SOCIAL CARE, HOUSING AND PUBLIC HEALTH POLICY OVERVIEW COMMITTEE - 2016/17 HOSPITAL DISCHARGE REVIEW UPDATE

Committee name	Social Care, Housing and Public Health Policy Overview Committee
Officer reporting	Gary Collier, Adult Social Care Services
Papers with report	Appendix 1 – Review witnesses
Ward	All

HEADLINES

To provide the Committee with an update on progress with delivering the recommendations in its report following the review of the hospital discharge process that was undertaken in Quarter 3 2016/17.

RECOMMENDATIONS

That the Committee:

1. **Questions officers and partners about progress following the 2016/17 review.**
2. **Instructs officers about further updates required by the Committee.**

SUPPORTING INFORMATION

Introduction

1. In Q3 2016/17 the Committee undertook a review that examined the discharge process for people aged 65 and over who were admitted to Hillingdon Hospital. The Committee interviewed a number of witnesses details of which are set out in **Appendix 1**.

2. The Committee focussed on Hillingdon Hospital as approximately 80% of the people admitted to it were residents of the borough. For people aged 65 and over the rate was actually 83%.

3. The Committee decided on hospital discharge as a topic for a review because of the very high national profile that delays in hospital of people who no longer required being in a hospital setting for treatment had at the time. The Committee will be aware that this issue continues to have a high national profile.

4. The Committee was made aware of research that showed that the longer an older person is in hospital the more confused they get and the more susceptible they are to hospital acquired infections. In addition, long stays in hospital can also lead to a rapid deterioration in physical health and wellbeing.

5. Following its review the Committee made eight recommendations that were accepted by Cabinet at its February 2018 meeting. This report sets out the recommendations from the Committee's review, the reasons behind them and the current position.

Current Context

6. A target for a reduction in delayed transfers of care (DTOCs) was set for Hillingdon for 2017/18 by NHS England (NHSE) that was challenging. The outturn for 2017/18 was actually 2,796 delayed days below the ceiling of 9,338 delayed days. Performance for the constituent parts of the target, i.e. delays attributed to the NHS, social care and to both, were all below their respective ceilings for the year.

DTOCs Defined

A DTOC occurs when a patient is ready for transfer from a hospital bed, but is still occupying the bed. A patient is ready for transfer when:

a) A clinical decision has been made that the patient is ready for transfer; AND

b) A multi-disciplinary team decision has been made that the patient is ready for transfer; AND

c) The patient is safe to discharge/transfer.

7. A consequence of success in 2017/18 was a much more challenging target for 2018/19. The target set for Hillingdon by NHSE was more stretching than any of the other fourteen areas within London that have been set a higher target for 2018/19.

8. However, a straight line projection based on activity from April to October 2018 suggests an outturn for 2018/19 25 delayed days above the ceiling of 4,991 delayed days. This is illustrated in table 1 below.

Table 1: DTOC Performance April - October 2018						
Delay Source	**Acute**	**Non-acute**	**TOTAL**	**2018/19 Ceiling (Delayed Days)**	**Projection**	**Variance**
NHS	1,252	968	**2,219**	3,289	3,804	515
Social Care	324	312	**636**	1,392	1,090	-302
Both NHS & Social Care	0	71	**71**	310	122	-188
TOTAL	**1,575**	**1,351**	**2,926**	**4,991**	**5,016**	**25**

9. In respect of Hillingdon's comparative position, there were fifteen areas in London where the total number of DTOCs was higher than Hillingdon's, twelve areas higher for delays attributed to the NHS, eighteen for social care and fifteen for delays attributed to both the NHS and Social Care.

10. Table 2 below summarises DTOC activity at Hillingdon Hospital during the period April to October 2018.

Table 2: Hillingdon Hospital DTOC Activity April - October 2018	
Delay Source	**Total Number Delayed Days**
NHS	755
Social Care	95
Both NHS & Social Care	0
TOTAL	**850**

Review Recommendations and Update

11. This section summarises the recommendations from the Committee's review, the reasons behind them and the current position.

Recommendation 1

12. The Committee recommended:

a) *That clear information about the discharge process is developed for people admitted to hospital and their families so that they know what to expect.*

b) That this information is provided to patients on admission, as agreed through a joint working policy.

13. *Reasons for Recommendation*: The Committee took the view that there needed to be clear information for patients about what to expect so that health and social care staff give a consistent message to enable patients, their Carers and families to make informed choices. This would also help to address unrealistic expectations and could help to prevent difficulties later over choices that may or may not be available.

14. *Current position*: Funding was made available through NHSE's Better Care Small Grants budget in Q4 2017 to fund the production of updated patient information leaflet called *'Working Together'*. This was produced by partners, including Healthwatch, and issued to wards in July 2017. The intention with the booklet was that it would be provided to patients following admission with the aim of setting expectations at the earliest opportunity.

15. This booklet is now being used across wards at Hillingdon Hospital. The booklet is supported by a letter that goes to patients and their families that explains in more detail the discharge process.

Recommendation 2

16. The Committee recommended:

a) That a joint working policy across all partners involved in the hospital discharge process is developed to clarify the roles and responsibilities of the appropriate teams within each organisation and to ensure consistency of approach.

b) That briefings with staff across organisations on the content of the agreed joint working policy are undertaken.

17. *Reasons for Recommendation:* From the evidence presented to it, the Committee concluded that joint working is essential for the effective management of discharge from hospital. In some cases, decisions on the best care for an individual following discharge from hospital are based on a professional assessment of the patient's health, social care and housing needs. It is therefore important that the input from these professionals is coordinated effectively and promptly.

18. The Committee also concluded that protocols and processes needed to be joined up, consistent, sending the same message to patients, to ensure that clear information is given to patients.

19. Current position: A new discharge policy that included patient choice was launched in 2017. This was a Hospital-focused document that did not reflect the inter-relationship with other partners. However, since that time procedures relating to the roll out of the Discharge to Assess (D2A) model (explained in more detail as part of the recommendation 3 update) have been issued and training undertaken across partners and professional disciplines.

Recommendation 3

20. It was recommended that partners explore options for delivering a more integrated intermediate care service that ensures that people admitted to hospital are supported to go home by the most appropriate professional first time and that the number of hand-offs between different organisations is reduced.

21. *Reasons for Recommendation*: The Committee heard that that there was a large range of services delivered by different health providers. This arrangement led to multiple transfers of responsibility for care between organisations, which sometimes resulted in the needs of residents being addressed by the most appropriate professional first time.

Intermediate Care Explained

Definition

Intermediate care services are provided to people (typically older People) after leaving hospital or when they are at risk of being sent to hospital. The purpose is to:

- Help people to avoid going into hospital or residential care unnecessarily;
- Help people to be as independent as possible after a stay in hospital.

Other key characteristics of intermediate care services include:

- They are time-limited, usually up to about six weeks; and
- They are free of charge.

Models of Intermediate Care

The range of models includes:

- **Bed-based Services** such as residential and nursing care homes, standalone facilities like Central and North West London NHS Foundation Trust (CNWL)'s Hawthorne Intermediate Care Unit (HICU) and Council's stepdown/step-up flat at Cottesmore House.

- **Crisis Response Services** that are based in the community and are provided to people in their own home or a care home with the aim of avoiding hospital admissions. The local example would be CNWL's Rapid Response Team.

- **Reablement Services** that are based in the community and provide assessment and interventions to people in their own home. These services aim to help people recover skills and confidence to live at home and maximise their independence. The local example would be the Council's Reablement Team.

22. Current position: One of the main reasons for the number of referrals between organisations and associated confusion was the high number of discharge pathways from the Hospital. Since May 2017 a new discharge model of care called discharge to assess (D2A) has been piloted and a new integrated model is now in place with an emphasis on D2A being the default pathway for all people admitted to Hillingdon Hospital. A target of 65 discharges a week being supported was set and this is now being achieved.

23. D2A is a recognised model of care whereby the assessment of a person's ability to successfully function and carry out their normal daily activities is performed in their own home and not in a hospital bed. It is based on the premise that people recover more quickly in their own home environment. Under Hillingdon's D2A there are three discharge pathways from the Hospital and these are:

a) **Pathway 0:** This is for people whose needs can be safely met at home with minimum support or where an existing package of care requires a restart. This pathway is managed by the ward and applies to approximately 77% of people being discharged from the Hospital;

b) **Pathway 1** is for people whose needs can be met at home with rehabilitation or reablement. This pathway applies to approximately 18% of people being discharged from the Hospital and is managed either by the Rapid Response Team provided by Central and North West London NHS Foundation Trust (CNWL) or the Council's Reablement Team depending on the needs of the resident. Whether a person is referred to Rapid Response or Reablement is determined by triage undertaken by the Integrated Discharge Team;

c) **Pathway 2** is for people who cannot return home because they require a bed based service due to them having more complex needs, although these needs do not have to be met in a hospital setting.

24. The Integrated Discharge Team includes the Hospital's Discharge Coordinators and CNWL's Community HomeSafe Team. It links with the Council's Hospital Discharge Team.

25. The first seven months of 2018/19 has seen a considerable reduction in the number of DTOCs attributed to Hillingdon Hospital activity, e.g. 850 delayed days compared to 1,201 delayed days during the same period in 2017/18. There has also been a reduction in the average length of stay from 7 days to between 3 and 5 days, which is evidence of an improvement. However, there are issues about the model that are in need of refinement and these include:

- There are separate pathways for people who are at end of life or living with frailty and these need to be aligned with pathways 1 and 2 referred to in paragraph 23 above.

- Collation of performance information is a challenge as data sources sit in different places and in different systems.

Frailty Defined

Frailty is related to people getting older. It describes how ageing makes some people vulnerable to sudden and dramatic changes in health triggered by seemingly small events such as a minor infection or a change in medication or environment. In medicine, frailty defines the group of older people who are at highest risk of adverse outcomes such as falls, disability, admission to hospital, or the need for long-term care. Older people with moderate to severe frailty will walk slowly, get exhausted easily and struggle to get out of a chair or climb stairs.

26. The Committee may wish to note that improvements to the D2A model during 2018/19 have resolved the issue of the high number of discharges being cancelled at short notice due to change of circumstances, e.g. availability of transport or medication, etc. Earlier in 2018/19 this was running at a rate of approximately 30% of referrals to Adult Social Care.

27. A business case has been developed that will lead to a single Integrated Discharge Service under a single management structure that it is intended will be implemented during 2019/20, subject to arrangements being agreed by partners. Key targets are to:

- Reduce length of stay of patients in hospital for up to 21 days by 27%;
- Keep bed occupancy levels at the Hospital to below 93%

28. The bed occupancy target is intended to enable the Hospital to have and maintain sufficient bed capacity to cope with demand surges without opening escalation wards that have higher costs associated with them.

Recommendation 4

29. The Committee asked that partners explore affordable options to enable people who are medically fit for discharge to step-down from hospital without the need to be admitted to a care home.

30. *Reasons for recommendation*: The Committee heard from witnesses that once a person has been admitted to a care home they become institutionalised very quickly, which can result in a loss of independence and a shorter life span. In addition, family dynamics can also make it difficult to move a person into a less restrictive setting because of the view that their relative is safer in a care home. The conclusion was that the best option was to avoid a person being admitted into a care home at all if it could be avoided.

31. *Current position*: A business case was developed concerning the possible use of four flats at Park View Court extra care sheltered housing scheme for intermediate care, e.g. step-down from hospital and/or step-up from the community. This was considered by the Hillingdon Health and Care Partners who decided that the case was not made. In the absence of a health funding contribution there was also no business case for the Council to pursue this option. However, the Council is currently leasing a two-bedroom flat at Cottesmore House from Paradigm Housing Association for use as intermediate care and the feasibility of replacing this with two one-bedroom flats within the same scheme is being explored.

32. The criteria for accessing the 22-bed HICU service provided by CNWL and commissioned by HCCG has been extended to enable the service to accept people who are non-weight bearing and are anticipated to still be non-weight bearing after three weeks and are likely to require active rehab when they are weight bearing. This avoids the need to commission care home beds to enable people to step-down from hospital.

Recommendation 5

33. The Committee asked that partners explore affordable options that will ensure an appropriate supply of care home places to address the needs arising from Hillingdon's changing population.

34. *Reasons for recommendation*: With the changing demographics of Hillingdon's population partners were asked to investigate affordable options to ensure there was an adequate supply of care home places to meet the likely increased demand in the future.

35. *Current position*: A key health and care objective reflected in the Joint Health and Wellbeing Strategy approved by the Health and Wellbeing Board in September 2017 is to enable residents to remain as independent as possible in their own homes for as long as possible. However, it is recognised that this will not be feasible for some people. The Council has therefore invested in the development of extra care sheltered housing as an alternative to residential care, e.g. Grassy Meadow Court (opened October 2018) and Park View Court (opening March 2019), but it is also recognised that there will inevitably be people whose health needs escalate to such an extent that a nursing care home placement becomes the most appropriate setting to safely address their care needs.

36. Opportunities for commissioning demand profiling research that reflects the impact of extra care in order to determine the likely required composition of the care home market in ten years' time is being explored by partners.

37. The Committee may wish to note that for the period April to September 2018 99% of people referred to the Council's Brokerage Team for a care home placement were placed between 0 and 2 days and with 0 meaning the day of referral. However, what is noticeable is the increase in fees that homes are now seeking to recover (based on discussions with providers, the Council anticipates that it will need to fund additional costs totalling £1.97 million in 2018/19, increasing to a full year effect of £2.62 million in 2019/20 to ensure that sufficient bed space is available) and the Committee may also wish to be aware that the Council is intending to use additional funding provided by the Department of Health and Social Care, totalling £1,041k for both 2018/19 and 2019/20 to support winter pressures and also for 2019/20 to support the care market in order to ensure continuing access to placements within the local market as well as retaining existing ones. This approach will help to prevent DTOCs arising due to lack of supply.

Recommendation 6

38. The Committee asked that partners explore affordable options for ensuring that people admitted to hospital and their families have access to advocacy to support them in making informed decisions about how their future care needs will be met, including the care setting.

39. *Reasons for Recommendation*: An advocacy service is provided by an advocate who is independent of social services and the NHS, and who is not part of the patient's family. An advocate's role includes arguing the case of the patient, and making sure the correct procedures are followed by health and social care services.

40. In the case of elderly vulnerable people, this is an important role, particularly during the stressful situation of being discharged from hospital. Being independent means they are there to represent the wishes of the patient without giving their personal opinion and without representing the views of the NHS or the local authority.

41. _Current Position_: The Council has in place an integrated advocacy contract with a provider to deliver statutory advocacy services such as:

- *Independent Mental Capacity Advocacy (IMCA)* - This helps to support decision making where a person lacks capacity;

- *Independent Mental Health Advocacy (IMHA)* - This is intended to support people who have been detained under the 1983 Mental Health Act;

- *Care Act Advocacy* - This is intended to help people who the Council has or may have duties to under the 2014 Care Act express their wishes and feelings, support them in weighing up their options, and assist them in making their own decisions.

- *NHS Complaints Advocacy* - This service supports people to make complaints about the service they have received from the NHS where they feel unable to so by themselves.

42. The gap in provision concerns advice and support for self-funders to access suitable care home or home care placements to address needs. Discussions are currently in progress between the Council and the Hospital about the implications (including resources) of the Council undertaking this function on behalf of the Hospital.

Recommendation 7

43. The Committee asked that Healthwatch Hillingdon consider undertaking a further review of the patient experience of the discharge process at Hillingdon Hospital in a year's time.

44. Reasons for Recommendation: Healthwatch undertook an extensive engagement programme between June and October 2016 that saw them interview and survey, 172 inpatients in Hillingdon Hospital, 52 of whom were post discharge and the professionals and staff from over 20 organisations. The Committee considered that it would be helpful if Healthwatch could revisit their review, as this would enable the extent to which the patient experience of the discharge process had improved.

45. Current Position: Healthwatch Hillingdon has decided to postpone undertaking a further review pending implementation of the results of the CQC inspection of the Hospital undertaken in 2018.

Recommendation 8

46. The Committee asked that a progress report be provided that included an update on recommendations 1 to 7 above as well as the following metrics that were identified as indicators as to the extent to which there was improvement in the hospital discharge process:

- **Number/% of Delayed Transfers of Care in Hillingdon Hospital attributed to patient/family choice** - The period April to September 2018 saw a considerable improvement in the number of delayed days attributed to the above reason. This reduced from 649 delayed days or 61% of all delayed days associated with Hillingdon Hospital's beds to 133 delayed days or 19% of all delayed days in the same period in 2018/19.

- **% of continuing health care assessments taking place in a hospital setting** - It is preferable for eligibility for NHS Continuing Healthcare to be considered after discharge from hospital when the person's long-term needs are clearer and for NHS-funded services to be provided in the interim. To this end a target has been set for 2018/19 for all CCGs that under 15% of full assessments should be undertaken in an acute hospital setting, such as Hillingdon Hospital. The average for the April to September 2018 period is 36%. The goal is to achieve the under 15% target by the end of the financial year and an additional 6 care home beds have been commissioned by the CCG for the winter period to enable people to step-down from a hospital bed where they no longer require treatment in a hospital setting.

- The Committee may wish to note a focus of the Continuing Healthcare Team during 2018/19 has been to ensure that CHC funding decisions are made within 28 days of referral. The target is 80% of referrals and this target was met in Q2 2018/19 and for October and November.

NHS Funded Continuing Healthcare (CHC) Explained
This means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need' due to the nature, intensity, complexity and unpredictability of their needs.

- **Number/% of patients discharged before midday 7 days a week** - Table 3 below shows that targets for 2018/19 are not currently on track.

Table 3: Hillingdon Hospital Discharges before Midday			
Item	**2017/18 Baseline**	**2018/19 Target**	**April - Sept 2018/19 Outturn**
Medicine Directorate, inc A & E			
Discharges before midday	20.4%	33%	18.5%
Weekend discharges	17%	65%*	15.9%
Surgery Directorate			
Discharges before midday	19%	33%	18.8%
Weekend discharges	15.9%	65%*	16.6%

* *Percentage of weekday discharges*

47. It was reported to the Committee's November meeting as part of the update report on the Better Care Fund (BCF) that there is infrastructure that needs to be put in place in order to support seven day discharge. This is summarised below with an outline of the current position:

- Consultant cover to sign off discharges: Criteria-led discharge is being rolled out in wards across the Hospital. This enables staff at junior sister grade and above to make discharge decisions after having completed appropriate training. This will help to expedite timely discharges when implemented across the Hospital.

- Hospital Discharge Coordinators availability at weekends: Consultation is due to take place in Q4 about the possibility of changing terms and conditions to support seven day working.

- Pharmacy availability: Funding for additional weekend pharmacy provision has been agreed and the Hospital is in the process of recruiting.

- Rapid Response cover for weekend triage and assessment: There is currently no funding available to support additional Rapid Response provision at weekends, but health and care partners are exploring how existing resources can be remodelled to provide necessary supporting capacity.

Implications on related Council policies

A role of the Policy Overview Committees is to make recommendations on service changes and improvements to the Cabinet who are responsible for the Council's policy and direction.

How this report benefits Hillingdon residents

None at this stage, pending any findings approved by Cabinet.

Financial Implications

None at this stage.

Legal Implications

None at this stage.

BACKGROUND PAPERS

Nil.

Appendix 1

Review Witnesses

Witness Session 4 October 2016	• Gary Collier (Health & Social Care Integration Manager) • Nina Durnford (Head of Social Work, Adult Social Care Services) • Dr Steve Hajioff (Director of Public Health)
Witness Session **2 November 2016**	• Gary Collier (Health & Social Care Integration Manager) • Nigel Dicker (Deputy Director Residents Services) • Nina Durnford (Head of Social Work, Adult Social Care Services) • Sandra Taylor (Head of Service - Early Intervention & Prevention) • Caroline Morison (Chief Operating Officer, Hillingdon Clinical Commissioning Group) • David Muann (Clinical Team Leader for the Continuing Healthcare Team)
Witness Session **14 December 2016**	• Kim Cox (Borough Director, Central North West London NHS Foundation Trust) • Claire Eves (Head of Adult Services, Central North West London NHS Foundation Trust)

	• Graham Hawkes (Chief Executive Officer, Healthwatch Hillingdon) • Melissa Mellett (Director of Operational Performance, Hillingdon Hospital) • Caroline Morison (Chief Operating Officer, Hillingdon Clinical Commissioning Group) • Vanessa Saunders (Deputy Director of Nursing, Hillingdon Hospital) • Julie Vowles (Consultant Geriatrician, Hillingdon Hospital) • Julie Wright (Director of Integrated Care, Hillingdon Hospital).