OVERVIEW AND SCRUTINY TASK AND FINISH GROUP

HOSPITAL DISCHARGE REVIEW

Joint Information Report: 12th February 2013

This joint report gives a general overview of the current situation and highlights areas for the review to examine in more detail. It does identify key themes across all service areas that require further scrutiny. These include the need for:

- Consistent, agreed data across all providers and shared IT systems.
- Improved patient flow and seamless pathways across the whole system and sufficient capacity in each part of that pathway.
- High Impact areas and service utilisation.
- Planning for discharge at time of admission and setting target dates for discharge.
- Improvements in the timeliness of key assessments and actively managing the actions required for discharge (to take away prescriptions (TTA's); transport, consultant ward rounds etc.)
- Clear admission and discharge processes and procedures, agreed and understood by all.
- Improved integration of services to support discharges and prevent admissions (including acute/community/ social care/ primary care and voluntary sector)
- Improved working knowledge of support services available to prevent admissions and discharge and clear processes for accessing.
- Management of out of area admissions and discharges.
- A robust strategy for preventing admissions and supporting safe, high quality and timely discharges agreed and signed up to by all stakeholders.

Early Intervention and Prevention Strategy and Action Plan

Luton has a number of services in place to identify those at risk of avoidable admission and to maintain them within the community. These include:

- Community Health and social care teams
- Step up Beds
- Out of Hours services
- 111
- Primary Care Services
- Walk in Centre
- Primary Care led Integrated Pilot

Luton Clinical Commissioning Group (LCCG) and Bedfordshire Clinical Commissioning Group BCCG have piloted the Navigator Nurse Service which sits within the A&E department and diverts service users back out to community support if they do not require urgent care services. The effectiveness of this as a sustainable admission avoidance service is currently under review, however commissioners

believe there would be benefits of greater avoidance focus at the front end of the hospital, with acute physicians providing in reach to A&E to support admission avoidance. Initial assessments by senior clinicians could reduce delays in assessment and diagnosis and turn around patients back into the community.

There is a need to improve the cohesiveness of admission avoidance services and ensure that service users are accessing or actively managed into the appropriate care service. There is also no clear plan on how to manage chaotic patients and frequent re attendees and a lack of flexibility across the care system to manage them.

Hospital Admissions/ Readmissions and Discharges

The vision for Luton Community Unit is to develop an integrated community service working in partnership with primary care and social care using the most up-to-date technical tools possible and reducing waste in the system. The joint Reablement Strategy and subsequent section 256 funding invests in services across health and social care to increase community capacity aimed at preventing admission and supporting discharges. Luton Borough Council (LBC) have developed a 75 whole time equivalent home care reablement team which now needs to be more actively utilised and integrated with Cambridgeshire Community Services (CCS) rehabilitation services.

There may be more opportunities to engage the voluntary sector and integrating them into statutory service pathways. Currently Age Concern Luton provides a successful Meet and Greet Service ; Headway provide community support to people discharged with Acquired Brain Injury and an Older persons counselling service provides a service to older people on discharge from hospital, to reduce depression and anxiety that may have resulted in a readmission.

The hospital currently has an integrated discharge team; however this could be strengthened by having a single assessment process and reducing the number of steps within the discharge process, especially for complex discharges. The discharge process needs to commence much earlier, preferably at the time of admission, with all staff proactively working to an agreed discharge date. Adopting a concept of “clinically stable” instead of “medically fit” and having individualised discharge plans and criteria for fit for discharge, may reduce extended length of stay.

Capacity of Community Service to Support Acute Care at Home

An internal review by Cambridgeshire Community Health Services (July 2012) showed Community Nursing services to have seen an increase in demand both in terms of referral numbers, acuity of need, complexity arising from co-morbidity and social pressures of patients. Demand for the service has changed in the last five years. Urgent care pressures, pathway redesign moving care from the acute to community and increases in acuity have all impacted on community nursing making it unsustainable in its current form.

Cambridgeshire Community Health Services is therefore developing an acute, crisis response team to support acute care at home. It has recently introduced a new triage system for 'on the day' urgent calls. This has increased capacity to support acute care. They are currently in consultation to develop a single point of contact for potentially LBC reablement as well as CCS services. The aim is to increase capacity through improved integration in the teams and with partners. The effectiveness of this acute service will be partly dependent on primary care practitioners providing timely medical support.

Intermediate Care:

LCCG currently commission BUPA St Mary's to provide 20 rehabilitation beds and Capwell 6 health care beds to provide step up and step down care. There are also 6 Extra care flats available at Colwell and Abigail Court. There are some concerns arising from the hospital that the inclusion criteria and processes for accessing the beds are too complex. However, the need exists for robust pathways and admission processes derived from Care Quality Commission (CQC) concerns, to prevent inappropriate discharges into placements and the risk this presents. The flow of service users through these placements needs actively monitoring and the outcomes of them performance managed. There have been cases of long and inappropriate stay. There is a need across the system to review if the correct level of bed provision is in place for different types of step up and step down requirements. In addition the need to reprioritise discharging patients back to their own homes as the first option.

End of Life Care:

The Keech Hospice in Luton provides an 8 bedded unit to support complex palliative care and End of Life Patients. However, there are a disproportionate number of deaths taking place in the Luton and Dunstable hospital and a need for cohesive services that facilitate the number of deaths in preferred place of care, in the community and at home.

Contractual changes within the care home contract could ensure that Luton care and residential homes work more flexibly to support discharges, including times that they will admit patients and reducing the need for reassessment following resident's admissions. There also appears to be a need to increase skills and competencies within homes to prevent avoidable admissions such as falls, urinary tract infections (UTI's) and dehydration and increasing their acceptance and management of palliative and End of life patients.

Mental Health:

Admission avoidance and timely discharge will be supported by the implementation of the liaison psychiatry service (July 2013) for:

- Early detection and treatment of dementia and depression to facilitate early discharge
- Short-term follow-up after discharge (post discharge clinic)

- Acting as a Responsible Clinician under the Mental Health Act for people detained under the Act, and receiving care in the acute hospital
- Supporting mental health Crisis team to reduce Emergency department waiting time (A&E Liaison for admission avoidance)
- Alignment with the L&D Dementia Nurse Specialist

In March 2013, the *Our Health Midlands and East Dementia Information* Portal will be launched and Luton will be required to have very clear admission and discharge pathways for dementia patients. The current pathways and the understanding of them by both providers and service users, require reviewing.

Quality Assurance and Performance Monitoring Procedures

Each organisation has quality assurance and performance monitoring processes in place. However, there is not an agreed assurance and performance system that ensures shared accountability for monitoring the quality of discharges and the appropriateness of placements. CQC raised safeguarding concerns in relation to inappropriate discharges into BUPA rehabilitation beds during 2011/12 and there is a need for shared responsibility to ensure safe, appropriate discharges and monitoring of discharge pathways to prevent this reoccurring. The LBC quality team and NHS Luton have previously worked jointly on the quality assurance of Nursing Home provision in Luton, producing joint reports and agreeing improvement plans, however with local structural reorganisation, this needs to be reviewed and a formulised approach agreed across local authority and health.

Hospital Discharge Officers' Group