CARE, HEALTH & WELLBEING
OVERVIEW AND SCRUTINY
COMMITTEE
7 March 2017

TITLE OF REPORT: Case Study – Delayed Transfers of Care from Hospital

REPORT OF: Sheila Lock, Interim Strategic Director, Care Wellbeing and Learning

---

Summary

The purpose of this report is to advise OSC of progress to-date to reduce delayed transfers of care from hospital, and to improve the system and experience for people who require a multi-agency approach at the point of leaving hospital.

The OSC is asked to consider the issues raised and the recommendations of the report.

Background

1. Healthier Communities (now Care, Health and Wellbeing) Overview and Scrutiny Committee received a case study in respect of delayed transfers of care in 2012. The OSC agreed to include an updated case study on this issue in its 2016-17 work programmes as this had been identified as an area where performance needed to improve. The focus of the case study has been the pressures on the health and social care system in respect of timely and safe transfers of care, and the work being undertaken jointly by the Local Authority, CCG and QE Trust to address the issues.

2. Comprehensive and multi-agency planning for discharge from hospital is an integral part of the care of patients and their overall experience of care. Work to ensure smooth discharge from hospital to community and other settings with minimum delays requires effective working arrangements across health, housing and social care as well as close liaison with patients, their carers and local voluntary and community support organisations. This case study looks at the arrangements in place in Gateshead, including some new initiatives which have been developed this year.

What is a Delayed Transfer of Care?

3. The recognition of the pressure on health and social care services is currently very high profile, both nationally and locally. The increasing number of frail older people living in our communities, many of whom have multiple and complex health needs, means that health and social care systems need to continuously improve and adapt, in terms of supporting to be discharged from hospital in a safe and timely manner. Many 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. Acute hospitals should only be used for the delivery of services that cannot be provided as effectively elsewhere in the health service, social care or housing system (DH, 2003).

4. A delayed transfer of care occurs when a patient is ready for transfer from acute care but is still occupying a bed for such care. To achieve a safe discharge there are three criteria which must be applied in order to make the decision that the patient is ready to be discharged. These are not separate or sequential stages; all three should be addressed at the same time whenever possible. They are:

a) A clinical decision has been made that the patient is medically fit for discharge/transfer AND,
b) A Multi-Disciplinary Team (MDT) decision has been made that the patient is ready for discharge/transfer AND,
c) The patient is safe to discharge/transfer.

Delays are measured in key areas, and reflect delays between NHS to NHS services, and NHS to Local Authority services.

Increasing Older Population

5. The number of older people in England is increasing rapidly, by 20% between 2004 and 2014, and with a projected increase of 20% over the decade to 2024. Hospitals have also experienced increases in the number of emergency admissions of older patients, by 18% between 2010-11 and 2014-15. Older patients now account for 62% of total bed days spent in hospital. (National Audit Office; Discharging Older Patients from Hospital 2016)

6. Older people's ability to perform everyday activities can reduce while in hospital. One study found that 12% of patients aged 70 and over saw a decline in their ability to undertake key daily activities (bathing, dressing, eating, moving around and toileting) between admission and discharge from hospital, and the extent of decline increased with age. (National Audit Office; Discharging Older Patients from Hospital 2016)

System Pressures

7. Both the personal and system impacts of delayed transfers of care are regularly reported in the media; across the popular and specialist press. A number of system leaders, including Dr Sarah Wollaston MP, Chair of the Health Select Committee; Sir Simon Stevens, CEO of NHS England and Cllr Iizzi Seccombe, Chair of the LGA Wellbeing Board, have all called on the Government to recognise and address the significant financial pressures across health and social care.

8. The costs associated with delayed transfers of care regularly provide headline news. Age UK in March 2016 estimated the national cost to have been £910million between June 2010 and January 2016, based on an average cost for a hospital bed and reported delays. Whilst data is reported and collected for each health and social care system, there is some recognition within the sector, that

slight differences in the interpretation of the regulations can make it difficult to accurately compare data from one area to another.

9. The solutions for people who require support at the point of discharge from hospital are as unique as the needs of the people themselves. However, they broadly fall into the following categories:

    - Equipment and Adaptations
    - Housing
    - Reablement/intermediate care (bed based and community based)
    - Planned packages of support (home care)
    - District nursing interventions
    - Residential or nursing care

    Best practice is that where possible people should be supported to return home directly from hospital. However with the increasingly frail older population and the need to give people the best opportunity to recover their independence, there is recognition that bed based reablement services are an essential part of the system. Furthermore, the fact that decisions regarding long term residential or nursing care should ideally not be made whilst someone is still in a clinical or hospital environment, mean that 'step down' alternatives are essential.

10. As well as focusing on delayed transfers of care and the activity to support discharge from hospital, integrated approaches are required across the health and social care system to prevent unnecessary admissions to hospital. These approaches need to ensure that those people with complex health and social care needs have clear and well understood plans in place, which mean that support can be mobilised where appropriate, to continue to support the person (& their carers) in their own home.

New Approaches

11. One of the areas most frequently identified as a pressure, in terms of arranging safe discharge from hospital, is the provision of packages of home care. Understandably, the preference of most people is to go directly home from hospital, and whilst for some people they require a period of reablement following a stay in hospital, for others, ongoing planned care is required. The pressures in the home care market are again well documented, both regionally and nationally, and the data collected in terms of delayed transfers of care identified that this was a particular pressure area in Gateshead.

12. Therefore the CCG, the QE Hospital Trust and the Local Authority have worked with our independent sector providers to develop a new and innovative approach to facilitating hospital discharges for those people who require a planned package of care. These "bridging" packages, which commenced in January 2017, have enabled independent home care providers to employ home care assistants on a salaried basis, thereby enabling them to provide a rapid response service, to facilitate timely discharge from hospital. Whilst the data for January 2017 has not yet been reported by NHS England, the feeling from the colleagues working within the system is that the approach has been successful, to such an extent that the original pilot period has been extended further.

13. The need for good multi-disciplinary working is essential in terms of arranging and facilitating safe discharge from hospital. Whilst across the health and social care system we have had a good track record of working together, this has usually been on a “patient by patient” basis, with little opportunity for system learning, and the need for individual escalation of issues, where problems occur.

14. Building on a model developed in other areas, we have introduced a weekly “surge” meeting, which provides the opportunity to bring together a range of health and social care professionals, to discuss more complex discharge issues, provide support to “unblock” problems, and enable system learning for future scenarios. These meetings can be stepped up to daily if and when required, e.g. when the ‘system’ is reporting significant pressures.

15. The transfer of community health services from South of Tyne Foundation Trust to the Gateshead Care Partnership (a joint approach led by Gateshead CBC, QE Trust and the Council), took place in October 2016. This Partnership bid was based on the intention to develop a new model of integration between the different sectors of the health service, and between health and social care.

16. Whilst the work over the winter period has rightly focused on the safe transfer and mobilisation of the workforce and service, going forward, all partners are committed to developing integrated ways of working, which will seek to reduce duplication and therefore improve the experience for people/patients. Even within the short timescale that the service has been delivered via the Partnership, there have been some positive examples which have demonstrated how the removal of organisational boundaries has improved the delivery of care.

Future Plans

17. As noted at point 13, the Gateshead Care Partnership has the development of integrated ways of working as core element of its delivery model. A number of different work streams are being developed to identify and deliver the new models of care, which will include engagement with the health and social care workforce and the communities we support. As well as focusing on hospital discharge, the need is recognised for integrated and effective systems across health and social care to prevent unnecessary admissions to hospital. Early discussion with health and social care union colleagues has been positive, with a plan in place for regular updates.

18. The pilot of the “bridging packages” of care model is being evaluated, and as noted, data from NHS England should shortly be available, which should help to establish whether there is an improvement in delays reported to be associated with community packages of support. We are also aware of other areas piloting similar approaches, and therefore will seek to undertake some shared learning, to identify whether there is a financial justification for the continuation of a longer term solution.

19. The surge meetings are now an established and successful process, and the intention is to continue with this approach. However, there is also the opportunity

to review the other meetings and groups across health and social care, to be clear that the arrangements are lean, and do not lead to duplication of discussion.

20. Other areas for development planned include the role of “trusted assessor” and “discharge to assess” models, both of which seek to streamline the assessment process, and the provision of pharmacy and patient transport support, which are both crucial to the safe discharge of people with complex health needs, whilst by their very nature, more complicated to arrange for people with complex needs.

21. Across the system we have taken the opportunity to explore models and ways of working in other areas, especially those that were identified as integration Vanguards. This has led to joint visits to Stockport and Sunderland, with a plan to visit Salford as well. Whilst such visits cannot provide a “blue print” for integration, it is helpful to understand what has worked well, and what has worked less well in other areas.

22. A review of Intermediate Care has been undertaken in Gateshead, and the outcomes from this review are feeding into a combined scoping paper, looking at the potential future model of Intermediate Care in Gateshead.

23. A crucial element of integration across health and social care is the ability for professionals from different sectors to be able to access and read information across electronic systems, on a system of role based access. Across the North East the Great North Care Record and Connected Health Cities are working on solutions which will facilitate this access, in a way which is embedded within existing IT and data base solutions.

Recommendations

24. Overview and Scrutiny Committee is requested to
    1) Note the content of the case study
    2) Provide views on the issues discussed
    3) Advise whether it is satisfied with the approaches taken so far and the future plans outlined.

Contact: Steph Downey, Service Director Adult Social Care (ext 3919)