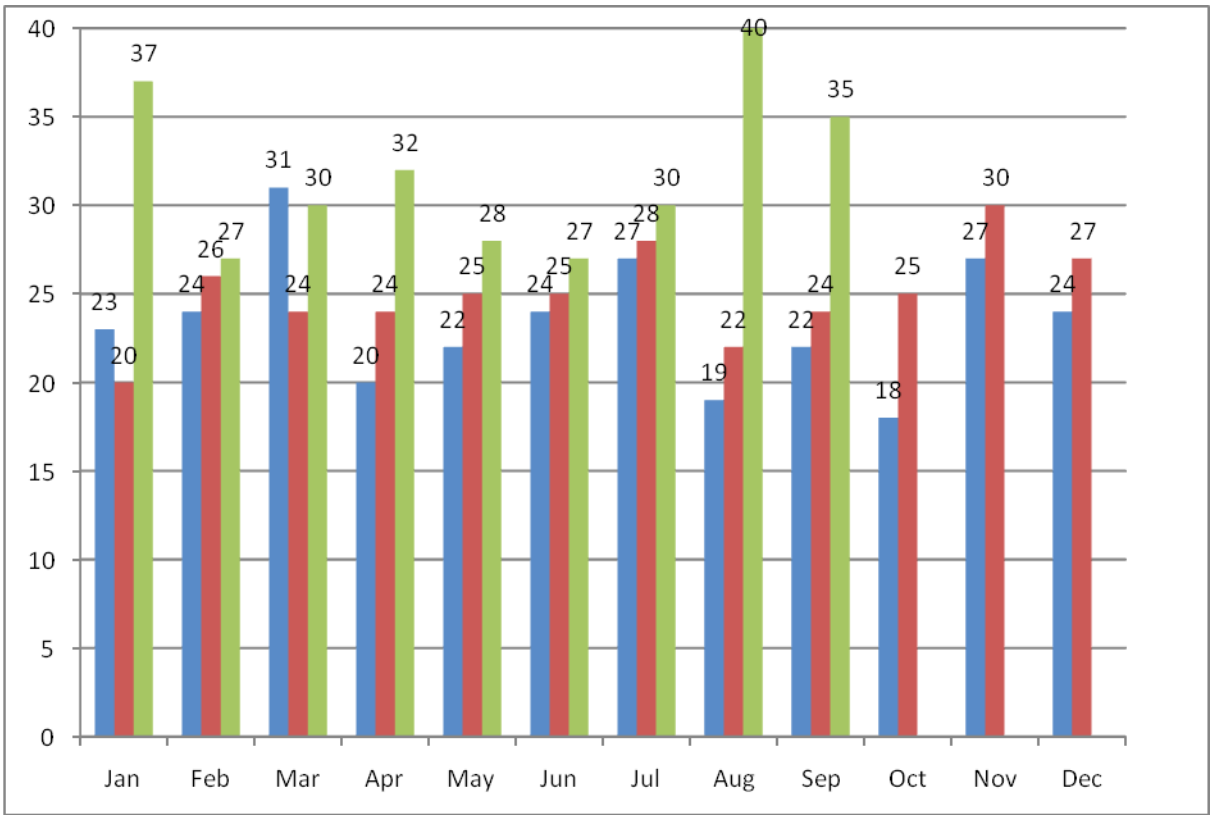
All patients are assessed on an individual basis, to determine with them and their families the most appropriate discharge plan. Traditionally the range of assessments have all taken place within the acute hospital environment, and as the complexity and number of assessments and the coordination of arrangements across a number of agencies increases, so does the patients length of stay.

National guidance advocates that many of these assessments should be ideally undertaken outside of an acute hospital environment, so that patients have had time to rehabilitate and reach their individual optimal potential for functioning independently, before decisions regarding their long term care arrangements are made.

3.1 The Current Patient Journey

On admission the patient is assessed as to the likely length of stay and a planned date of discharge (PDD) is set. This PDD is the date that everyone works towards and should only be changed if the patient's medical condition changes. If the patient is assessed as requiring support on discharge, the patient's consent is obtained for a social care referral to be completed. Ward staff complete a Section 2 notification and fax this to the hospital social work team. The Community Care Act (2003) establishes timescales, dependent on the proposed date of discharge, but not less than 72 hours, within which social services must assess need and effect discharge from hospital.

However if a patient is thought to require commissioned services, a Continuing Health Care (CHC) checklist must be completed and if the patient "triggers" for a Decision Support Tool (DST) assessment, further nursing assessments are made and a meeting arranged by the CHC team, currently provided by the North East Commissioning Support Agency on behalf of the CCG. The demand for CHC assessments has increased substantially over the past 12 months as the graph below illustrates



Number of Continuing Healthcare Assessments undertaken on JCUH site 2011-2013

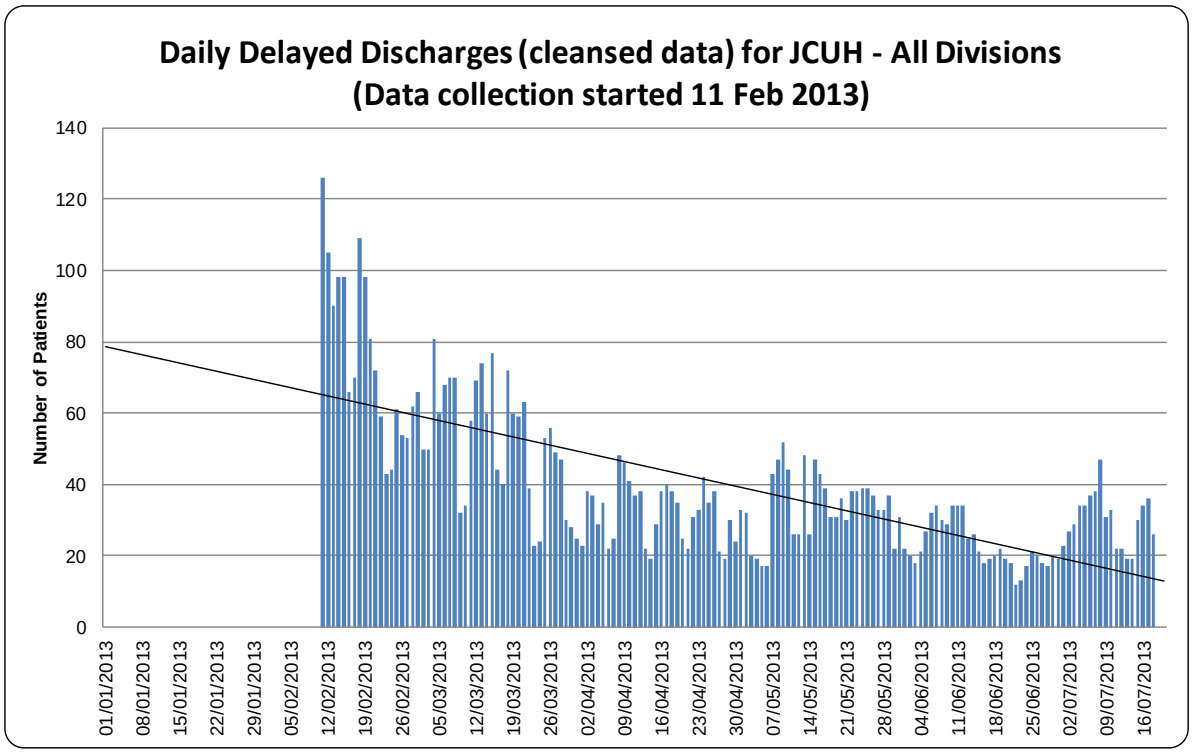
Further assessments are required if it is thought that the patient lacks mental capacity.

Once a decision is made regarding whether the patient requires residential or nursing care, families are supported by the hospital social work team/continuing healthcare team to find a suitable facility. Once chosen, the nursing/residential home is required to assess the patient to ensure they can support the individual patient's needs and once this has been determined the patient can be safely discharged. This will generally take a number of days. Appendix A outlines the flow chart which has been agreed by all agencies to support this process.

3.2 Delayed Discharges

A delayed discharge is recorded from the date at which a patient is medically fit to be discharged from a hospital bed, but could not be discharged (DOH data standards, 2007).

The graph below demonstrates a reduction in delayed discharges over the past 6 months. It is not yet clear whether this is due to seasonal trends or the impact of the intensive programme of improvements undertaken over this period with partner agencies.

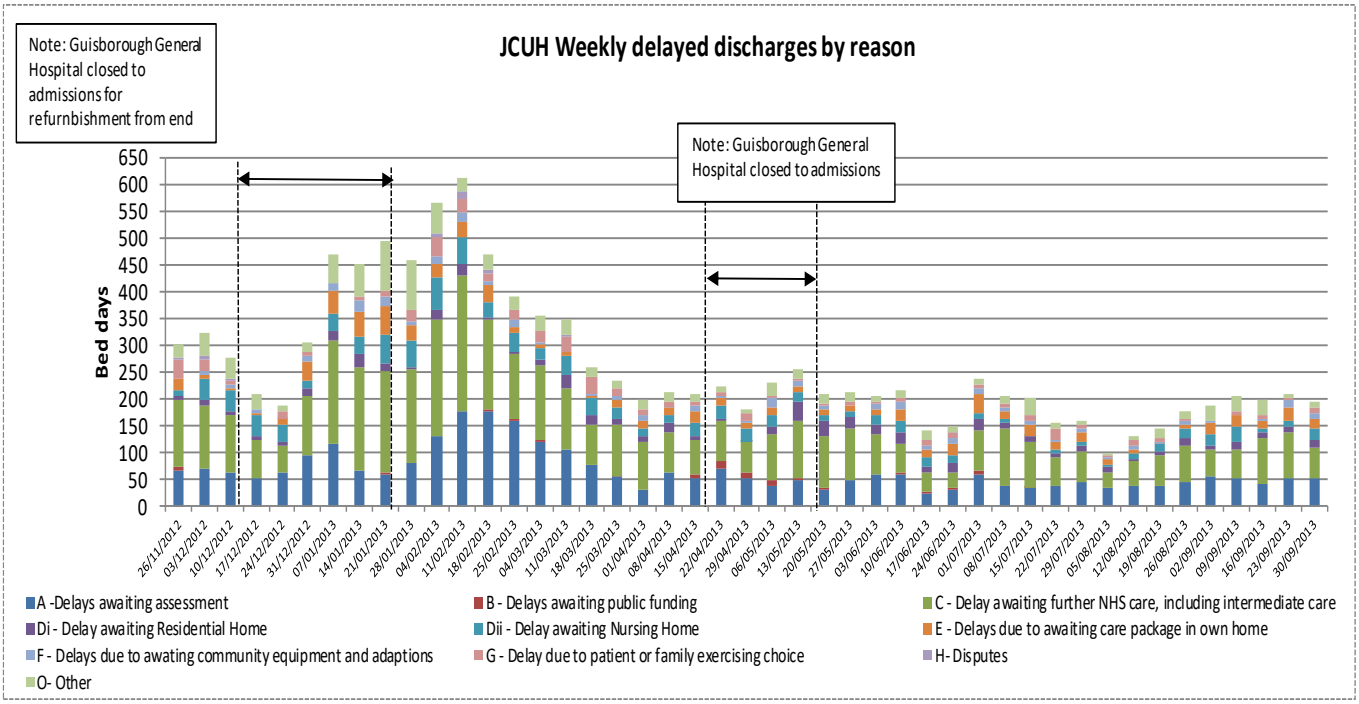


There are 11 codes which identify the reasons for delayed discharges as outlined in the table below.

Table 2:Delayed Discharge Codes

Code	Reason for delay
A	Assessment – DST, social services, nursing home etc.
B	Funding
C	Awaiting further NHS care this includes intermediate care
D1	Residential home
D2	Nursing home
E	Package of Care
F	Community equipment and / or adaptations
G	Patient / Family choice
H	Dispute over funding
I	Housing
O	Other

The two most common delays experienced within JCUH over the past 12 months are delays due to assessment and awaiting further NHS care, including intermediate care, as outlined below.



As this graph also demonstrates there has been a considerable reduction in the number of delays, particularly in relation to these two reasons in recent months. Once again it is difficult at this stage to determine how much of the improvement is due to the changes put in place in recent months and outlined below, or seasonal variation. However the graph does demonstrate the impact of closing beds in the system for a period of time. Impacts on lack of capacity in other areas is not always so evident to identify, so it is important that all agencies inform others of changes in services that either increase or decrease capacity in the system. It is vital that sufficient appropriate capacity is available to match demand. Where this is not available there is a backup into acute hospital beds and an increase in delays to discharge.

3.3 Social care delays

- The Community Care Act makes provision for a system of reimbursement for delayed discharges, that are solely attributable to social care, i.e. where a patient remains in hospital because the council has not put in place the services the patient of carer needs for discharge to be safe. There has been longstanding agreement not to implement the levying of fines, as it is considered to place considerable administrative demands on demonstrating delays and is thought to run the risk of undermining the improvements made via partnership working. The hospital social work team generally provides a very timely response to referrals. It did struggle to cope with the backlog of

  referrals that accumulated over Christmas 2012 and New Year 2013, within the required statutory timeframe. However improved arrangements for the 2013/14 holiday period are to be implemented.

- The hospital social work team has seen an increase in demand of 13.2% since 2009 (Scollay, 2013). The Trust is not in a position to determine whether there is sufficient capacity within the team to meet this increasing demand; however the Trust does already fund a number of posts within the team (5WTE specialist social workers and 3.41 administrative staff). A review of the Hospital Social work team has commenced and the Trust has been invited to participate in this piece of work.

- The hospital social work team leader is very responsive to adapting to needs of the Trust with the resources available. The Trust would like to see a greater number of social workers allocated to specific areas in the hospital, so that close working relationships can be established and an extension to work being undertaken regarding assessment of patients prior to an elective admission who are likely to need support from social care following discharge.

- Where a patient already has a community based social worker, it is the responsibility of this worker to liaise with the hospital regarding a patient's discharge. From the Trusts perspective, it is more challenging to communicate with these workers and ensure that the response is within the statutory period outlined within the Act and it has been agreed that all referrals will go directly to the hospital social work team for allocation.

- The hospital social work team works a standard council working day and there is currently no provision for working at weekends and bank holidays. Weekends can be some of the busiest days of the week for non-elective patient attendances at the Trust. There are also fewer hospital discharges over the weekend than Monday – Friday. Insufficient support service capacity (including social care) can prevent patients being discharged the same day or over the weekend. The Trust would like to propose that there is a social worker available on-site, particularly at Front of House during peak periods of activity for A and E and the Acute Assessment Units, to support hospital staff in the coordination of discharge of patients who do not need to be admitted to hospital but do require support to return home safely.

4. Continuous Improvement

Over the past 12 months an intensive programme of work has been undertaken in partnership with South Tees CCG and Middlesbrough and Redcar and Cleveland Councils, via the Hospital Discharge Steering Group to redesign processes relating to hospital discharge and integrate with new services available in the community. These have included;

- *Improvements in the recording of PDDs and Delayed discharges.* This has allowed greater scrutiny of the reasons for delay and an ability to act promptly on system level issues as they occur.

- *Regular meetings and/or teleconferences to discuss delays with partner agencies, particularly during periods of peak activity.*

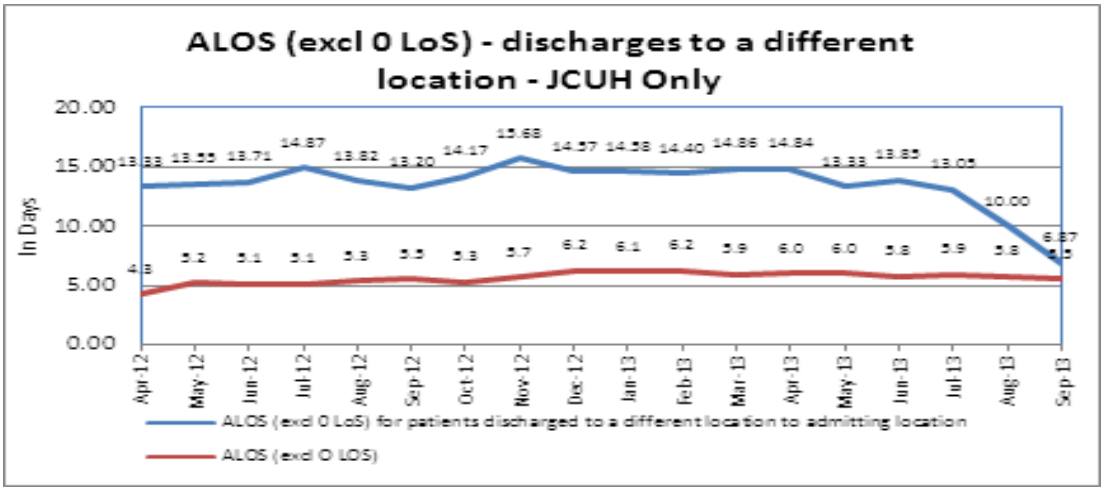
- *Redesign of processes relating to social care and CHC assessments.* The streamlining of assessments and determining clarity on roles and responsibilities will enable us to identify and address problems relating to capacity and demand, as we move towards winter.

- *Introduction of a single point of referral within JCUH to organise transfers of care to community hospitals and MICC.* This pilot scheme has already demonstrated that it has reduced waiting time to transfer by an average of 2.5 days per patient. This service is funded until 31 March 2013 after which a decision will be made about making it a permanent arrangement.

- *Introduction of hospital case managers, who assess patients and coordinate discharge arrangements for patients with complex needs.* This pilot will continue until March 2013 and a full evaluation is currently being undertaken.

- *Extensive programme of discharge improvement workshops across all acute and community adult ward areas, between May and October 2013.* This programme of improvements is introducing all new agreed standard processes outlined above and enabling ward based staff to identify and improve a range of internal processes, such as ordering of medications, transport etc. that impact on hospital discharge.

  The graph below demonstrates the substantial improvements made in the average length of stay, for patients who are discharged to a different location from where they were admitted, which primarily includes those patients who have more complex needs on discharge.



  Maintaining these improvements will require on-going efforts across all health, social care and independent sector agencies.

5. Strategic System Level improvements

The improvements outlined above, will all contribute to making improvements to the planning and coordination of complex discharges from hospital. However in order to significantly reduce the length of stay of such patients, who require a significant period of rehabilitation, reablement and subsequently assessment for 24 hour care, a more radical system level redesign is required.

- There is increasing evidence from other parts of the UK, which have moved from an "assess to discharge" approach to one of "discharge to assess". Such an approach would require health and social care commissioners and providers to develop pathways of care which enable patients to be discharged to their own home or a step down facility, where their on-going health and social care needs can be assessed and agreed. (Improving Patient Flow, the Health Foundation, April 2013). The South Tees CCG urgent care group has established a task and finish group to identify what system level change is required to establish such an approach.

- To support this approach, there also needs to be sufficient community based services to support a patient's recovery either in their own home or other facility. This agenda has been supported nationally with the allocation of reablement monies that have been utilised by health and social care commissioners to invest in services that promote and support independent living.

- Where patients have already experienced services or had a number of admissions they may have limited potential for recovery and rehabilitation. These are the patients who currently have an extended length of stay in hospital whilst CHC assessments are undertaken. Sunderland Council have introduced a scheme of "Time to Think Beds", provided by a range of private providers and commissioned by the Council. These are for people who are medically stable but require a further period of time to facilitate recovery, whilst undergoing an assessment of need to support their longer term requirements. Options for rehabilitation remain a consideration with the availability of therapeutic interventions on-site to enhance personal recovery and support care planning. The South Tees CCG IMPROVE advisory group received an initial paper in August regarding what changes would be required to implement a similar scheme and further work is currently being undertaken to pilot this approach over the winter months.

6. Conclusion

Hospital discharge encompasses a set of complex processes responsibility for which spans all health and social care commissioners and providers. There is good partnership working across the health and social care agencies and the system has seen some demonstrable improvements.

The system is already experiencing increasing demand for services that support the frail elderly and those with long term conditions and has responded by making some significant improvements to current processes.

Evidence from other parts of the UK would indicate that a bolder whole system approach may be required if the health and social care system in Middlesbrough is to enable this vulnerable group of patients to stay as independent as possible in their own homes, for as long as possible following a period of acute illness.

Prepared by

Gill Collinson

Deputy Director, Service Transformation

South Tees Hospitals NHS Foundation Trust

Sponsored By

Susan Watson

Director of Operational Services

South Tees Hospitals NHS Foundation Trust

October 2013