HEALTH AND ADULT SOCIAL CARE
OVERVIEW AND SCRUTINY COMMITTEE

17 DECEMBER 2015

JOINT REPORT ON COMPLETE CARE PATHWAY FROM ADMISSION TO DISCHARGE

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Summary

Following a Member visit to Medway Maritime Hospital on 3 September 2015, this report sets out the joint response from Medway NHS Foundation Trust and Medway Council to the request from Members for clarification of the issues facing both organisations in dealing with delayed transfers of care.

During the visit Members discussed with ward staff the issue of delayed transfers of care. It was apparent from the discussions that there were differing views between the hospital and Adult Social Care about the reasons for these delays. Members, therefore, requested a joint report from Medway NHS Foundation Trust and Medway Council's Adult Social Care setting out the issues each organisation faces when dealing with this issue.

This report is provided to inform the Committee of the processes relating to discharge from Medway Foundation NHS Trust (MFT), the challenges presented whilst preparing someone for discharge from hospital and some potential solutions provided by existing work as well as the opportunities provided through involvement with the Emergency Care Improvement Programme (ECIP).

1. Budget and Policy Framework

1.1 The frameworks within which this report is set include:

- Care of patients being discharged from hospital is covered by the Care Act 2014 and the Care and Support (Discharge of Hospital Patients) Regulations 2014.

- The national guidelines for the recording of Delayed Transfer of Care (DToC) revised October 2015 which can be accessed by following this link: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/10/mnth-Sitreps-def-dtoc-v1.09.pdf
- The collaboration across the whole health and social care system[1] to deliver improvements encompassed within the Better Care Fund.

1.2 The information brought together in this report is offered to provide the context requested as a result of the Member visit to MFT on 3 September 2015.

2. Background

2.1 Any issues that impact of the "flow" of people through an Acute Hospital Trust will raise concerns about patient safety, quality of care both within and outside of hospital and capacity within the wider health economy to confidently react to challenges and provide appropriate and targeted care in a safe and timely manner.

2.2 In line with the national picture, the challenges to meeting these needs in Medway require a "whole system" response and, as part of the Emergency Care Improvement Programme (ECIP) with which Medway is engaged until the end of March 2016, this is currently broken down into three themes: Admission Prevention and Avoidance; Patient Flow; Discharge and Community Care.

2.3 Addressing admission prevention and avoidance requires a concerted whole system effort to ensure that only those who require care from a hospital end up going there, and once there, are only admitted if absolutely necessary..

2.4 To ensure that all efforts are put in place to guard against people being admitted to hospital who do not need to be there, there are a number of initiatives across community services, voluntary sector settings, Primary Care and at the Emergency Department / "front door" These include:

- Working with nursing homes to ensure that these service providers have the skill-set to support the care of vulnerable elderly people within that setting
- Liaison with the 111 Service to ensure that they have up-to-date information on community-based initiatives for their "Z" (non-clinical) information codes ensuring that common messages are provided to the public in terms of where to find alternative help other than via the Emergency Department (ED) at their local hospital e.g. via local and community pharmacies, Walk-in Centres and their GP
- Public Health supports prevention initiatives across the system in terms of information, advice and guidance relating to how people can make healthier changes to their lifestyles
- Working with Primary Care to provide support to those settings where the frail elderly are living, whether that is within a residential home setting or in their own home, so that they can stay and be treated in surroundings with which they are familiar and comfortable

[1] The "health and social care system" is short-hand for all those organisations that contribute to the whole "health economy" across Medway.

- Ensuring that people who do turn up at ED are effectively triaged and, if appropriate, diverted to a GP service, such as that provided by MEDDoc at the “front door” of Medway NHS Foundation Trust
- Where someone has been treated in ED but does not require an in-patient bed, ensuring that they can be seen by their GP or another clinician (at the weekend) the next day, thus avoiding an unnecessary admission (Non-clinical Navigator Pilot programme)

2.5 When people are admitted, it is essential to their wellbeing and the efficient operation of the hospital that they occupy a hospital bed only for the appropriate time until their treatment from acute care is completed.

2.6 Addressing “flow” within the hospital system is a complex issue. The reality is that there will always be a cohort of people in hospital who are ready to go home but are “waiting for something”. The larger the number of people going through the hospital, referred to as “flow”, the greater the number of people there will be waiting for a variety of things to be resolved.

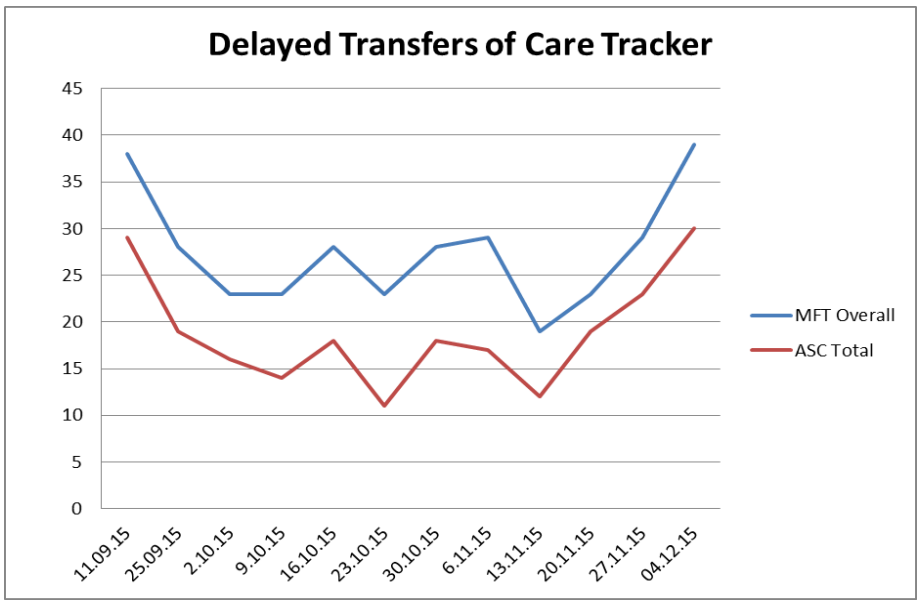
2.7 In addition to the regular daily discharge challenges which will be dealt with by the Hospital Discharge Team, there is the cohort of patients with more complex requirements affecting their discharge that are dealt with by the Integrated Discharge Team (IDT).

2.8 IDT is a multi-disciplinary team drawn from across the wider health and social care system designed to put in place those additional resources to ensure a timely and safe discharge from hospital for those people who require additional support for that to happen.

2.9 Every month Medway NHS Foundation Trust (MFT) is required to report the Delayed Transfer of Care (DToC) to NHS England. The parameters for this are set out in the national guidelines and includes delays attributable to both Health and Social Care.

2.10 Overall, Medway’s DToC performance compares well with both its Local Government Association cohort and nationally: delays reported to NHS England for the last six months that were attributable to Adult Social Care were on average 8.4 a month.

2.11 Over the same period the delays attributable to health were an average of 25.5 a month which includes delays where people were in community beds (Medway Community Healthcare) as well as other acute providers such as Maidstone and East Kent as demonstrated in the figure below.



2.12 Typically, MFT discharges between 150 and 170 people per week with complex needs through IDT.

2.13 There are a variety of reasons why, after their treatment, someone remains in a hospital bed. These include:

- Delays in the multi-disciplinary team to assessing their capacity and functionality to return home or to access rehabilitation in another facility such as residential care
- Delays in arranging the delivery of equipment essential to the patient's discharge
- Delays attributable to medication items from the hospital pharmacy
- Delays in transport if it is needed

2.14 In some cases the reasons for the delay are multiple from the list above and require continuous co-ordination across the system to ensure the discharge happens smoothly.

2.15 The Length of Stay review which took place on 19 November 2015 and was undertaken as part of the ECIP programme will identify some of the internal areas where MFT can improve the flow from improving their own systems.

2.16 The issue of people remaining in an acute bed when they do not need to be there, and indeed it would be better for their health if they were not, is not new. Understanding the reasons behind why this happens is not new either, although recently partners from across the Medway health and social care system have invested a significant amount of time and effort to "drill down" below the surface to gather an understanding of the sort of issues that lead to a DToC.

2.17 DToCs are reviewed weekly at a Friday meeting of a team including representation from St Bart's community hospital, Adult Social Care from both Kent and Medway and senior staff from MFT. This is chaired by the Head of Better Care Fund. At this meeting the numbers and reasons for DToC are agreed, the reasons for delay discussed with actions allocated and recorded.

2.18 The trends surfacing from this detailed review are fed into a monthly Integrated Discharge Team Review with actions and impacts arising from this meeting reported to the Medway and Swale Executive Programme Board.

2.19 In addition to those reportable as DToC there is a cohort of patients who are medically optimised[2], that is those who no longer require any clinical input, however they may still be requiring:

- A multi-disciplinary team assessment (MDT)
- An external Package of Care (PoC)
- A short term bed-based assessment or rehabilitation equipment

There are a number of patients whose treatment is complete and, although they might require a period of further care, are deemed to be medially optimised or "fit to move" from their hospital place where there are other non-medical reasons that lead to a delay, these include:

- The ward staff are required to complete a continuing health care (CHC) checklist
- Patients will be assessed to establish if they qualify for ongoing financial support under CHC or social care
- Assessment and Best Interest meetings for those patients who do not have the capacity to make those decisions for themselves and have no-one available to make those decisions on their behalf. Sometimes, if there are people able to act on someone else's behalf there are delays in contacting these and getting them to agree a course of action
- For those who neither have capacity nor have anyone able to make decisions on their behalf, it is necessary to engage the services of an Independent Mental Capacity Advocate (IMCA) and there are frequently delays in allocating this resource as well as delays attributable to the length of time the process itself takes to reach an outcome
- Patients whose assessment outcomes suggest that they are eligible to be considered for continuing healthcare funding require a Decision Support Tool (DST) to be completed and a subsequent eligibility decision arrived at
- Those not eligible for CHC or social care funding (also referred to as "self-funders") that remains in a hospital bed while they, or more likely their family / carers, sort out an appropriate onward path for them. This frequently involves dealing with family-based financial issues

2.20 This last group is the people frequently referred to in short-hand as "Choice", which often means that their care has finished, they may or may not be eligible for funding under continuing health or social care so may need to fund any placement in a nursing or residential care home for which there is a charge themselves. Sometimes, the patient or their family or carers will decide on a placement that does not presently have vacancies, the patient then remains in a hospital bed until that place becomes available.

[2] The term "medically optimised" is also sometimes referred to as "fit for discharge" or medically fit for discharge". Essentially what it means is that the patient's treatment, the reason they are in hospital, has been completed and they no longer require being in a hospital bed to continue their treatment or facilitate their recovery.

2.21 Frequently these are the most vulnerable people, with families that sometimes have difficulties engaging with this process because of time and other family pressures.

2.22 Sometimes, though, the families of these patients do not engage and this leads to the person remaining in a hospital bed while the hospital team and IDT continue to attempt to find a way to engage. Currently there is no "sanction" to bring about a solution: if they fail to engage, for whatever reason, then the hospital simply has to continue to supply what are by this time "hotel services".

2.23 However, there is a well documented danger that people in this last cohort frequently enter a spiral of gradual decline in their health, not a good situation for them, their families or the hospital.

2.24 Finally, there are people in the system for which there is presently no appropriately robust provision. These are those patients have become "stuck" in the system who have a multitude of issues and needs that frequently fluctuate in their intensity which means that they appear to "yo-yo" between fitness and continuing to require acute care.

2.25 These patients may also be among a growing number who are not currently catered for in existing residential provision, specifically because they increasingly present with the more challenging facets of dementia.

2.26 There are also patients who present with no fixed abode or become homeless while they are in hospital and do not qualify for assistance from the local authority, or have other complex issues such as drug and, or alcohol addictions..

2.27 The ability to discharge either into a residential or a nursing home also has the potential to bring delays to the rapidity of a safe and effective plan as many providers need to reassess people, whether or not they originally came from that placement, which builds delays into the process when there are capacity issues within the placement to ensure that reassessment takes place in a timely manner.

2.28 Finally, there are a series of services which because of contractual issues are outside of the direct control or influence of the Medway system these include:

- The provision of inpatient services for people with mental health needs which are provided as a Kent-wide service from Kent and Medway NHS and Social Care Partnership Trust
- Capacity within the local care "market" for those requiring specific support such as dementia and those with mental health issues
- National companies operating within the Medway area providing domiciliary, residential and nursing home care resulting in local issues with provision of domiciliary packages of care or nursing home capacity
- The provision of patient transport which is currently provided by NSL until 31 March 2016 after which a new provider will be in place: the retendering of the contract is being undertaken by West Kent CCG
- National housing guidelines that result in complexities in terms of discharging someone who has become homeless while in hospital

3. Options

3.1 It is clear that the outcomes of the ECIP work will have an impact on how the local health economy reacts to the pressures of this winter although that has yet to be finalised.

3.2 Work understanding and mapping existing services across the system that can have a positive impact of the avoidance or delay of admission is underway as part of the ECIP programme and a workshop took place on Friday 11 December to take this forward.

3.3 Development of the Home to Assess and Intermediate Care strategies will also impact on the ability to provide stability across the system and affect the rate of discharges. The “Home to Assess” trial began Monday 21 September A workshop focussing on this discharge pathway took place on 2 December.

3.4 As part of the Discharge work, there will be some who require a further period of time-limited reablement and support which following this would be able to progress home. It is likely that the more appropriate place for these patients would be a place in a community setting and this is covered within the emerging Intermediate Care Strategy.

3.5 Understanding of internal pinch-points within MFT from the ECIP length of stay review will provide pointers to internal improvements to capacity.

3.6 Understanding the practical issues relating to and acting on the best practice relating to establishing the Fair Cost of Care in the Medway system.

3.7 Working to stimulate the local market, work with national providers with local capacity and encouraging the development of care services where there is presently a lack of provision.

3.8 Work needs to be undertaken to establish some kind of temporary accommodation where people with additional housing needs might be temporarily placed until their permanent accommodation is resolved: specifically those who can not return home due to delays in undertaking minor alterations or cleaning.

4. Advice and analysis

4.1 A significant amount of work is already under way to join together the various facets across the whole health and social care economy to ensue that the system works for people in the best possible way.

4.2 The capacity within the market governs the rate at which people can be discharged; this is a national issue from which Medway is not exempt.

4.3 Medway Council and the CCG are in the process of commissioning a range of community services and are also examining how to make the best use of the local market, how best to encourage investment in those areas that require it and this work is proceeding at pace.

4.4 Medway's Better Care Fund identifies that increase in community resilience will assist in delays to hospital admissions, changes to the way services are configured, frequently referred to as "pathways", will clarify how professionals might address patient needs in the most effective and timely manner and increases in whole-system collaboration are bringing together the facets of the health and social care system in Medway to produce a more joined-up response for the citizen.

4.5 The insight gained from working with the ECIP team will undoubtedly be invaluable and the focus on the three work-streams, Admission Prevention, Hospital Flow and Discharge and Community Care will further enhance how the Medway systems work for the best outcomes for citizens.

4.6 The continuing focus on understanding and ironing out the pinch-points in the system that lead to DToC will reduce further those delays which are avoidable.

5. Risk management

5.1 The specific risks associated with this report are detailed below

Risk	Description	Action to avoid or mitigate risk	Risk rating
Inability to change a complex-interdependent system.	Day-to-day operational involvement from providers prevents them from making the required changes to develop a long-term integrated vision.	Commissioners will work closely with providers throughout the process and ensure that they have the necessary support and resources to deliver the essential changes in the timeframe required.	Medium
Inability to change complex working practices.	Inability within the timeframe required to address the cultural and competency requirements across the whole workforce to enable integrated working to be successful.	Whole system approach to change-management will be developed to ensure staff feel "safe" to change their working practices.	Medium
Inability to affect the market to produce sufficient capacity in high-risk areas.	The Medway market is not a stand-alone situation so encouragement to invest in provision in this area may require some specific incentivisation to bring urgently required resources into the area.	Partnership Commissioning will develop a system-wide view of the areas requirements and take a joined-up approach to commissioning plans.	Medium

Adverse publicity	Current challenges and service gaps are outlined in this report which may cause some short term adverse publicity.	Communication of intention to work through existing processes already in place, specifically the ECIP programme, to bring about improvements in a system-wide and timely manner.	Low

6. Legal and financial implications

6.1. There are no specific legal or financial implications directly arising from this report.

7. Recommendations

7.1 The Committee is invited to consider the report and comment.

7.2 The Committee is invited to suggest that a review report of the outcomes from the ECIP programme is resubmitted at the first meeting of the new Municipal year.

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Appendices

None

Background papers

None