Adult Inpatient Discharge

Report from Imperial College Healthcare NHS Trust to the London Borough of Hammersmith & Fulham Health Adult Social Care and Social Inclusion Policy and Accountability Committee

1. Summary

This report to the Health, Adult Social Care and Social Inclusion Policy and Accountability Committee from Imperial College Healthcare NHS Trust (the Trust) covers the current picture of delayed transfers of care and plans to reduce delays in partnership with stakeholders across the sector.

2. Imperial College Healthcare NHS Trust overview

The Trust provides acute and specialist healthcare for a population of nearly two million people in North West London, and more beyond. We have five hospitals – Charing Cross, Hammersmith, Queen Charlotte’s & Chelsea, St Mary’s and Western Eye – as well as a growing number of community services.

With our academic partner, Imperial College London, we are a founding member of one of the UK’s six academic health science centres (now expanded to include Royal Brompton & Harefield NHS Foundation Trust and the Royal Marsden NHS Foundation Trust), working to ensure the rapid translation of research into better patient care and excellence in education. We are also part of Imperial College Health Partners, the academic health science network for North West London, spreading innovation and best practice in healthcare more widely across our region.
3. Discharge Services

The discharge team provide a Trust-wide service of specialist nurses and administrative staff that support pathways for patients with complex needs across all five Imperial College Healthcare NHS Trust sites. The service works in collaboration with Adult Social Care, North West London Collaboration of Clinical Commissioning Groups (CCGs), Community Health Care partners including the Community Independence Service (CIS), and the Voluntary Sector providers to facilitate discharge. The team are responsible for the management of the medically fit pathway for patients and for delayed transfers of care.

4. Performance and activity

Figure 2 shows the reasons for delayed transfers of care (DTOC) across West London, Hammersmith & Fulham and Central London CCGs at Imperial College Healthcare NHS Trust for the period April 2016 to March 2017.

NHS England defines the term ‘delayed transfer of care’ as follows:

“A delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. Delayed transfers of care can occur for a range of reasons.”

The impact of the delays is seen across the Trust and in all specialties. Delays have an impact on patient experience, length of stay and flow through our hospitals.

As Figures 3 and 4 show, the number of delayed transfers of care (DTOC) has increased significantly in 2017/18 compared with the two previous years. Since January 2015, the Trust has seen an average of 96 patients experiencing DTOC each month, with numbers steadily rising. This increase has continued even though the Trust moved to a seven-day model for complex discharge services during 2016/17.
Appendix 1

Figures 3 and 4 – Overall number of DTOC lost bed days across Imperial College Healthcare NHS Trust January 2015 – May 2017

An analysis by borough of residence of patients shows that the London Borough of Hammersmith & Fulham (H&F) lost the most bed days during 2016/17 due to DTOCs. This is shown in Figures 5 to 10.

Figures 5, 6 and 7 – Health and Social Care DTOCs by borough 2016/17
An analysis of health DTOCs by category shows that for H&F residents, the majority of days lost were due to waiting for non-acute NHS care e.g. a rehabilitation placement or continuing care home placement. The delays in this category are primarily for NHS Continuing Care assessment and access for Care at Home or Placements. This is followed by waits for assessment for interim nursing or permanent placement – particularly Dementia Nursing. It is anticipated that delays for these categories will be reduced through the implementation of Trusted Assessment (see below). Delays experienced due to community equipment, such as beds, mattresses or hoists, will be improved through the implementation of Integrated Discharge Teams (see below).

37 per cent of delays for Adult Social Care relate to residential and nursing placements represents. It is anticipated that these delays will be reduced through a combination of Integrated Case Management and Integrated Discharge teams (see below). However, capacity and access to assessment for care homes poses a risk to DTOC reduction plans. There are plans to recruit two Nursing Home Nurse Assessors as part of the better care plans to support hospital discharges to facilitate access to nursing home assessment and placements.

5. DTOC reduction plans

The Trust has committed to reducing DTOCs by 50 per cent in H&F as part of an improvement plan to include the following:

- Early discharge planning – discharge planning commenced early in the pathway, with multidisciplinary board rounds, ward allocated Social Workers and assessment of need from admission or pre admission if possible.
- Multi-agency discharge teams – teams that are co-located where possible and include specialist discharge nurses/CHC assessors, British Red Cross, specialist homeless workers and therapy teams. The teams will work together, reducing duplicate assessments and referrals, streamlining processes and handovers of care needs.
• Home First – this is a pathway whereby people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.

• 7 day service – providing a service for patients and access to clinical review and senior decision making 7 days a week, resulting in access to care requirements and discharge from hospital when they are medically fit to leave. Services provided across the Trust 7 days a week include the specialist discharge team, social services and CIS.

• Trusted assessor roles – delays in patient discharge can be harmful to patients but most can be avoided, particularly if the delay is caused by waiting for a care provider to assess and accept a patient into their service. A trusted assessor carrying out the assessment – someone acting on behalf of and with permission of the provider – is an effective way of dealing with these delays.

• Focus on choice – partnership working to support where feasible choice of care provision and ensuring patients and families are given information on options available. Where first choice options and provision are not available ensuring a joint approach across health and social care to provide alternative care arrangements. Early discharge planning and information will aid the choice discussion and ensure all of the multidisciplinary team understand expectations and limitations.

This is being addressed through three interlinked strategies:

i. Home First (Discharge to Assess)
   A Home First pilot commenced in July on four wards across the St Mary’s and Charing Cross Hospital sites. This model has demonstrated significant benefit in reducing delays in other areas of North West London, although it has been more challenging than anticipated to identify suitable patients for discharge using this pathway in our hospitals. These challenges are being addressed through dedicated medical and nursing leadership and targeted communications to wards teams.

ii. Trusted Assessor
   The Trust now has six trained trusted assessors in place to establish and the process for trusted assessment will be implemented by the newly established Integrated Care Management Team. The team is hosted by the Trust and works across the Imperial College Healthcare NHS Trust and Chelsea & Westminster NHS Foundation Trust sites. Since its establishment, and in the last two months, the team has supported increased occupancy and reduced length of stay at the Farm Lane bedded community rehabilitation unit thereby freeing up acute capacity.

iii. Integrated Discharge Team
   The Integrated Discharge Team includes hospital-based specialist discharge nurses and co-ordinators working collaboratively with hospital-based social workers to address issues of complex social care. A pilot has been running on three wards across the Trust since June with positive feedback received from acute teams. Information technology and governance issues are delaying the reduction in duplicated health and social care assessments. The pilot was extended to include a further three wards from July.

In addition, the Trust is in the process of scoping the potential for establishing a winter ward in a local care home, potentially providing 10 beds for medically optimised patients awaiting

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1 Clinically optimised is described as the point at which care and assessment can safely be continued in a non-acute setting. This is also known as ‘medically fit for discharge’ ‘medically optimised.’ NHS England (2015).
placement in residential care. This would be focused on a cohort of patients for whom the Home First model would not be appropriate. The Integrated Care Management Team would be responsible for managing the flow of patients from acute beds to the winter ward. The scoping exercise will be completed and a decision on whether to proceed with this plan taken by the Trust by the end of September.

6. Risks to delivery

The enablers are key in delivering a sustainable and partnership based model of care for patients discharged from the acute setting. There has been significant work and focus on the enablers and success to date, however there are still potential risks to achieving a 50 per cent reduction in the delayed transfers of care for H&F. These include:

- Recruitment and retention – shortages of staff with the skills required to support the work is evident. There is a significant vacancy factor in specialist discharge services currently and work is continuing to evolve rotational posts and develop roles for alternative trained professions and non-clinical staff. Training staff to undertake what can be a complex and challenging role in the NHS takes time and resource also impact on delivery.
- Contractual arrangements – current contracting arrangements require amendment to deliver change that better supports patient criteria and care needs.
- Choice issues – ensuring all staff have the same focus and understanding of choice and communicating with patients/families early in the pathway. Poor communication and lack of patient / family involvement increases what can be a complex situation to navigate causing distress and anxiety and impacting on length of stay. A wide reaching approach to train and support staff in the management of discharge options and provision is required to ensure patients have the required information at hand to be involved in the decisions made.
- Capacity within adult social care – constraints on the availability of social workers to support assessment and expedite panel decisions can further increase delays to discharge.
- Community capacity – with limited options and capacity across local care providers the availability of both care homes and homecare impact on access to choice. Utilising independent care providers and private care sourcing agencies at Imperial has supported access to capacity.

7. Summary

The number of DTOCs has shown a significant increase in 2017/18 compared with the two previous years. To address this, the Trust has put a plan into place working in collaboration with partner organisations that will also improve patient experience, reduce length of stay and improve flow through our hospitals.

In order to deliver this plan it will be essential to maintain close working relationships with adult social care, community care providers and the voluntary sector and for these organisations to ensure that there is sufficient capacity across the system for patients to receive care in the most appropriate setting.