Social Services, Housing and Public Health Policy Overview Committee - Major Review 2016/17 - Hospital Discharges

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REASON FOR ITEM

The Committee is asked to give consideration to the evidence given during the review and to consider making suggesting recommendations to take forward.

OPTIONS OPEN TO THE COMMITTEE

The Committee is asked to give consideration to the evidence received during the review and with the assistance of officers, suggest recommendations for inclusion in the Committee's draft final report.

INFORMATION

1. For Members information the evidence from the witness sessions held on 4 October, 2 November and 14 December 2016 is detailed below. A further report will be circulated prior to the meeting which will outline some themes and some suggested recommendations for Members to discuss.

4 OCTOBER 2016

2. The aim of the review was to examine the discharge process from hospital and how people were supported into the least restrictive care setting in order to maximise their independence and safely meet their needs.

3. The focus of the review would be on Hillingdon Hospital where around 80% of the people admitted were from within the Borough of Hillingdon. Of those admitted as emergencies, almost 30% were of people aged 65 and over and registered with Hillingdon GPs.

   The Committee agreed that this age profile would be the focus of the review.

Current context

4. The Committee was informed that changes in the levels of activity in the last two years had increased patients delayed transfer to care. Reference was made to research which showed that the longer an elderly person was in hospital, they were more likely to become increasingly confused, and there was also an increasing risk of them contracting a hospital acquired infection.

5. In addition, delays in discharging people who were medically fit added increasing pressure on hospital bed provision, which could lead to higher costs.

6. Reference was made to NHS England (NHSE) who had reported that nationally, everyday more than 6,000 patients who were well enough to leave hospital were unable to do so because of insufficient local care models. With a 23% rise of delays in discharge nationally since June 2015, “joined-up care” remained the single most important feature for ensuring greater patient safety and efficient hospital discharge planning.

7. The National Audit Office (NAO) estimated the cost to the NHS of older patients in hospital beds, no longer in need of acute treatment, totalled £820 million every year. Longer stays in hospital also led to increased social care costs.

Preventative Initiatives

8. The most effective method for addressing hospital admission was to prevent hospital admissions from occurring in the first place.

   - Development of an anticipatory model of care for older people

   This was where older people, who had been identified as being at risk of hospital admission, were invited into their GP surgery to explore the completion of a care plan.

   This was to identify any interventions which might prevent an escalation of need.

   For people with more complex needs, a multi-disciplinary team (MDT) approach was taken. For example, an approach which would involve professionals from different health and care organisations, seeking to identify solutions which would prevent or delay further escalation of need and enable the management of the person in their usual place of residence.

   H4All (a consortium of local third sector organisations) played a crucial role in this initiative.

   - Better Care Fund Plan (BCF*)*

9. A key priority of Hillingdon's 2016/17 BCF was the prevention of admission to hospital and this was reflected in its eight schemes that looked at issues such as addressing the needs of older people at risk of falls, stroke, dementia and/or social isolation, preventing admissions to hospital from care homes and supporting people at home who have had an escalation of need but did not require admission to hospital. This initiative involved cross over work with what was happening in GP surgeries.

10. The Committee was informed that delayed transfer of care occurred when a patient was ready for transfer from a hospital bed, but was still occupying such a bed. This was a joint health and social care issue.

11. Reference was made to improvements being made in acute care which were helping support discharges from hospital. These were included in the draft scoping report for Members information.

12. Members were informed that discharges from hospital were complex issues and increased integrated working was required from both health and social care professionals.

13. Reference was made to the work of LondonADASS, who were working in collaboration with NHSE and the Local Government Association to support local systems to improve the performance of hospital discharges. The Hospital Admission and Discharge Pathways Network had been created which aimed at developing and sharing good practise in addressing delayed transfers.

14. Discussion took place on the information provided and the Director of Public Health reiterated that patients leaving hospital was often a complex issue. Additionally there were instances where people had been admitted to Hillingdon Hospital who need not have been admitted in the first place.

15. The Committee noted that progress was being made, but it was recognised that there were inconsistencies, which would only be eradicated once changes in working practices had been given time.

16. Discussion took place on communications with the family of the patient and whether families were given details of options in terms of different care homes. The Head of Social Work reported that there was on-line information available for families and early discussions took place on patient pathways.

17. The draft scoping report provided details on the issues and challenges to a smoother discharge process and pathway in Hillingdon. Some of these were discussed, particularly around the need to align hospital processes. This would require the alignment of decisions on availability of medication and transport home, which was not consistently occurring across all wards at Hillingdon Hospital.

18. The fragmentation of out of hospital services created a problem of multiple hand-offs between organisations which on occasions meant that the needs of residents were not being addressed by the most appropriate professional.

19. Members asked that data be provided on what the over 65 year olds were in hospital for to enable a focus on the key health issues. It was noted that during the winter

months that hospital admissions were higher, with respiratory conditions increasing and potentially more falls taking place.

20. Particular reference was made to the quarter 1 2016/17 statistics which showed there had been 430 emergency admissions to Hillingdon Hospital from care homes, with many of these being older people suffering from dementia.

2 NOVEMBER 2016

21. For this witness session, the Committee was provided with evidence from the Chief Operating Officer of Hillingdon Clinical Commissioning Group and from the Clinical Team Leader for the Continuing Healthcare Team.

Clinical Commissioning Groups' Perspective on Hospital Discharges

22. The Committee was informed that the Clinical Commissioning Group was **clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.**

23. Commissioning was about getting the best possible health outcomes for the local population, by assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as hospitals, clinics, community health bodies, etc.

24. The Chief Operating Officer, Hillingdon Clinical Commissioning Group attended the meeting and reported that there had been a 12% increase in the over 80s age group attending Accident & Emergency at Hillingdon Hospital. With an ageing population and the increase in the number of dementia cases, the planning of hospital discharges had become challenging.

25. It was important that the needs of the patients were clearly identified and there needed to be a consistency of processes to enable all agencies to identify who was accountable for providing particular elements of care and support. Care Planning was vital with an overarching Care Plan for each person. This required close working with social care professionals and the timely carrying out of processes.

26. As hospitals were busy, often there was reactive rather than proactive responses to people's needs. The aim should be to work closely with partners to get patients home sooner and help combat the growing pressures the hospital was experiencing, which were being exacerbated by delayed transfers of care.

27. The transfer of care planning requirements should improve patient experience and quality of care and enable all medically fit patients to be discharged with appropriate care and support at home, wherever possible. This would reduce delayed transfers of care and lower the readmissions of patients.

Continuing Healthcare Team perspective on Hospital Discharges

28. The Clinical Team Leader for the Continuing Healthcare Team reported that Continuing Healthcare (CHC) was the name given to a package of care which was arranged and funded solely by the NHS for individuals outside of hospital who had on-going health care needs. Adult Continuing Healthcare was provided when an individual had been assessed by a multi-disciplinary team and they had been deemed to have a primary health need. After this had been defined, a package of care would be developed.

29. Members were informed that continuing healthcare was available in any setting to meet assessed needs, including the patient's own home or a care home. Reference was made to assessments for continuing healthcare being triggered when a person was admitted to hospital. A person who was eligible for CHC would typically have complex health conditions and would be eligible for NHS care. If a person was not entitled to NHS care they would be eligible for means tested local authority social care.

30. Reference was made to the decision-making process which should always be centred on the person requiring the care. This meant putting the individual and their views about their needs and the care and support required at the centre of the process.

31. Reference was made to the use of the Checklist Tool, which was a screening tool used to assess whether a full assessment of eligibility for continuing healthcare was required. Once the Checklist had been completed and it indicated that there was a need to carry out a full assessment of eligibility for NHS continuing healthcare, the individual completing the Checklist would contact the Clinical Commissioning Group (CCG) who would arrange for a multidisciplinary team to carry out an up-to-date assessment of the person's needs.

32. Unfortunately hospitals were very busy so it was inevitable that there would be delays. It was important that families of patients and the hospital were involved in discussions regarding eligibility for care but that expectations of families should be managed due to issues of choice of care and the cost of care packages.

33. A lack of clarity for patients and their families about care choices, including the funding of care, was identified as a cause of some delays in discharge. It was recognised that this could be addressed by the availability of better information at an earlier stage in order to manage expectations. The Committee was informed that addressing this was included within the DTOC action plan for 2016/17.

34. Eligibility criteria assessments had to be completed within 30 days, but disputes between parties sometimes resulted in delays. Making decisions on a relative with health needs was a stressful and upsetting time for family members, with disagreements sometimes taking place in relation to making the right health care choices for their elderly relative. The important role of Advocacy Services in the process was noted.

35. Discussion took place on the changing demographics of the population with an increasing number of dementia cases in the elderly age group. The number of these cases, made the process of discharge challenging.

36. It was generally noted that the provision of care homes for dementia was a difficult area, in terms of costs and affordability. Members asked for details on what the proportion of delays of transfer from hospital were dementia cases. Reference was made to the provision of "step down" beds which were used for patients who were awaiting discharge, but where final decisions on care had not been decided.

37. There were inconsistencies in how quickly the discharge process started which meant that sometimes the complexities about a person's personal circumstances and their health and care needs were not identified at an early stage to enable them to be discharged quicker from hospital. An example was given of where adaptations were required in people's homes, which would enable people to remain in their own homes and retain some independence. In the main, adaptations could be installed the next day, however, more complex adaptations could take time, which could delay a discharge.

14 DECEMBER 2016

38. For this witness session, the Committee was provided with the perspective on hospital discharges from patients (Healthwatch) and from Hillingdon Hospital and Central North West London NHS Foundation Trust.

Healthwatch Hillingdon

39. Graham Hawkes, Chief Executive Officer of Healthwatch attended the meeting and provided Members with a summary of the recent review which had been carried out by the organisation into hospital discharges from Hillingdon Hospital.

40. The project aimed to gain an understanding of the discharge process from the perspective of the patient. It looked at what went well, and what did not go well. The project focused on adults over the age of 65 and their experiences of being discharged from Hillingdon Hospital.

41. The methodology of the review was split into three stages. Stage 1 involved 172 patients being interviewed and completing a survey on 17 different wards at the Hospital. Dependent on the condition of the patient, patient's advocates completed the survey. Stage 2 involved interviewing patients 30 days after being discharged, in which they were asked for their experience of the discharge process and whether their post discharge care had been adequate. 52 discharged patients/advocates completed the second survey.

42. At Stage 3, Healthwatch met with over 20 organisations who commissioned, or provided care services within hospital and the community for the over 65s in Hillingdon. This stage helped the review to identify and understand the processes and procedures involved in hospital discharges, and the factors, barriers and enablers which contributed to providing patients with a safe transfer from hospital to being cared for, out in the community.

43. The Committee was informed that generally the results showed that the over 65s had expressed an overwhelming feeling of pride in the NHS and hospital discharges. However, it was found that staff were working under intense pressure and that care could not always be delivered to the required standard.

The review's findings were summarised into three categories:

- **Communication and Information**

44. Communication between patients / carers and health professionals and the information provided, was sometimes poor. Reference was made to patients being unable to speak to doctors, patients not remembering what had been told to them, patients not knowing which medicines to take, who was coming to see them at home and how to arrange a private care home placement or a care package.

45. Discussion took place on how this could be improved and whilst it was acknowledged that hospitals were very busy, it was suggested that providing clear written information for patients / carers, would improve communication and improve outcomes for patients.

46. Details of the review's recommendations were reported which included updating the Trust's "Working Together" booklet, to include a Patient Journey booklet which provided information for patients / carers.

- **Process and Procedures**

47. There was a marked difference in the discharge procedures on each ward which meant there were discrepancies on how patients were treated in terms of being prescribed medication and how transport was processed. Examples were given on how some patients had been left many hours without hot food and refreshments, either in the discharge lounge, in their beds or in the ward's day room. The recommendation of the review would be to standardise as far as possible the discharge process across all wards. A standardised process would help both staff and patients and improve the quality of care to patients.

- **Closer Integration and Joined up Working**

48. Reference was made to the perception from patients that organisations did not appear to communicate well with each other or work closely enough. Examples of these were assessments being carried out separately by social services and hospital staff, not all relevant partners being invited to multi-disciplinary team meetings etc.

49. It was important that all organisations were aware of each other's services and that the effectiveness of the Joint Discharge team was maximised to its fullest. A possible solution could be a single point of access for discharge which would provide an information hub for professionals and provide integrated care for the patient.

Hillingdon Hospital

50. The following witnesses from Hillingdon Hospital attended the meeting Vanessa Saunders (Deputy Director of Nursing), Dr. Julie Vowles (Consultant Geriatrician) and Julie Wright (Director of Integrated Care).

51. The context to the situation was provided which was that for the over 65s age group, the average length of stay in Hillingdon Hospital had increased when compared to 2015/16. The Committee was informed that a Discharge Task Force Programme had been implemented which was a dedicated “task force” group which would be focusing on improvement and transformation. This would undertake a forensic investigation of the discharge process for every ward at the hospital.

52. The Committee was informed that the task force consisted of 5 individuals, who were mainly drawn internally. Data was collected over 9 weeks and the hospital held a clinical summit reviewing the findings.

The key actions which were agreed to take forward were:-

- Appointing patient flow coordinators to help with communication
- The implementation of a Red to Green system
- Patient involvement in discharge

53. Reference was made to the trial which had taken place on Fleming ward which involved the engagement of patients in managing their own discharge. One of the initiatives involved patients wearing their own clothes. This had a positive outcome with research showing that patients wearing their own clothes spent an average of 0.75 days less in hospital than patients wearing hospital clothes.

54. Work had been taking place with wards to place patient's estimated discharge dates on "About me" notice boards. Overall the results had been positive.

55. Reference was made to the SAFER and Red to Green schemes, which were two national tools which had been introduced to improve the flow of discharges. SAFER consisted of a **Senior Review** which was where all patients would receive a consultant review before midday. **All** Patients would have an expected discharge date which would be based on the medical suitability for discharge status agreed by clinical teams. **F** - **Flow of patients** would commence at the earliest opportunity (by 10am) from assessment units to inpatient wards. **E** – **Early discharge, 33%** of the hospital's patients would be discharged from base inpatient wards before midday. Medication to be taken home for planned discharges should be prescribed and with pharmacy by 3pm the day prior to discharge wherever possible to do so. **R** – **Review**, A weekly systematic review of patients with extended lengths of stay would take place to identify the issues and actions required to facilitate discharge. This would be led by clinical leaders and be supported by operational managers who would help remove constraints that lead to unnecessary patient delays.

56. Details of the Red to Green scheme were reported which was a scheme used to signify progress on patient treatment and eventually discharge. A red day was what every patient started off on. Green days were when patients received interventions

which supported pathways of care through to discharge, a day when all that was planned or had been requested, had taken place on the day it had been requested, which resulted in a positive experience for the patient. In addition a green day was when a patient received care, which could only be delivered in hospital.

57. The Committee was informed that the following improvements would be made to the Discharge work stream:

- Redrafting of the hospital's Working Together leaflet to encompass all the above mentioned suggestions.
- The development of written information for patients and carers in relation to NHS Continuing Healthcare Assessments.
- The continuation of work in progress to review and revise discharge processes and procedures including prescribing and issuing of medication to take home and the format of Multi-Disciplinary Meetings to aid discharge planning.
- The development of an in-house survey to capture patient and carer feedback and satisfaction scores following discharge.

58. Particular mention was made of the improvements needed in relation to communication at patient's bed meetings, the introduction of virtual Multi-Disciplinary Meetings for Mt Vernon wards, the introduction of ward based medication to take home and therapy communication.

59. The Committee was informed that both the hospital and Healthwatch were working together and sharing information and ideas on improving the discharge process. This was welcomed.

Central North West London (CNWL) NHS Foundation Trust

60. The following witnesses from CNWL attended the meeting Kim Cox, Borough Director and Claire Eves, Head of Adult Services.

61. The Committee was informed that the needs of people with mental health issues were catered for by Liaison Psychiatry who saw patients who presented themselves at A & E. with symptoms ranging from self-harm, suicidal ideation to psychotic symptoms. Patients were assessed and sign posted to other services. Patients were also seen in general hospital wards where again they were assessed, staff were advised and help was given with the discharge plan if their mental health needs dictated it.

62. The Clinical Health Psychology service helped patients who were having serious difficulty coping with an illness or a disability, which impacted on their lives.

63. Reference was made to the Rapid Response Team (RRT) who provided a rapid response 7 days a week in A & E. Assessments were made of patients to facilitate their discharge home. Specifically in relation to patients over the age of 65, RRT Clinicians attended wards to assess patients and if suitable for discharge, they were discharged under the care of RRT.

64. The Committee was provided with details of the Homesafe scheme which was commissioned to help facilitate early supported discharge, which included people aged 65 years and over. Through this service, patients had access to therapy, nursing and/or care support, including a night sitting service.

Areas which had been identified to improve discharges were:

- Better information sharing through IT. Sharing information would avoid duplication of assessments. It was important that the service had information of other health issues of patients they were treating with mental health issues
- The development of 15 Care Connection Teams
- Reviewing and improving the current Rapid Response Service
- The establishing of a single point of access
- Better integration of intermediate care services

Discussion

65. Recognition was made of the requirement for a single point of access for discharge which would improve the communication to the patient / carer. The Committee was reassured that this was already being put in place across North West London and would greatly improve the process of discharge.

66. It was acknowledged that joint and closer working would improve the process and maximise the use of resources and avoid duplication. Members acknowledged that hospitals were very busy places and health professionals had heavy and involved workloads, but the suggested improvements would ultimately improve the discharge experience for patients.

67. Discussion took place on the funding for social care and the difficulties in terms of recruitment, but the Committee was informed that authorities were introducing new schemes to attract and fill vacant posts.

68. The Committee was provided with demographic information for the Borough which indicated that there were an increasing number of older people living in the Borough. With people living longer the incidences of people with dementia was on the increase, which was impacting on social and health care. This was likely to increase with Projecting Older People Population Information projections suggesting that the number of people with dementia was likely to increase by 14% to 3,133 between 2015 and 2020 and by 25% to 3,606 in the period between 2020 and 2025. This would be a challenge for the provision of health and social care services.

69. A cause for the delay in discharge was because of the changing demographics of the population and some of the complex care needs of patients.

70. The Committee noted that the diversity of Hillingdon's population needed to be taken into consideration and that certain ethnic groups were sometimes reluctant to come forward.