LONDON BOROUGH OF CAMDEN	**WARD:** ALL

REPORT TITLE:

Hospital Discharge arrangements

REPORT OF: Director of Housing and Adult Social Care

FOR SUBMISSION TO:	**DATE**
Health Scrutiny Committee	13th June 2007

SUMMARY OF REPORT

This report notes the arrangements that are in place to ensure effective discharges from hospital for people requiring support from Camden Adult Social Care and actions taken to ensure continuous improvement.

Local Government Act 1972 – Access to Information
No documents which are required to be listed were used.

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Recommendation:
Members are asked to note the report

Signed by Assistant Director

Date: 31 May 2007

1. Background

Members will be aware of recent national focus on requirements for effective discharge and transfer of care of patients. In 'Discharge from hospital: pathway, process and practice' the Department of Health stated that all acute hospitals should have formal admission and discharge policies ensuring that people are identified on admission and that their pending discharge be notified to relevant primary health care services. More recently, 'Our health, our care, our say', made clear that better integrated health and social care can help prevent the inappropriate use of specialist or acute health care and can help prevent or reduce readmissions. 'Commissioning a patient-led NHS – Delivering the NHS **Improvement Plan'** emphasises the need to change systems to be more responsive to patients needs through better integration of services.

In Camden, Adult Social Care, Camden PCT and the UCLH and Royal Free NHS Trusts have been working closely over the last two years to ensure unnecessary admissions are avoided and effective discharge is facilitated by a 'whole system approach' to assessment processes and the delivery of services.

In previous years, an Overview and Scrutiny Panel dedicated to monitoring arrangements to reduce delayed transfers of care was set up. With input and advice from this Panel and effective partnership working, Camden's numbers in delayed discharges from hospital have significantly reduced.

This report summarises the range of interventions in place to improve hospital discharge arrangements for Camden patients.

2. Discharge Policies and Protocols

2.1 Both the Royal Free and UCLH revised their discharge policies during 2006. Both trusts had a formal launch of the policy to raise staff awareness. At UCLH's launch the PCT and Adult Social Care provided information either via a short presentation or a stall that staff were able to visit and ask questions. Both policies are available to staff on the local intranets.

2.2 Both trusts also have a 'Discharge Handbook' available on the respective intranets. These handbooks are guides for staff to help them plan discharges by providing information on services available,

how to refer and access them. These include Intermediate Care Services, Adult Social Care, Carer's Support and Housing advice.

2.3 Both trusts have implemented a Facilitated Discharge Protocol. This provides guidance for staff on how to work with patients who are exercising unrealistic demands on their discharge plans.

2.4 Both trusts have access to Camden's delayed transfer of care protocol booklet (revised in February 2007). These protocols explain the definitions and notification requirements as outlined in the Community Care (delayed discharges) Act 2003.

3. Discharge Procedures

3.1 Operationally, Royal Free and UCLH have different procedures in place.

3.2 Royal Free have a discharge team comprised of a senior nurse, three discharge advisors and one person for administration support. The advisors are allocated a number of wards each. They attend the multi disciplinary team (MDT) meetings weekly, advise on any issues around discharge and support the MDT with complex discharges. They also determine any potential delays, monitor and progress actual delays for agreement at the weekly delayed discharges monitoring meeting where reasons and responsibility for delays are determined.

3.3 UCLH have recently employed two Pathway Coordinators, one for Emergency and one for Elective patients. The role of these coordinators is similar to the discharge advisors. They provide support to the ward staff and have a key role to play in escalating issues where there may be disputes or delays in progress. However, their main role is to develop patient pathways to improve patient flow. In addition there is a discharge support worker who is able to pick up on complex discharges and assist with progression. This person, along with the discharge administrator, meets with Adult Social Care and the whole systems coordinator for the PCT to agree the number of delays, the reasons and responsibility each week.

3.4 Each trust has developed their own system for processing the assessment and discharge notifications (section 2&5's) to Adult Social Care. UCLH has made several changes over the last three years to improve systems. There is now an email system set up for referrals that are completed by ward staff and emailed to the discharge administrator who then faxes to the relevant social services. At Royal Free, ward staff physically deliver the notifications to the discharge team who check that they are completed correctly and then they fax to the relevant borough.

3.5 All staff in Camden (acute trusts, Adult Social Care and PCT staff) have access to the Multi disciplinary training day on discharge planning facilitated by the whole systems coordinator, Camden PCT. This training provides information on national policies and how they can influence good discharge planning skills, encourages participants to look at their own areas of practice and gives them ideas on how to improve discharges using a multi disciplinary approach.

3.6 Both acute trusts and the PCT hold monthly discharge officer steering groups. Membership for each hospital group includes PCT and adult social care staff and vice versa for the PCT. At these groups, trends in delayed discharges are discussed and suggestions and ideas for future actions are taken forward. This is also the forum for any discussion regarding future policies and changes in procedures. At UCLH, individual case studies are discussed where discharge has been difficult. This promotes learning for future cases.

3.7 Both trusts and hospital social work teams have access to the delayed transfer of care database which was developed by staff at the Whittington in 2004 and was funded by the DTOC Grant and a small annual contribution is paid for maintenance and on going training needs. This database provides up to date information on the referrals to social services and allows health and social care to communicate with one another on the progress of individual discharges.

3.8 Both trusts developed a discharge checklist, which is recommended good practice in "Achieving timely 'simple' discharge from hospital" Department of Health, 2004. The use of the checklist is promoted at both Trusts via the Steering groups on discharge (Discharge Steering at UCLH and the Interface Group at Royal Free). A quarterly audit on the use of discharge documentation occurs at UCLH that allow specific areas to be targeted for further education but similar work needs to be taken forward at Royal Free. The checklist is also promoted at the training day (Multi disciplinary training day on discharge planning) as a vital tool to ensure an equitable and smooth discharge planning process for all patients.

4. Referrals for community services

4.1 The statistics for this current financial year (06/07) show that 1,934 assessment notification forms (section2's) were received from acute trusts to Camden Adult Social Care services this is an increase of 16% from the previous year.

4.2 The number of new care plans completed for discharge packages as a result of the assessment notification process was 677 (35%) for 06/07. This is a decrease of 5% from 05/06.

4.3 The number of permanent placements (nursing and residential) agreed for funding and implemented as a result of comprehensive multi disciplinary assessment was 51 (3%) for 06/07. This is a 1% decrease on 05/06 figures.

4.4 62% of all referrals (section 2's) did not result in either new care packages or placements being arranged during 2006/07, this is an increase of 7% from 2005/06 figures. Most of the work undertaken with these patients and their families involved social work information and advice, identifying other support and assistance, liaison with housing and rehabilitation services and supporting patients and families in relation to loss and change issues e.g. adapting to disability.

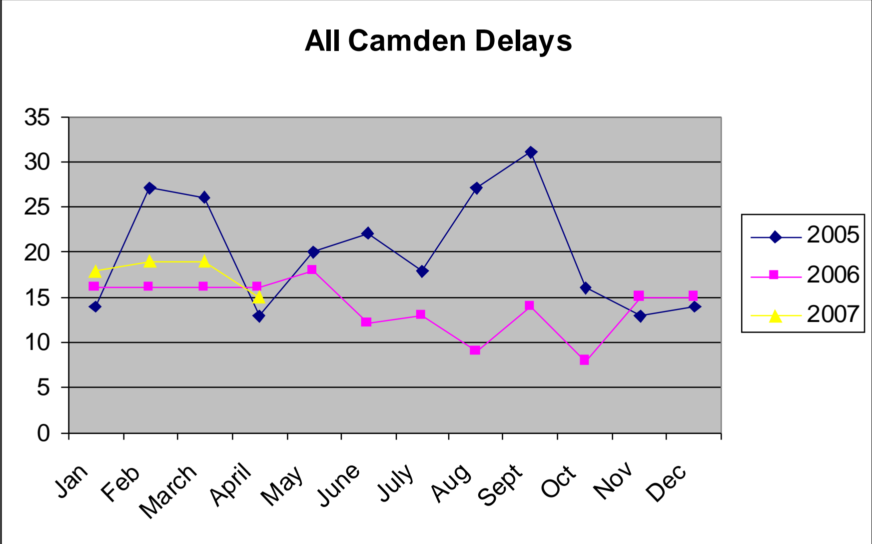
5. Camden's delayed transfers of care

5.1 Each year an annual report is written by the whole systems coordinator and distributed to relevant stakeholders and staff members. A Delayed Transfer occurs when a patient is ready for discharge from an acute hospital bed following a multi-disciplinary team decision that the patient is ready for discharge and the patient is safe to discharge/transfer but the patient continues to occupy a hospital bed.

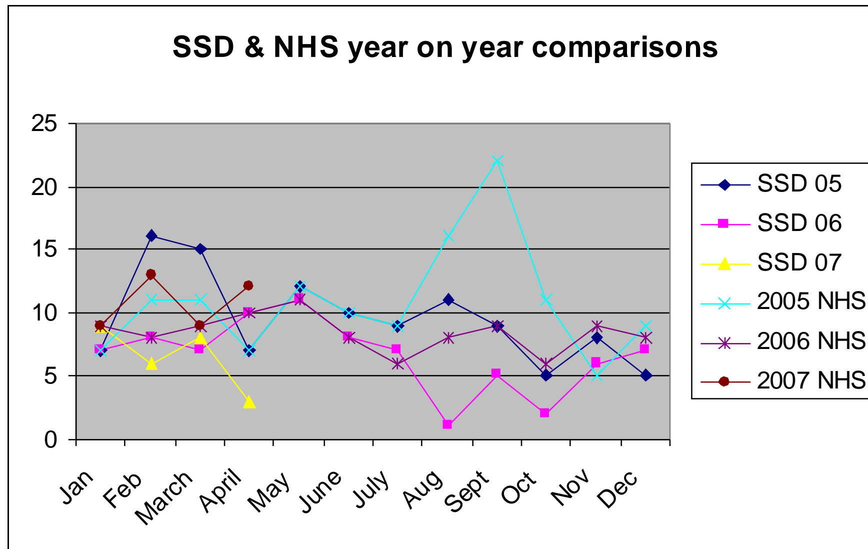
5.2 For 2005/06 Camden reported the lowest number of delays in the North Central London sector and were at number seven in the top ten lowest reporting boroughs for all London boroughs according to SITREP data.

5.3 The good performance has been sustained during 2006/07 and the weekly combined NHS and social services delays target of ten has been achieved every week except one.

5.4 The chart below shows a year on year comparison of total numbers of delays for Camden.


All Camden Delays
35
30
25
20
15
10
5
0
Jan
Feb
March
April
May
June
July
Aug
Sept
Oct
Nov
Dec
2005
2006
2007

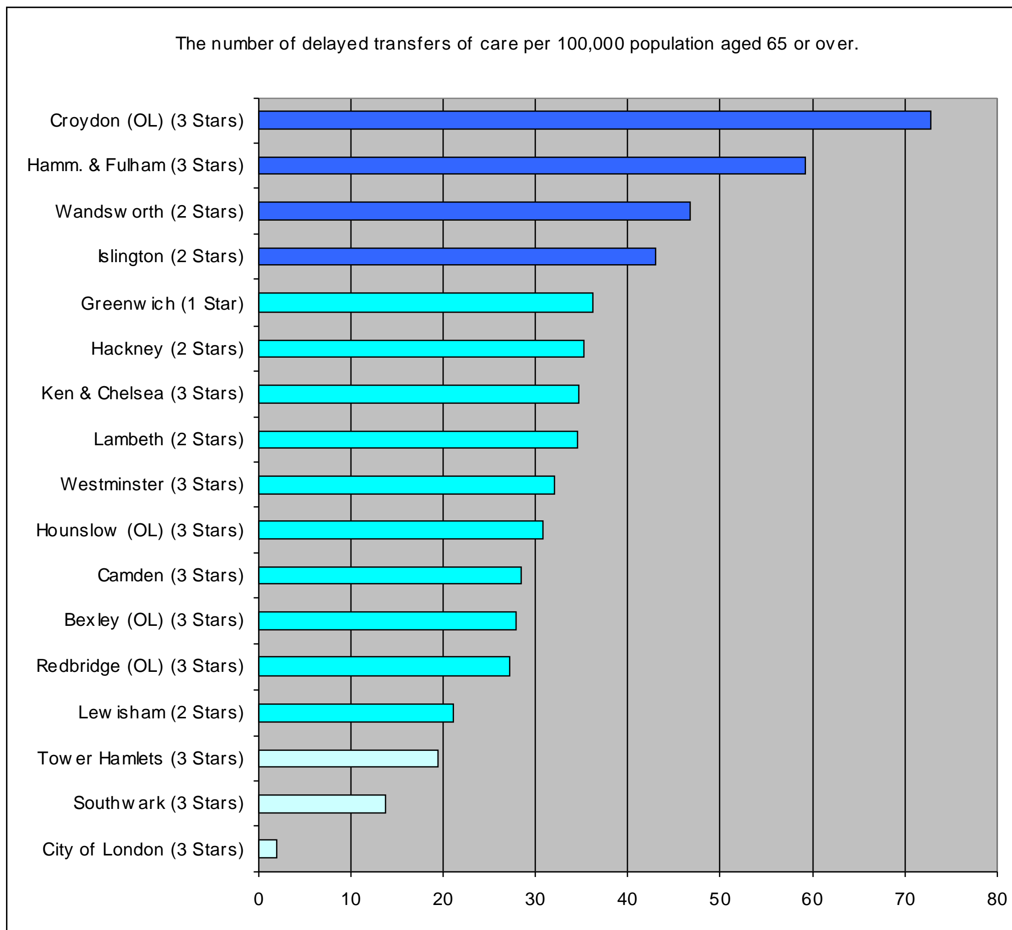
The chart below shows the year on year comparisons of health and social services delays separately.



5.5 The main reason for Adult Social Care delays is patients waiting for permanent residential or nursing placement which includes those waiting for dementia registered care homes. This has been the main reason since data was first collated in 2004 although significant improvement has been made. This is not necessarily because of a shortage of beds, rather that the process involved in arranging placements, such as giving service users the opportunity to visit homes beforehand and homes carrying out pre-admission visits which is a CSCI requirement, takes more time than is allowed for in the discharge planning process. In some instances it may be inappropriate to move someone into an interim bed whilst these arrangements are finalised.

5.6 The main reasons for NHS delays are more complex and are for patients awaiting further NHS Care which includes rehabilitation (mainstream and specialised), 100% fully funded NHS Continuing Care and patients exercising choice - this can be choice on discharge destination e.g. care home of choice not available or refusal of offers. Those patients who are self funding their own placements are also reported under the category of choice and attributable to the NHS. The Facilitated Discharge Protocols were introduced to address these issues.

5.7 In relation to performance against key PAF indicator (D41 Delayed Transfers of Care) Camden has shown continued improvement against this key interface performance indicator. The table below shows the latest comparative data we have against this PI for 2005/6. At the end of 2005/6 Camden was rated within the 2nd highest banding with a performance of 28. During 2006/7 performance has further improved to 21.57.

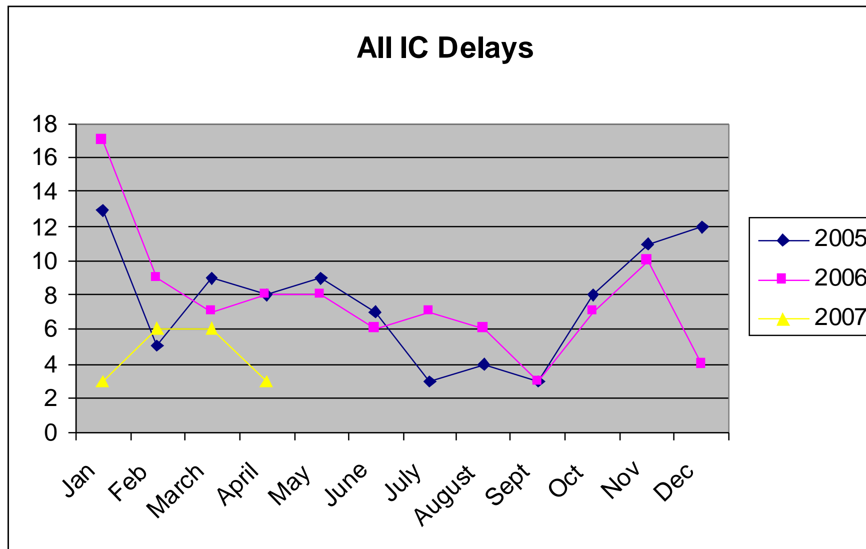


6. Intermediate Care

6.1 It is acknowledged that delays in discharges in the intermediate care setting have a direct effect on the acute sector, restricting patient movement and causing delays in appropriate patient care.

6.2 Camden has been preparing for extension of the reimbursement system for Intermediate Care beds at St Pancras for the past two years. However, there is currently no firm decision from the Department of Health on when and if this will happen.

6.3 All the data collection and monitoring systems in place mirror those used in the acute settings and the implementation of the assessment and discharge notification process was implemented in June 2006.Data below shows the year on year comparisons for intermediate care



6.4 The main reasons for delays in intermediate care are similar to those in the acute sector.

6.5 For Adult Social Care, again delays are for patients waiting for residential and nursing home placements, which include dementia-registered homes.

6.6 The NHS delays have largely been attributable to patient choice and St Pancras also implemented a Facilitated Discharge Protocol from January 2007.

6.7 The NHS has also seen some lengthy housing delays in intermediate care. These cases can be complex and difficult to resolve. The whole systems coordinator has now developed strong links with housing and provided she is alerted early can bring potentially difficult cases to the right department's attention for progression.

6.8 The whole systems coordinator has invested a large amount of time in training staff working in intermediate care. This has involved developing an action plan which incorporates the following:

a) Helping staff in predicting discharge dates and auditing the effectiveness of the education

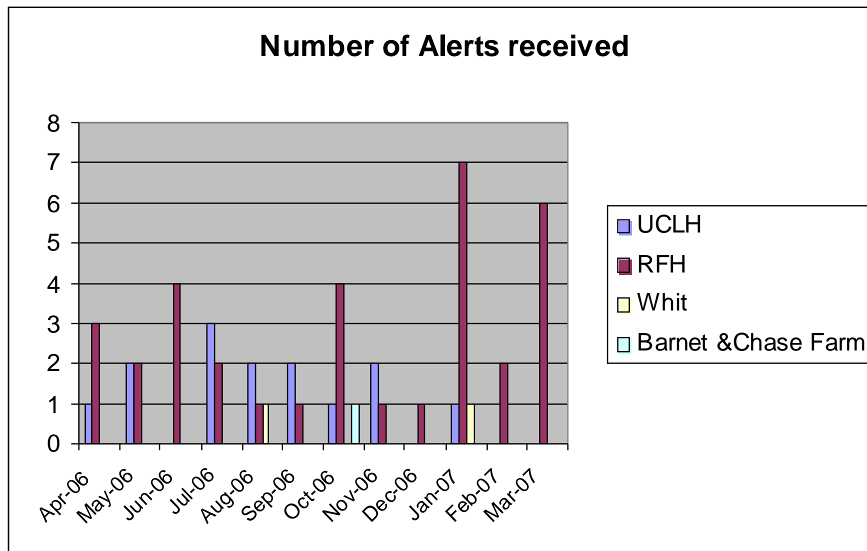
b) Referral processes to Adult Social Care and working with social care as part of the multidisciplinary team

c) Implementing the Facilitated Discharge Protocol

d) How to effectively manage case conferences

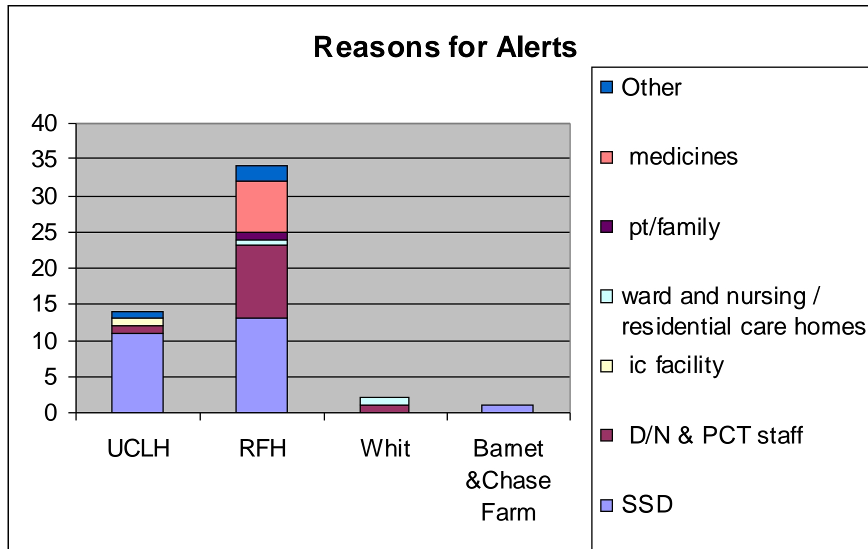
7. Inadequate discharge Planning

7.1 The discharge alert system was introduced in May 2005. The aim of this system is to alert senior managers to the problems around hospital discharge, to follow up on any serious issues raised and to record and analyse trends to inform strategic decision-making. The discharge alert is not a complaints form and a no blame approach is used when further investigation is needed. The trends are considered quarterly at the Discharge steering groups. Below is a chart showing the number of discharge alerts received on discharges from UCLH, Royal Free and others for 2006/07.



7.2 The largest numbers of alerts have been received on discharges from the Royal Free, 34 for 2006/07. In comparison, 14 were received on discharges from UCLH; however, the Royal Free discharged 5% more patients than UCLH in 2006/07. Proportionally, 0.2% of discharges that were discharged with clinical consent resulted in an alert being completed at Royal Free where at UCLH, 0.08% alerts were completed.

7.3 The chart below looks at the main reasons that led staff to complete a discharge alert.



7.4 All categories relate to inadequate communication either written or verbal with the following groups, Adult Social Care, district nurses, PCT employed therapists, St Pancras and Ingestre Road rehabilitation units, nursing or residential homes and the patient themselves or families. Issues around medication have a separate category and have only been highlighted as an issue on discharges from the Royal Free. The 'other' category includes alerts relating to issues such as no equipment, lost dentures and readmissions within 24 hours.

7.5 All delays are followed up with the acute trusts. The majority of alerts raised have resulted in responses from those involved in the discharge and are then passed back to the originator.

8. Actions taken as a result of the discharge alert system

8.1 Training sessions have been held on targeted wards to reinforce the process of referral to Adult Social Care, highlighting the assessment and discharge notification procedure (Section 2 &5).

8.2 Wards have been encouraged to utilise the discharge checklists as these are comprehensive guides to all aspects of discharge and provide good reminders and prompts for staff to address all areas with patients, families and carers.

8.3 Each medication alert has been followed up with the Royal Free and addressed internally between the Assistant Director of Nursing, Pharmacy and the relevant ward.

8.4 Reasons for alerts & the alert system are always discussed at the MDT training day on discharge planning. The main points considered and discussed are:

a) Communication between all agencies and disciplines and the effects poor communication has on patient care

b) Medication issues and the potential for serious incidents to occur

c) Early involvement of all agencies involved with discharge and staff are encouraged to adopt a holistic approach to discharge planning and to consider it as a process from admission and in some cases pre admission, and not as an isolated event.

9. Finance Comments

This report is for information only and does not ask members for a decision. It reflects Camden's performance on dealing with delayed transfers of care. Members should be aware that although reducing transfers of care reduces costs for the whole system it can have the effect that savings are made in the acute sector while costs increase in the social care sector (for example when a client is moved from hospital to a social care residential placement). Local budget pressures can therefore sometimes have an impact on reducing delayed transfers of care.

10. Legal Comments

The Head of Law (Acting) has no comments to add

11. Conclusion

Overall, good progress has been made in Camden to ensure that patients are discharged from hospital in a timely and appropriate manner. Robust arrangements are in place to ensure that discharges are monitored and where not undertaken effectively, that immediate action is taken and that any further improvements needed are put in place. Hospital discharge continues to be an area that requires a collaborative and partnership approach to deliver the best outcomes for patients and to ensure the most efficient use of both health and social care resources.