Norfolk Health and Wellbeing Board

Item 8

Report title:	**Hospital discharge in Norfolk**
Date of meeting:	**27 September 2017**
Sponsor (H&WB member):	**James Bullion, Executive Director of Adult Social Services**

Reason for the Report

Effective discharge is vital to a good experience and good outcomes for individuals who have been admitted to hospital. It is also important in order to manage the available capacity of the services in our hospitals. Delayed discharges or delayed transfers of care (DTOCs) are receiving national attention and are seen as a key indicator of how well local health and care systems are functioning. The purpose of this report is for the Board to consider how partners are able to contribute to effective discharge from hospital which secures good health and wellbeing outcomes for citizens.

Report summary

The report considers why timely and effective hospital discharges are so important in allowing people to continue to recover their wellbeing after a hospital stay and notes the evidence from a national review by Healthwatch of where difficulties may arise. It provides summary data about delayed discharges from hospital across the Norfolk system. It notes that while delays in Norfolk have been consistently lower than the Eastern Region and national averages, numbers are rising over the past year.

The report sets out expectations for action in local areas in relation to hospital discharge, noting that as part of the Better Care Fund targets have been proposed nationally for local areas which give Clinical Commissioning Groups and Local Authorities who provide social care responsibilities for substantially reducing delayed discharges. The report highlights examples of good practice in Norfolk and provides detail of the activities which the system is committed to in the High Impact Change plan (Appendix 2). However, the pressures on local systems are clear and targets are challenging.

It is clear that successfully enabling people to return home once they no longer need acute medical care may be reliant on many parties: health and social care, but also families and friends, district councils and voluntary and community services.

Action/decisions needed:

The Health & Wellbeing Board is asked to:

- Consider the existing performance and commitments and agree how stakeholders can support effective hospital discharge in Norfolk**.**

1. Why does hospital discharge matter?

1.1 Going home from hospital, even without significant continuing needs, may call on the co-ordination of a range of services such as transport home, medication and follow up clinical support. However, some people need considerable support to progress their recovery and indeed their long term needs may have changed significantly. In these circumstances, assessing needs, understanding the most suitable pathway of support and putting in place the necessary services are vital. This is particularly likely to be the case for older people with more complex pre-existing conditions.

1.2 Timely hospital discharges matter. Delays in discharging people from hospital when they are ready can have a negative impact on health outcomes and the wellbeing of individuals. If they are not able to leave hospital to continue their recovery, older people particularly risk losing their mobility and ability to manage daily living tasks, increasing their level of care needs and impacting on their independence and quality of life. It has been estimated that 10 days unnecessary stay in hospital for an older person will lead to the equivalent of 10 years loss of muscle strength and associated loss of functioning. Ensuring services are available to support timely discharge is vital to avoiding this kind of impact.

1.3 With longer lives, we are living with more long term conditions and around half of older people have three or more long term conditions. Frailty can make people more vulnerable to loss of functioning after a crisis, such as a fall, and they may need particular treatment and support in the right setting to get the best health outcomes. Ensuring such services are available in a timely manner is essential to achieving good outcomes.

1.4 The risk of deterioration in wellbeing and longer term loss of independence following a delay in discharge may apply in acute, mental health or community hospital settings.

1.5 Alongside the outcomes for individuals, hospital discharges are important to ensure the capacity in services is optimised. With increasing demand for hospital care, making optimum use of the available resources is critical to provide for all those needing such specialist care.

1.6 Ensuring effective and timely discharges from hospital requires co-ordination and planning across the wide health and care system, working closely with individuals and families. It should start early and be planned with the individual.

2. The experience of hospital discharge

2.1 In 2015, Healthwatch undertook a national project to understand the experience of discharge from hospital, engaging with older people alongside people with mental health needs and who were homeless. They set out five core reasons people felt their departure was not handled properly:

i. People are experiencing delays and a lack of co-ordination between different services;

ii. People are feeling left without the services and support they need after discharge;

iii. People feel stigmatised and discriminated against and that they are not treated with appropriate respect because of their conditions and circumstances;
iv. People feel they are not involved in decisions about their care or given the information they need; and
v. People feel that their full range of needs is not considered.

2.2 Whilst we do not have such detailed local research, these findings were derived across a wide range of the country. Local experience tells us that critical to our success is our shared focus on the individual and achieving the right outcomes for them, alongside understanding the intelligence which our data can provide for us in terms of how to improve our systems.

3. Current performance in Norfolk

3.1 NHS England, the body responsible for monitoring delayed transfers of care nationally, defines a patient as being ready for transfer when:

- a clinical decision has been made that the patient is ready for transfer, and
- a multidisciplinary team has decided that the patient is ready for transfer, and
- the patient is safe to discharge/transfer.

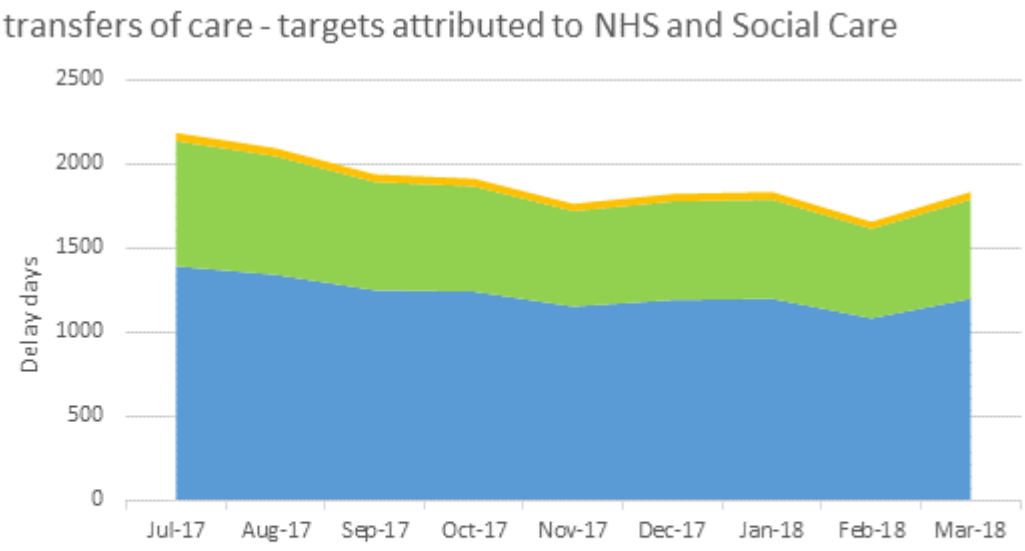
3.2 When an adult patient meets these three conditions and remains in hospital, they are classified as 'a delayed transfer'. There is a process to classify delays as either due to NHS, social care or to both. All hospitals are required to collect this data and provide it to NHS England. Reporting is well-established and we are testing our process across local services to ensure it is consistent.

3.3 The proportion of discharges from hospital which are delayed in Norfolk has been consistently lower than the East of England and national picture. However, this number has been rising overall. See figures 1 and 2 in appendix 1.

3.4 In terms of local providers, figures 3 and 4 in appendix 1 set out the trends and reasons for delays as formally designated. The constraints of the social care market are significant locally as they are in many areas, with insufficient availability of home care, residential care and nursing care in some localities. However, a wide range of factors can be seen to be impacting on timely discharges.

3.5 Whilst the numbers of formally designated delayed transfers of care are important, it is vital that the outcomes for individuals are also optimised, for example, being able to return home with reablement and therapy support to regain independence where possible rather than moving into residential care. As we approach winter and the system prepares for potential additional demand, ensuring effective discharges from hospital – alongside admission avoidance – is an important element of making sure that capacity is available in hospital services for those who need it.

3.6 As part of the Better Care Fund process, targets have been set for each area. These are challenging, particularly given the increase in demand for services but reflect Department of Health expectations.



	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Jointly attributed delayed days	48.5	47.7	45.3	45.9	43.6	45.0	45.3	40.9	45.3
Social Care attributed delayed days	744.8	705.0	643.8	625.4	566.7	585.6	589.4	532.3	589.4
NHS attributed delayed days	1393.9	1343.9	1252.1	1243.8	1155.3	1193.8	1201.4	1085.2	1201.4
Total Delayed Days	2187.2	2096.5	1941.1	1915.1	1765.6	1824.4	1836.1	1658.4	1836.1

4. National requirements

4.1 Next Steps on the NHS Five Year Forward View, published in March 2017, sets out key deliverables for 17/18 and 18/19 from NHS England in relation to effective hospital discharges:

- "By October 2017 every hospital and its local health and social care partners must have adopted good practice to enable appropriate patient flow, including better and more timely hand-offs between their A&E clinicians and acute physicians, 'discharge to assess', 'trusted assessor' arrangements, streamlined continuing healthcare processes, and seven day discharge capabilities."

See section 4.4 below on High Impact Changes.

- "Hospitals, primary and community care and local councils should also work together to ensure people are not stuck in hospital while waiting for delayed community health and social care. They need to:
  - ❖ ensure that the extra £1 billion provided by the Chancellor for investment in adult social care in the March budget is used in part to reduce delayed transfers of care, thereby helping to free up 2000-3000 acute hospital beds – the equivalent of opening 5 new hospitals – and regularly publish the progress being made in this regard."

4.2 Clear agreement is in place for iBCF spend on activity which will be focused on reducing delayed discharges including in mental health, reduce A&E attendance and reduce non-elective admissions including social work assessment capacity, home care capacity, trusted assessor arrangements. This has previously been notified to the board (link to the report to the 12 July 2017 meeting).

- ❖ Ensure that 85% of all assessments for continuing health care funding take place out of hospital in the community setting, by March 2018.

4.3 Focused and innovative work has been undertaken locally to ensure that people are not delayed in hospital as they await assessment for continuing health care, that assessments take place outside of the hospital setting and that we have improved 'discharge to assess' pathways. This work is being considered for adoption across the area and is provoking national interest.

- ❖ Implement the High Impact Change Model for reducing DTOCs, developed by the Local Government Association, the Association of Directors of Adult Social Care Services, NHS Improvement and NHS England."

4.4 Appendix 2 sets out our response to the high impact changes framework. We have created a joint programme of activity between hospitals and community health and care services to implement the changes to ensure timely and effective discharge. This is supported by funding from across health and care. District Councils and the voluntary and community sector make an important contribution to effective discharge, for example in addressing housing needs and in practical support when returning home.

4.5 Of course preventing admissions is key, particularly for frail older people and the work between primary care and community health and care continues to identify and actively support people most at risk.

5. Local practice examples

5.1 There is a range of examples of good practice, with a number of integrated approaches supported by the existing Better Care Fund. There are well-established integrated discharge arrangements in place at each hospital, with multi-disciplinary teams planning, reviewing and facilitating discharge. This is supported by local information systems to understand flow and capacity in the hospitals and work to develop better visibility of the capacity outside of hospitals.

5.2 District councils are bringing housing expertise to contribute to preparation for discharge and admission avoidance at each hospital. Approaches include:

- Supporting access to suitable housing and welfare benefits
- Co-ordinating actions required to ensure the home environment is suitable
- Providing access to services including welfare entitlements and debt advice
- Connecting people to a range of other agencies as appropriate including Early Help Hubs, community and voluntary organisations and private landlords regarding suitability of accommodation
- Accessing food banks and community projects
- Providing key safe installation and adaptations
- Support to access assistive technology such as lifeline and telecare.

5.3 A pilot is underway at Norfolk and Norwich University Hospital with South Norfolk Council, Broadland Council, North Norfolk Council, Norwich City Council and Breckland Council, at the James Paget Hospital with Great Yarmouth Borough Council and between Kings Lynn and West Norfolk Borough Council and the Queen Elizabeth Hospital.

5.4 Voluntary sector services provide practical support on returning home, for example ensuring homes are warm and people have provisions at home, alongside supporting people's independence and future resilience.

5.5 Work is underway with independent care providers to understand how we best facilitate discharge to care services where this is needed and how we support care services to prevent admissions, including considering how the Trusted Assessor models will work best for Norfolk.

6. Key issues for discussion

6.1 Given the existing plans to support effective discharge, what can partners contribute to secure success?

Officer Contact

If you have any questions about matters contained in this paper please get in touch with:

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Figure 1: Delayed Transfers of Care: attribution

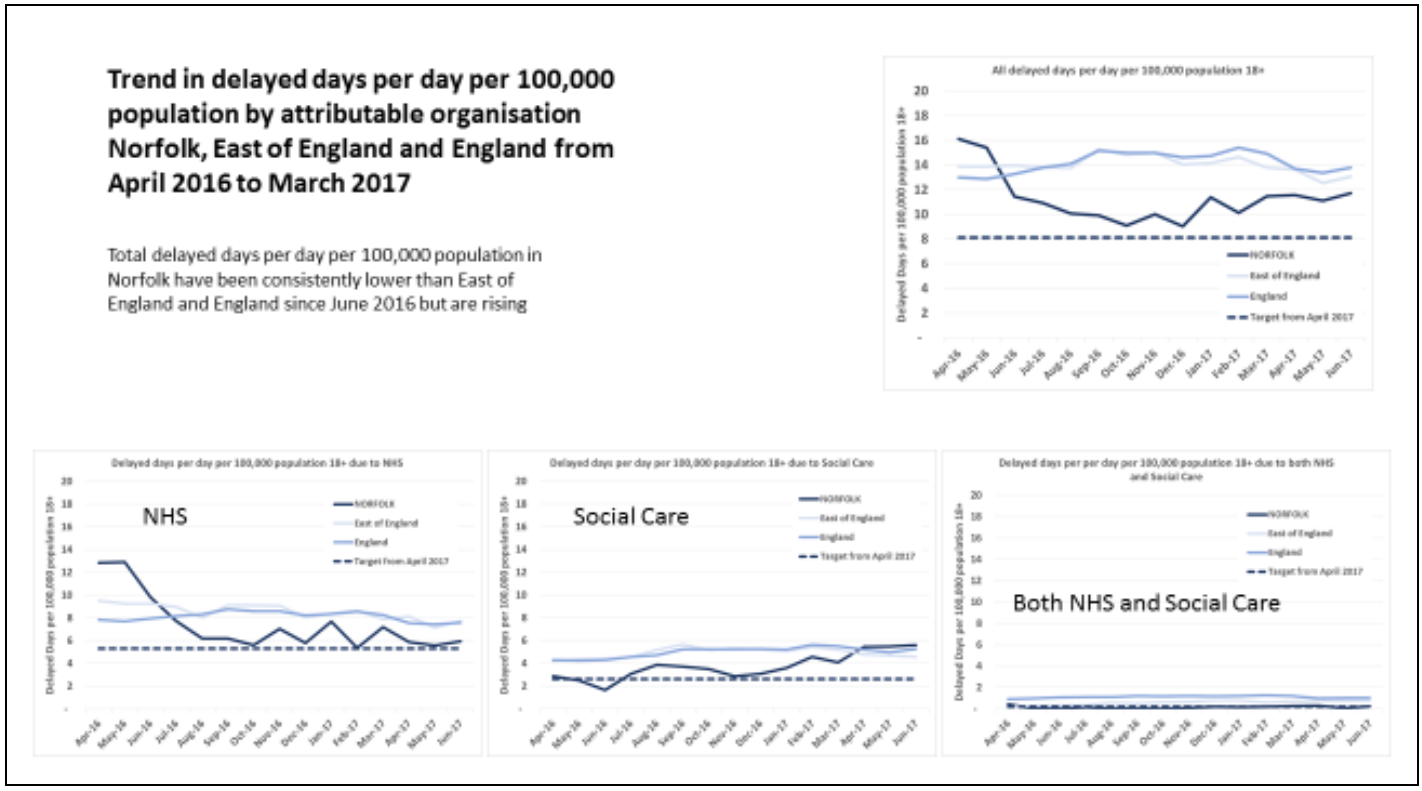


Figure 2: Delayed Transfers of Care: comparative performance

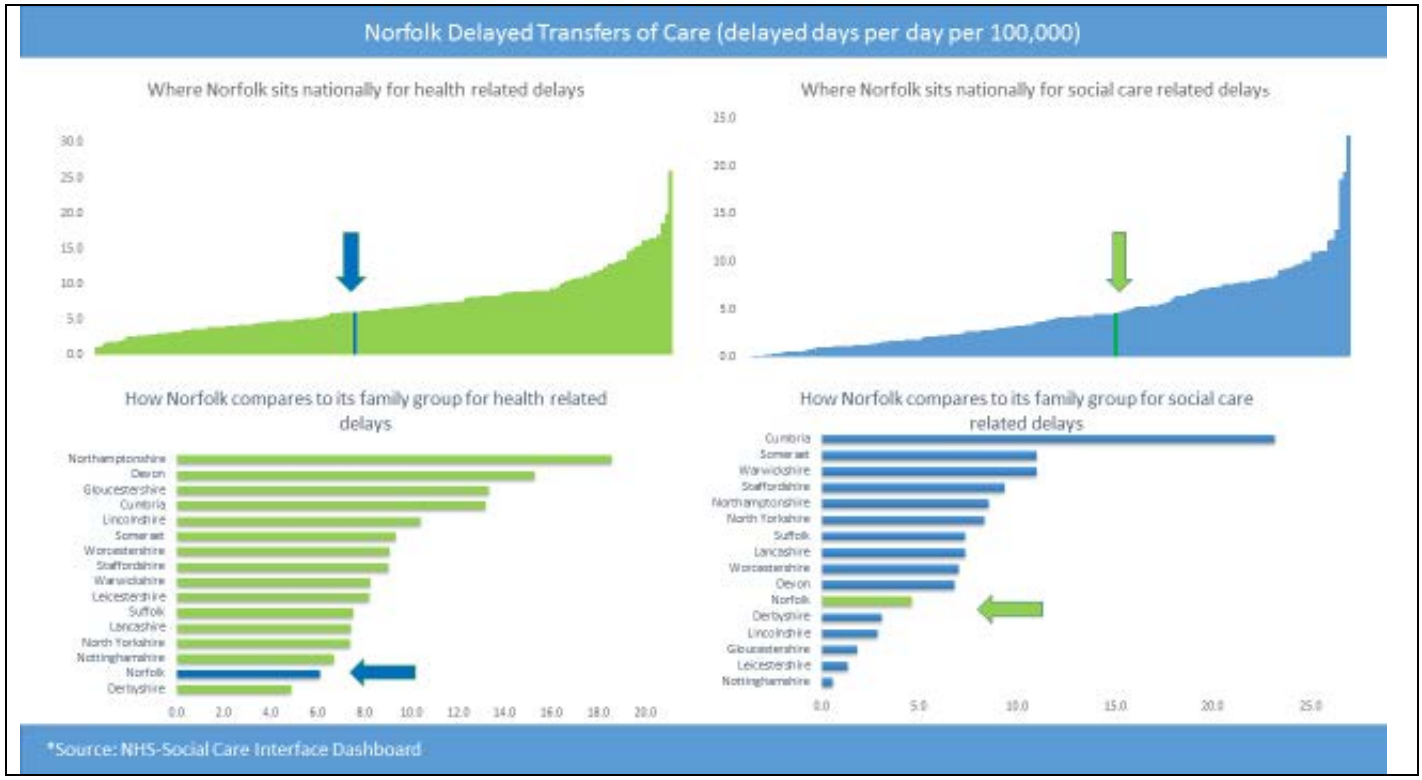


Figure 3: Provider overview and delays by reason

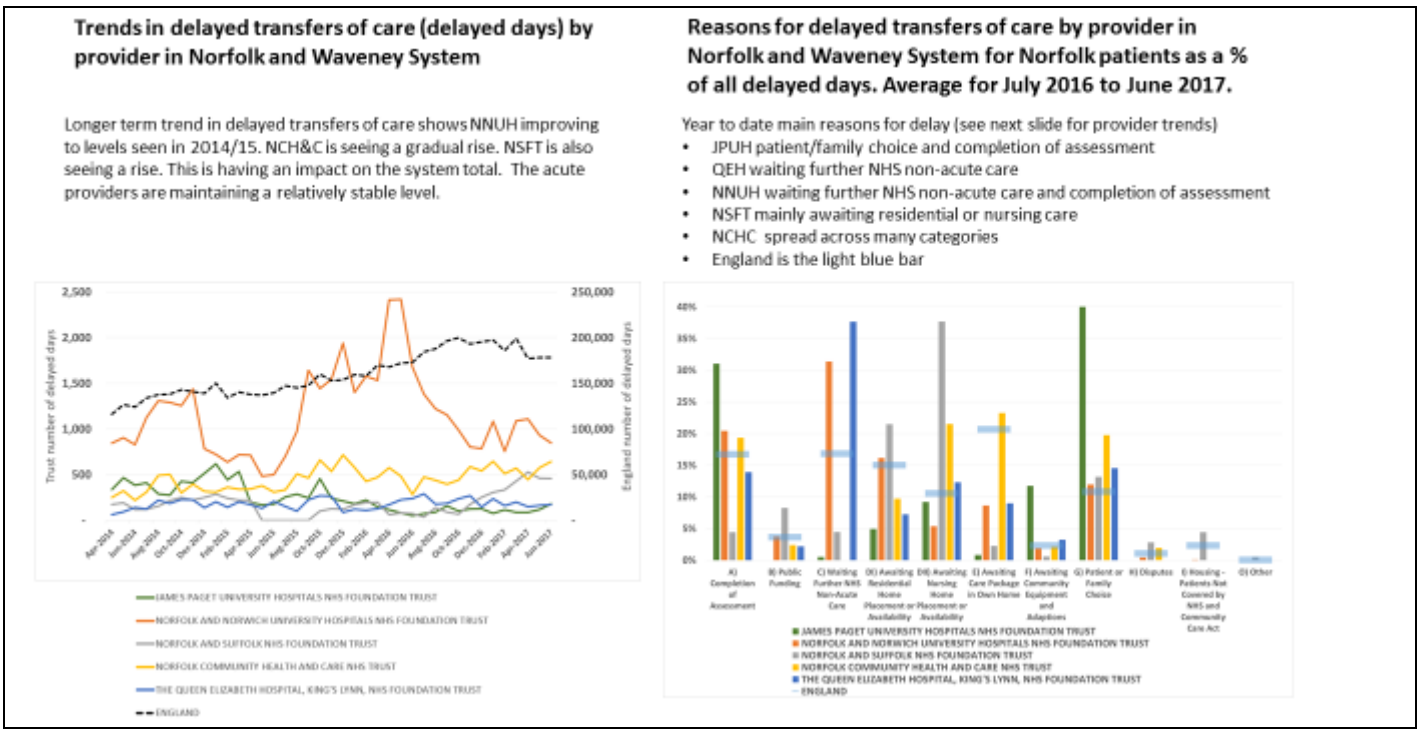
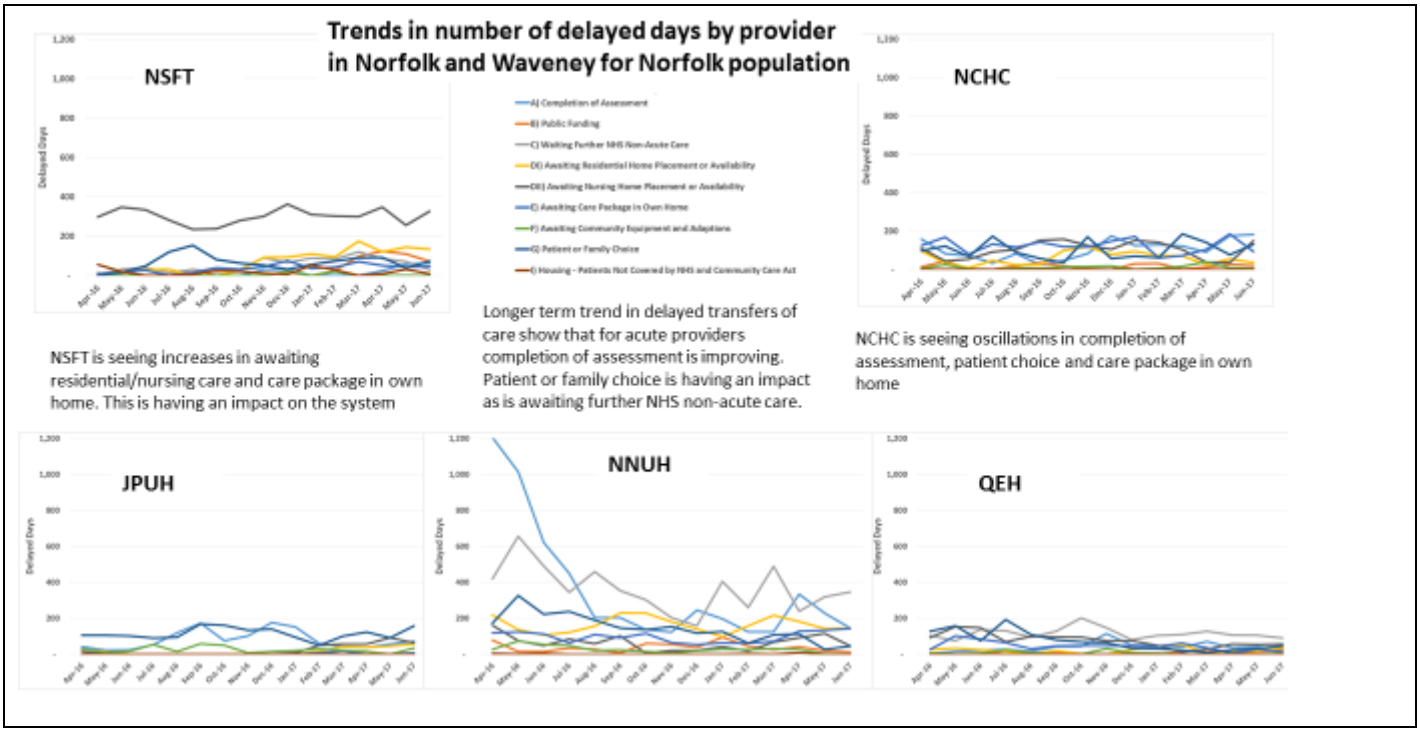


Figure 4: Breakdown by provider in more detail



High Impact Change Model Milestone Plan

Change descriptor		Norfolk wide	Key dates
Early Discharge Planning. In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected dates of discharge to be set within 48 hours.	**Current Position**	All 3 acutes have a planned approach in place, but have identified areas for improvement. Some will be at a local system level, others at County / whole system level	April 2017
	Planned Activity	Increased focus on supporting the red to green approach and board and ward round attendance. (Local) Increased focus use of Integrated Care Co-ordinators & Multi-Disciplinary Team Meetings in GP surgeries.(Local) Plan to be developed to improve discharge date planning across the system including community hospitals.(System wide) Appointment of a Capacity Manager post to understand, monitor and facilitate capacity across the system (System wide)	Work commenced July 17 Systemwide plan to be approved October 17 By October 17
Systems to Monitor Patient Flow. Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services	**Current Position**	Silver systems in place at two acutes NNUH & QEH, with dashboards and information monitored daily. JPH takes Red & Green bed day approach.	April 2017
	Planned Activity	JPH A&E delivery board to review plans linking with NNUH and QEH. (Systemwide) Consider introduction of electronic patient flow systems (Local / Systemwide)	A&E Joint Delivery Board to have approved plan by Oct 17

around the individual.			
Multi-disciplinary/Multi-Agency Discharge Teams, including the Voluntary and Community Sector. Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients	**Current Position**	Across the system plans are established to mature, with daily MTD meetings taking place. Involvement of voluntary sector and housing varies across the system. In NNUH; discharge to assess in place with care providers, adult social care and community health provider. CHC assessments increasingly undertaken outside hospital (D2A).	April 2017
	Planned Activity	Review involvement of voluntary sector and housing. (Local) Expand Social prescribing wider than GPs (Systemwide)	 Plans shared with stakeholders Sept 17
Home First/Discharge to Assess. Providing short-term care and reablement in people's homes or using 'stepdown' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.	**Current Position**	Due to the variance in DTOC figures across the whole system each acute has a slightly different current model and future plan. Development of Intermediate Care Strategy Discharge to asses review undertaken with Emergency Care Improvement Programme (ECIP)	April 2017 June 2017 July 17

	Planned Activity	**Discharge to assess** Proposals to joint A & E Board for a programme of work to support Pathway 1 (System wide). Existing Pathway 3 work in East & Central being evaluated with support from Healthwatch to inform future investment in posts to support D2A (System wide) **Home First** Commissioning to support increased capacity and improve sustainability in the Home Care Sector (system wide) Crisis Homecare – To include: Home support wrap around service, Enhanced flexible dementia offer. (systemwide) Micro Commissioning to support Homecare (local) Bed Based Reablement – Delivery models being developed (system wide)	August 2017 September 2017 October 2017
Seven-Day Service. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs	**Current Position**	Plans are in place system wide for social care services, including availability of Care Arranging Services at weekends. Local schemes are in place such as Healthy Homes Project and Hospital Care at Home	April 2017
	Planned Activity	Further work is required at both system wide and local level to: Define the core level of services that are required at weekends. Clarify 7 day service not 7 day working. What this means for health services?	Ongoing
Trusted Assessor. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response	**Current Position**	No consistent system wide approach in place, some local examples of Trusted Assessor models at QEH	

times so that people can be discharged in a safe and timely way	**Planned Activity**	**Systemwide model** Research of Trusted Assessor Models undertaken. Planning commenced at Health & Social Care Consultative Forum. Data analysis to inform demand. Meetings with all 3 Acutes. Meetings with representatives of the provider market to support co production. Link with Enhanced Health in Care Homes Project.	July 2017 August 2017 September 2017
Focus on Choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.	**Current Position**	Local arrangements in place including contracts with provider working within a Trust to expedite a range of patients – predominantly family choice / self-funders.	
	Planned Activity	Each acute is looking at their current system with a focus on how Discharge Coordinators link with Integrated Care Coordinators /GP surgeries / Local voluntary organisations. (Local)	Ongoing
Enhancing Health in Care Homes. Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital	**Current Position**	Well established project with a clear forward looking plan.	April 2017

as well as improve hospital discharge.	**Planned Activity**	Development of a robust care homes dashboard. Workforce development. Develop and introduce a falls prevention tool for care homes. Improve the pathway between hospital and care homes. Introduce a communication tool to support decision to support decision making by care home staff. Target support at care homes making most use of 999.	30th June 2017 30th Sept 2017 30th November 2017 31st December 2017 31st March 2018