Report regarding Hospital discharges in Brighton & Hove

The purpose of this paper is to provide a briefing to the Adult Social Care and Housing Overview Scrutiny Committee on hospital discharges (including delayed transfers of care) and the actions being taken by the local health and social care economy to manage this process.

Background information

Admission to and discharge from any hospital is often a very stressful time for individuals, their families and friends. Most people, after treatment will return home and their usual way of life continues with very little or no help or assistance from state funded bodies. Some people however will need additional help to enable them to do so over and above their medical treatment. These needs cannot be met by one single organisation working alone. Effective hospital discharges can only be achieved when there is good joint working between the NHS, local authorities, housing organisations, primary care and the independent and voluntary sectors in the commissioning and delivery of services.

The local health and social care economy have been working together on this issue for some years to ensure that the discharge process is effective and efficient and there have been significant improvements over this time. These improvements have been both in the numbers of people being delayed and the length of time people remain in hospital e.g. most delays are usually for only a day or two.

In Brighton & Hove the partnerships established are based on the following premise:

- Acute hospitals should only be used for the those people who need acute hospital care, delivering services that cannot be provided as effectively elsewhere in the health service, or in parts of the social care or housing system
- The majority of people admitted to hospital fear the experience of hospitalisation and of losing their autonomy; they want to return to living their previous lives as soon as possible, with the support of family and friends
- There should be a presumption that every effort should be made to enable people to return to their lives as soon as possible and the NHS and City Council should help them do so.

- The provision of long term residential or nursing care for people coming out of hospital is the last option, other options need to be considered first.

NHS Brighton & Hove (NHSBH) and Brighton & Hove City Council, Adult Social Care & Health (ASC&H) jointly commission and fund arrangements to provide services for people who need support when leaving hospital, these include an Intermediate Care service (both a bed based and home care service); transitional beds and daily living equipment. These services are provided by South Downs NHS Trust, Brighton & Hove City Council Adult Social Care in house teams and Age Concern.

NHSBH also fund people through the Continuing Healthcare funding arrangements for people who need long term specialist health support, they are able to do this for people living at home or in residential or nursing homes. These arrangements include a clinical assessment of need and are not charged for when used. There are also arrangements for those people needing end of life care.

ASC&H fund residential placements through the use of the Community Care budget for those people who are unable to live at home or where there is a need to provide care at home. A social care assessment (including a financial assessment) is made to determine the needs of each individual, and services are increasingly being provided through the use of Self Directed Support or Personalised budgets where people require financial support. Where people are 'self funders' and do not require financial support they are also entitled to an assessment of need and are able to access the service of their choice from a range of services and organisations.

Delayed transfer of care

The national definition of a delayed transfer of care is when a patient is ready for transfer from acute care, but is still occupying an acute bed. A patient is ready for transfer when

a. A clinical decision has been made that patient is ready for transfer **AND**

b. A multi-disciplinary team decision has been made that patient is ready for transfer **AND**

c. The patient is safe to discharge/transfer.

A multi-disciplinary team in this context includes nursing and other health and social care professionals, caring for that patient in an acute setting.

Non acute services also experience delayed transfers and whilst these are not monitored via national targets, they are monitored closely in Brighton and Hove and improvement plans are as relevant to these services as they are to the acute hospital trust.

The current delays in for Brighton & Hove residents equate to on average of 16 delayed discharges per week, this is for a variety of reasons including NHS and social care delays. It is has been recommended there should be a total of approximately 14 delays across BSUH on a weekly basis (8 for Brighton & Hove residents).

Why delayed transfers of care occur?

Patients become delayed for a number of reasons.

- It might be that they require further assessment before their discharge destination can be decided, there may be a lack of capacity in local care homes or community hospitals or they may need a specialist placement or have complex housing issues.
- Some delays are related to personal choice with the patient or their family/carer taking time to make a decision about a long-term placement.
- Sometimes there is a lack of planning when people are admitted to hospital.
- There are also more systemic issues with the discharge process that result in delayed transfers of care. These include delays in requesting assessments and referral to the various services whose input is required to help plan for and facilitate discharge. Some services also require their own assessment and do not fully utilise information in existing assessment. The result is that patients experience serial assessments and minimal 'joined up' working between services.

In comparing acute and non acute reasons for delays it is clear that patients delayed requiring some kind of long term placement or package of care are tending to move to non acute provision first. This is consistent with good discharge planning in that decisions about long term care should not be made in acute setting however patients are remaining in non acute care for extensive periods beyond the decision that they are fit for discharge.

Impact of delays

Delayed transfers of care are important as they have a direct and negative impact on the quality of care of individuals. Older people, for example, are at risk if kept in acute hospital once their medical needs have been met – they lose their independence, mobility, and social networks, and are at risk of falls and infection. For patients with confusion or dementia there are additional risks of losing capacity and of premature entry into a care home.

Delayed transfers of care also have a negative impact on the system as a whole with acute hospital bed days 'lost' to the system making the delivery of key national targets such as the 4 hour standard in A&E particularly challenging for BSUHT.

Monitoring hospital discharges

It is recognised that delayed transfers of care is not something that can be completely eradicated from the system, however the local health and social care economy is measured on delayed transfers of care by the Department of Health and has agreed some local indicators.

Delays are monitored in the following ways:

- The number of delayed transfers of care and reasons for delayed is agreed between social services, the PCT, BSUH and community providers on a weekly basis. This information is collated and used to inform a return (known locally as SITREP) which is submitted to the Department of Health. This information is a snapshot position only and shows the number of people delayed as of midnight on a Wednesday.
- Local organisations are now measured differently, the methodology for measuring individual organisations' performance varies in construction, time periods and data sources:
    - PCTs are measured on delay in acute and community beds as a rate per hundred thousand population.
    - Acute Trusts are measured on acute delays as a percentage of the number of acute admissions.
    - Adult Social Care are measured on delays as a rate per 100,000 population
    - Other organisations including third sector organisations are managed through contracts for service

Funding (Payment by Results and Reimbursement)

Acute trusts are currently recompensed for delayed transfers of care in two ways:

- Under Payment by results, the PCT pays an additional charge on a daily basis when the length of stay of an admission exceeds what is know as the 'trim point' for that particular condition. In the example of a bronchitis admission, a daily charge of £171 would be incurred by the PCT if the admission exceeded 17 days.
- Under the provisions of the Community Care (Delayed Discharges etc) Act 2003, acute hospitals are entitled to levy a daily charge of £100 on local authorities for patients whose discharge is delayed as a consequence of the local authority not putting in place the services the patient or their carer need for discharge to be safe**.** This process is otherwise known as reimbursement**.**

However this still means that a significant proportion of acute capacity is occupied by patients who no longer need acute care. Non acute providers are not entitled to the same recompense.

Actions to address delays

To improve hospital discharge across acute and community services to reduce length of stay and delayed transfers of care a group has been set up with representatives from across the local health and social care economy including commissioners and service providers (representatives from 3rd sector organisations providing care, NHS and the local authority). This group, the Hospital Discharge Operational Group aim to:

- Focus on addressing practical issues to reduce length of stay and delayed transfers of care in acute and community services
- Monitor performance against key performance indicators and national targets relevant to improving hospital discharge
- Determine priority work streams and establish appropriate operational groups to ensure delivery of these priorities
- Monitor the progress of priority work streams ensuring they are delivered within agreed timescales and deliver measurable outcomes
- Review patient case studies and identify opportunities to develop joint solutions to improve discharge planning processes
- Act as an information sharing forum and disseminate national best practice
- Escalate issues as appropriate to the Urgent Care Programme Board (a Board made up of representatives from the local health and social care economy who have responsibility for hospital discharge).

The underlying principles are that:

- Individual organisations take responsibility for managing their own capacity
- There should be tighter management of complex discharges from acute and community
- There should be consistently rigorous reporting of delayed transfers of care

Individual providers are expected to proactively manage their own capacity recognising the impact on the health system if capacity is reduced. They should:

- provide timely and regular briefings to the health system via the threshold meeting if capacity is reduced, for example, due to diarrhoea and vomiting or deep cleaning or staffing issues
- have a robust process in place with clear timeframes for proactively managing the situation so that capacity can be maximised as soon as possible – that this is shared with the local health economy so everybody has the same expectations
- be proactive in identifying immediate solutions to mitigate the loss of capacity with a timeframe clearly specified seek LHE advice and assistance where appropriate, for example, if capacity is reduced for a sustained period (>48 hours).

- Tighter management of complex discharges from acute and community services

There is a daily review of complex discharges at the 'threshold meeting' (conference call). The purpose of the threshold meeting is to:

- undertake a multi agency review of all patients on the complex discharge list (including those patients who are a delayed transfer of care)
- agree actions to expedite discharge
- hold organisations to account for delivering on agreed actions to expedite discharge.

The core membership of this group includes as a minimum a representative from each provider to include South Downs Health NHS Trust, Adult Social Care and BSUH. Where appropriate a member from Sussex Partnership Foundation NHS Trust is invited if there are people who have complex mental health needs. Representatives are sufficiently senior to assume the chair, be able to speak on behalf of their organisation as a whole and able to discuss issues at an individual patient level.

There is a proposal that this meeting should:

- extend to include Saturdays by the end of May and either Sunday or Bank Holiday Monday over a long weekend
- once a week extending the scope of the meeting to review community complex discharges

Underpinning this meeting is an escalation process for those patients who have exceeded their planned discharge date by 48 hours. This applies to patients on the complex discharge list with a confirmed discharge date and destination. Patients for escalation are identified at the daily threshold meeting along with the organisation with lead responsibility for expediting discharge. The lead organisation named senior manager is expected to explain the rationale for the delayed discharge and develop an alternative plan which facilitates discharge within 24 hours.

Each organisation has been tasked to set out an action plan for how they will support the above. There are also discussions regarding the current performance and a general agreement that this needs to improve if as a local health economy are to ensure safe and high quality care that is sustainable for our local population.

Conclusion

Ensuring that people are discharged from hospital in a timely fashion to the placed most suited to each individual remains a cornerstone of the Local Health Economies priorities and delayed transfers of care remain a significant issue for all partners.

The hospital discharge process relies on all agencies ensuring that they are 'playing their' part. Improvements have been made and it is anticipated that the actions currently being taken will mean the whole health and social care community can address the underlying issues and there is a firm commitment to work collectively to ensure a good discharge process and reduce the number of delayed transfers of care.

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