Agenda No 4

AGENDA MANAGEMENT SHEET

Name of Committee	**Adult Social Care & Health OSC**
Date of Committee	**29th June 2011**
Report Title	**The Report of the Hospital Discharge & Reablement Task and Finish Group**
Summary	This review was commissioned to examine the Reablement Service and the hospital discharge process to see how effectively health and social care services are working in partnership to enable people to remain independent in their own homes, reduce unnecessary admissions/readmissions into hospital and avoid unnecessary delays on discharge. This is a report on the findings and recommendations of the Task and Finish Group
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Would the recommended decision be contrary to the Budget and Policy Framework?	No.
Background papers	None

CONSULTATION ALREADY UNDERTAKEN:- Details to be specified

Other Committees	☐	.....
Local Member(s)	☒	N/A
Other Elected Members	☒	Cllr Les Caborn, Cllr David Shilton, Cllr Sid Tooth, Cllr Kate Rolfe
Cabinet Member	☒	Cllr Bob Stevens, Cllr Izzi Seccombe
Chief Executive	☐	.....

Warwickshire County Council

Legal	☒	Alison Hallworth
Finance	☐	.....
Other Strategic Directors	☒	Wendy Fabbro
District Councils	☐	.....
Health Authority	☐	.....
	☐	.....
Police		
Other Bodies/Individuals	☐	.....

FINAL DECISION NO

SUGGESTED NEXT STEPS: Details to be specified

Further consideration by this Committee	☒	.....
To Council	☐	.....
To Cabinet	☒	
To an O & S Committee	☐	.....
To an Area Committee	☐	.....
Further Consultation	☐	.....

Agenda No

Adult Social Care & Health OSC - 29th June 2011.

The Report of the Hospital Discharge & Reablement Task and Finish Group

Recommendation

The Committee to:

1. Consider the Task and Finish Group's report on Hospital Discharge & Reablement Services.
2. Consider and agree the recommendations of the Task and Finish Group
3. To forward the recommendations to Cabinet & appropriate partners for consideration.

I. Introduction

1.1 A Task and Finish Group of councillors was set up to examine the Reablement Service and the hospital discharge process to see how effectively health and social care services are working in partnership to enable people to remain independent in their own homes, reduce unnecessary admissions/readmissions into hospital and avoid unnecessary delays on discharge. This is a report on their findings and their recommendations.

CLLR JOSE COMPTON
Chair of Hospital Discharge &
Reablement Task & Finish
Group

Shire Hall
Warwick

24 May 2011

The Report of the Adult Social Care Prevention Services Task and Finish Group

Acknowledgements

The Task and Finish Group would like to thank all those below that helped contribute to the review of 'Adult Social Care Hospital Discharge & Reablement in Warwickshire'

Joanne Allen – Warwickshire County Council	Sheila Peacock - NHS Warwickshire
Zoe Bogg - Warwickshire County Council	Rachel Pearce – NHS Warwickshire
Jo Galloway – NHS Warwickshire	Nitin Shuka – Warwickshire County Council
Carl Holland – University hospitals Coventry & Warwickshire	Mags Sumel – NHS Warwickshire
Jane Ives – South Warwickshire Foundation Trust	Janet White – University Hospitals Coventry & Warwickshire
Kath Kelly - George Eliot Hospital	Julie Whittaker - George Eliot Hospital
Di King - Warwickshire County Council	Rob Wilkes – Warwickshire County Council
Michelle Linnane - University Hospitals Coventry & Warwickshire	Caron Williams - NHS Warwickshire
Kerrie Manning - University Hospitals Coventry & Warwickshire	

Foreword by Councillor Jose Compton

The Reablement Service became a countywide service at the end of November 2010. This service provides support in their own home for adults and older people that have experienced an episode of poor health or being discharged from hospital. The support focuses on adults and older people doing things for themselves rather than things being done for them to enable them to regain the skills and confidence to live independently in their own home as well as reducing the reliance on social care services

The Task and Finish Group's aim was to examine this service, the hospital discharge process and how effectively health and social care services are working in partnership to secure better outcomes for people with more choice and control to remain independent for longer and thereby reduce the need to rely on social care.

The Task and Finish Group were made aware of the importance of not admitting older people unnecessarily into hospital especially where medical intervention would not help improve their quality of life, but may increase dependency on social care services. They also learned that delayed discharge, if admission was necessary, increases not only dependency, but also the possibility of contracting a hospital acquired infection.

Councillors from the Task and Finish Group were very impressed with the good examples of collaborative working relating to both the Reablement Service and the discharge process, which will hopefully ensure future services will meet the needs of patients, families and carers. However the review did highlight the importance of hospital staff being aware of what the Reablement Service provides.

It was considered important that the views of patients, relatives and carers were included in this review. Although many people had a good hospital experience there were still concerns regarding the communication of discharge arrangements, which caused increased anxiety for patients, families and carers on how they were going to cope.

I am confident the findings and recommendations in this report will go some way to achieve the aims above and ensure the Reablement Service continues to encourage independent living to reduce the reliance for residential or social care in later life, as well as, reducing the number of avoidable admissions and readmissions into hospital.

I would like to thank my fellow councillors and all those from the County Council and NHS who supported and contributed to this review.

Executive Summary

The longer people remain in hospital the more dependent they become and the more difficult it is to rehabilitate back to independent living, creating an increased pressure on adult social care services.

Getting people out of hospital and back into independent living at the earliest opportunity is cost effective for both health and adult social care services with a better outcome for the individual. Whilst it is important to ensure that discharges are timely, it is also fundamentally important to ensure that the outcome of the discharge is appropriate to individual needs. Government guidance states that no one should be admitted to residential care directly from hospital. Currently, it is thought that the numbers of people admitted to residential care direct from hospital in Warwickshire is too high.

Positive work has been undertaken with acute hospital trusts to identify and resolve delays across the health and social care system; both at an operational and strategic level such as transforming community based services. However there are still issues around delayed discharges that need to be resolved, because this affects the most vulnerable and frail people in the County, who get caught up in the complex issues involved.

The Adult Social Care & Health **'Reablement'** service is now a countywide service. It is a service designed to help people to regain the skills and confidence they need to live independently at home, particularly after an illness or spell in hospital. With the revision to the NHS Operating Framework 2010/11 and the funding allocation provided to the PCT to develop local plans it is an opportunity to provide seamless care for patients to prevent avoidable admissions.

It is considered essential that health and social care colleagues are working effectively in partnership to ensure Reablement Services form part of a single or coordinated intermediate care service. However, complications still arise when discharging patients, which can cause undue delays.

A Task and Finish Group of councillors with support from lead officers of Adult Social Care and the NHS was set up in January 2011 to consider what improvements could be made to the discharge process to reduce the number of delays, the number of people being admitted directly into residential care and the number of people being admitted/readmitted into hospital and to review the effectiveness of the new Reablement Service. During the review the T&F Group decided to consider the complaints procedures for NHS Trusts following the concerns raised in the Ombudsman Report, 'Care and Compassion' on ten investigations into NHS care of older people.

Findings

1 The unit cost of Reablement Service is more than basic social care, but the benefit for users is in the longer term by enabling them to remain independent for longer so they can stay in their own home. The costs of Reablement are initially higher and the Social Policy Research Report commissioned by the Department of Health identified there are limited savings for social care in the longer term, but there may be more potential for savings to be made in health. It was considered important that ways were found to ensure the service remains sustainable and if a whole systems approach was taken by both adult social care and health (where each organisation understands the impact of any change they make has another) could help identify potential savings that could be made jointly. This could be reinvested in the service which will enable the service to develop to meet the likely increase in demand when further changes are made to the eligibility criteria.

2 It was considered important that hospital staff not directly involved with the Reablement Team including relatives and carers were not only aware of the benefits of the Reablement Service, but of the prescriptive eligibility criteria to ensure any patient referral made to the service was appropriate for their immediate needs.

3 A Concordat to improve partnership arrangements is currently being developed by the County Council and NHS Warwickshire, but it was considered important that it went further than reviewing current policies and procedures, but continued to look at the development of a set of key performance indicators to be included in any contractual arrangements with providers to ensure the future needs of residents are met.

4. Age UK advisors attend the University Hospitals Coventry and Warwickshire Trust two afternoons a week to provide discharge information for patients which is currently funded until July 2011. This was considered an example of good practice which could benefit patients attending all hospital trusts

5. Although discharge planning in recent years has helped families become more aware of what is available there are still instances where bed blocking can occur. It was considered important that families and carers are involved in the discharge process from the beginning and are aware of the health complications that can occur if their relative stays in hospital longer than necessary.

6. Section 2 and 5 of the Community Care Act 2003 and Continuing Healthcare (CHC) assessment process still causes delays with discharge from hospitals, which needs to be resolved.

7. Bed blocking still causes problems for the hospital trusts, therefore in addition to the information provided for patients it was considered important that hospital staff follow through the guidance relating to the

Department of Health, 'Choice Directive' to ensure that the requirement to implement the trespass law is used as a last resort.

8. George Eliot Hospital worked with NHS Warwickshire to spot purchase care home beds to transfer patients to a care home to resolve serious bed shortages caused by adverse weather conditions in 2010. Their discharge rates are consistently lower than the other hospital trusts that serve Warwickshire and it was considered beneficial if these hospital trusts work with NHS Warwickshire in a co-ordinated way to implement this scheme.

9. The University Hospitals Coventry and Warwickshire's A&E Department have a React Service which takes a holistic approach when assessing a patient's and carer's needs to reduce unnecessary admissions into hospital by approximately 20%. It was suggested if social care workers worked jointly with a hospital team, in the same department, it could further reduce the number of admissions.

10. (i)For those reaching the end of their life being admitted into hospital was considered not beneficial for either the patient or their families, but there were instances when this occurred, which was thought mainly due to insufficient training in end of life care in care homes. End of life care training packages are being developed, but these need to be implemented to reduce hospital admissions.

(ii)The T&F Group were also made aware that there were circumstances where a GP would not come out to a nursing home to deal with a patient with a urinary tract infection and would advise care home staff to call an ambulance.

11. It was considered important that future contracts with care homes included arrangements to ensure their employees are given incentives to encourage them to participate in further training, such as an increase in pay or credits towards qualifications in care.

12 There was an issue relating to the high costs of providing future needs assessments and CHC in a hospital setting where it could be possibly cheaper if it was provided elsewhere.

13 Communication between clinical staff, patients and their families is still a cause for concern. It can make a difference on whether the patient has a good or bad discharge experience.

14 GP aftercare was another area where improvement in communication could be of benefit to the patient and their families.

15 Some patients were provided with helpful information that ensured they knew who to contact if they had complications on discharge, but there were still instances where insufficient information was given which caused consternation for both them and their families. It was suggested that information from Age UK and other third sector

organisations should be included, to help those that may not be eligible for health or social care packages.

Recommendations

1. The County Council and NHS Warwickshire to conduct a feasibility study to establish if a whole systems approach to the Reablement Service would reduce NHS costs to enable the PCT to provide funding to support this service in the future.

2. That hospital staff not directly involved with the reablement team are provided with information about the Reablement Service, but this is to be well managed to ensure they are aware of the service's prescriptive eligibility criteria so that any referral made is appropriate to the patient's needs. This could be a single point of access service, like a triage service, to ensure patients receive the right information and a service that is appropriate for their needs.

3. That hospital discharge is included within the development of the Concordat agreement between WCC and NHS Warwickshire, which includes a review of the current policies and procedures and to continue the development of a set of key performance indicators, which can be used when commissioning services from providers to ensure the Reablement Service and discharge arrangements meet the future needs of Warwickshire residents.

4 All Hospital Trusts to approach Third Sector organisations such as Age UK or the Stroke Association to assess the benefits of having an advisor once a week to provide information and advice to patients on what support is available on discharge.

5. Both the County Council and the Hospital Trusts to work in partnership to consider how they can involve families from the onset of admission in the discharge planning process and use this process to raise awareness of the complications that can arise if their relative stays in hospital longer than necessary.

6. NHS Warwickshire, the Hospital Trusts and the County Council to work in partnership to deliver the Continuing Healthcare assessment process and resolve matters relating to Sections 2 and 5 of the Community Care Act 2003. This should include the development of a strategic approach to reduce delays on matters relating to the prescribing medicines to take out (TTOs) and the taking up of placements in nursing homes.

7. When patients are admitted, the Hospital Trusts ensure patients and their families are made aware on how long they are expected to stay in hospital, when they would be expected to leave and what arrangements are made prior to discharge. If there is a complication where an agreement for discharge cannot be reached with the patients and their families all staff should be encouraged to follow the guidance relating to the Choice Directive (Department of Health 2003). This will

hopefully ensure that the implementation of the trespass law to remove patients into more appropriate care is only used in exceptional circumstances.

8. NHS Warwickshire to ensure the Winter Plan is resilient to ensure resources are used in a co-ordinated way, such as the spot purchasing of care beds across the health economy to reduce delayed discharges. This would benefit all the hospital trusts including the West Midlands Ambulance Service by reducing delayed discharge rates, which will enable more acute beds to be available for emergencies.

9. Sharing good practice and taking the University Hospitals Coventry and Warwickshire's React Service into consideration we recommend that all hospital trusts should incorporate social care within a hospital team to help reduce unnecessary admissions and these social workers to be trained to provide support for carers as well as those requiring care services.

10. (a)The County Council, NHS Warwickshire and the Hospital Trusts to work in partnership to develop and implement end of life care training packages for care home staff.

(b)This to include a pilot study working in partnership with a Care/Nursing Home and GPs to identify cases where hospital admissions could be avoided and examples of good practice. The aim will be to produce guidance on approaches that can be taken to reduce unnecessary hospital admissions, which can be implemented throughout the county.

11 The County Council and NHS Warwickshire as part of their commissioning arrangements with care homes ensure they encourage their employees or give them incentives to participate in further training to help prevent unnecessary admissions into hospital or where medical invention will not improve or change the outcome for those reaching the end of their life.

12. To test the suitability of providing assessments in a home setting the County Council and NHS Warwickshire invite the Borough and District Councils to look at whether future needs assessments including CHC assessments could be carried out at a lower cost in an alternative setting such as Extra Care Housing.

13. Patient findings from recent reviews indicate that communication is still the main concern for them. Recommend that both NHS Warwickshire in partnership with the County Council should actively seek ways to improve the lines of communication between clinical staff, the patients and their families.

14. The GP Consortia with NHS Warwickshire and the Hospital Trusts to review how discharge information is provided to NHS Community

Services, including GPs, to enable them to be more proactive in providing aftercare.

15. All Hospital Trusts to review the discharge information they provide to patient and carers to ensure patients are aware of who to contact to receive help if they have complications. This to include information about the support Age UK and other third sector organisations can provide.

17. For all the responsible authorities such as NHS Warwickshire, University Hospitals Coventry and Warwickshire, South Warwickshire Foundation Trust, George Eliot Hospital and Warwickshire County Council to report back to Adult Social Care and Health OSC in six months time with their implementation plan for all the recommendations above.

1. Introduction

1.1 Positive work has been undertaken with the acute hospital trusts and the County Council's adult social care in Warwickshire to identify and resolve delays across the health and social care system, but despite this, the target of 17.5% to reduce the number of delays in transferring patients from hospital to social care was not achieved in 2010/11. The West Midlands Strategic Health Authority's Performance Report in March 2011 showed that the South Warwickshire Foundation Trust and University Hospitals Coventry and Warwickshire both exceeded the 5% threshold from September 2010 through to January 2011 for delayed discharges. Although this may have been cause by the adverse weather conditions in the winter, it is still a cause for concern.

1.2 The NHS assessment process accounts for over three quarters of the delays in hospital discharge but assessments carried out by social care alone are relatively low. As well as reducing the number of beds available for emergencies delays in discharge can have severe financial implications for hospitals, for example the UHCW had a loss of almost £0.2 million associated with delayed discharges which included operational targets relating to A&E and ambulance turnarounds.

1.3 A Task and Finish Group of councillors with support from leading officers of Adult Social Care and the NHS was set up in January 2011 to consider what improvements could be made to the discharge process to reduce the number of delays, the number of people being admitted directly into residential care and the number of people being admitted/readmitted into hospital and review the effectiveness of the new Reablement Service.

1.4 The Councillors on this T&F Group were:

Jose Compton (Chair)
Martyn Ashford
Robin Hazelton
Kate Rolfe
Sid Tooth
Claire Watson

1.5 The objectives of the T&F Group were to:

a) Establish how effectively health and social care services are working in partnership to ensure timely discharges and appropriate discharge outcomes
b) Identify the factors which cause delays in discharging people from hospital and lead to inappropriate discharge outcomes and to consider the effectiveness of any plans/actions which have been taken to address the issues
c) Identify the barriers to improve hospital discharges (process and outcomes) and the affordable options or solutions which will enable improved outcomes for people

d) Assess the impact the Reablement Service can have on hospital discharges and outcomes using the joint care pathways process
e) Review the proposals for the new Reablement Service
f) Identify whether there are inequalities across the county, differential waiting assessment times or differential outcomes
g) Identify whether there are areas where improved working with partners could improve the outcomes for people and reduce the demand on resources
h) Reduce the number of delayed discharges from hospital
i) Reduce the number of people admitted directly to residential care from hospital
j) Understand the NHS Operating Framework 2010/11
k) Understand the Continuing Healthcare (CHC) requirements
l) Understand the needs of carers as well as patients on discharge
m) Understand the NHS complaints process following the Ombudsman Report 2011 which raised concerns around the care provided to older people by the NHS

1.6 The T&F Group decided to include the following in the scope:

- The views and experiences of staff and patients, relating to delayed discharges, of the three acute trusts that serve Warwickshire residents
- The information provided by Adult Social Care, NHS Warwickshire and Acute Trusts should be evidence based and not anecdotal

1.7 The T&F Group excluded the following from the scope:

- Specific conditions that may cause admissions into hospital
- Past services apart from acknowledging examples of best practice that may be appropriate to consider
- Services provided by Coventry and Warwickshire Partnership NHS Trust

2. Reablement - National Perspective

2.1 The Department of Health's definition of reablement is:

'the use of timely and focused intensive therapy and care in a person's home to improve their choice and quality of life, so that people can maximise their long term independence by enabling them to remain or return to live in their own homes within the community. This approach focuses on reabling people within their homes … so they achieve their optimum stable level of independence with the lowest appropriate level of ongoing support care'.

2.2 Reablement is also defined as one of three partially overlapping forms of social care outlined in Table (A) below from a report by De Montfort University - Evaluating a service in Leicestershire.

Table (A). Promoting independence: providing the support needed for people make the most of their own capacity & potential.

PREVENTION	REHABILITATION	REABLEMENT
Services for people with declining physical or mental health to help them avoid unplanned or unnecessary admissions to hospital or residential care. This can include short-term emergency interventions as well as longer term low-level support.	Services to people with declining physical or mental health to help them achieve optimum independence.	Services for people with declining physical or mental health to help them self manage their condition by learning or re-learning the skills necessary for daily living.

2.3 It is expected that customers using this service will benefit from intensive short term reablement programmes as it will help them to learn or relearn basic skills necessary for daily living. Such reablement programmes may be particularly applicable in the context of discharge from hospital, but are also applicable under other circumstances. As well as being of great benefit to the individual, experience in other local authorities suggests that effective reablement programmes can significantly reduce the level of ongoing social care support required for many people.

3. Reablement in Warwickshire

3.1 The Reablement Service is seen as a priority in Warwickshire for promoting independence and encouraging customers to do things for themselves rather than traditional care services where carers did things for the customer. At the time of this review every customer was given a reablement package if they met the following eligibility criteria which were:

- To be Fair Access to Care (FACs) eligible
- Over 18 years of age that have a physical impairment
- Or require a home care package (but were not in receipt of an existing home care package)

3.2 The T&F Group were made aware that there were plans for the eligibility criteria to change to make the service accessible to more people. Customers receive up to six weeks free of charge, but after six weeks if the customer still remains FACs eligible they may receive domiciliary care.

3.3 People excluded from the Reablement Service were those that:

- Only require equipment or a moving and handling assessment
- Need a rapid response service,
- Have a continuing care or ongoing health need or not medically fit to be able to participate

- Have a functional diagnosis of dementia, but those with early onset may benefit from reablement services
- Have cognitive impairment, where they would find it difficult to listen and retain information. However there are plans to reconsider this in the future.

3.4 The T&F Group acknowledged the Reablement Service will not be appropriate for everyone as there will always be a need for long term care for those with continuing care or health needs.

3.5 The Reablement Service in Warwickshire was considered a very quick accessible service with very few delays. It has led to more openness between WCC Social Care and NHS colleagues in identifying the reasons for any delays in discharge whether it is in relation to the assessment process, or a requirement for equipment or home care. South Warwickshire Foundation Trust has found not having to reassess patients that already have a package of care a significant improvement for them, but has found the prescriptive criteria for reablement has caused a few issues. However, with plans to open up the criteria, to enable more people to access this service should alleviate some of these concerns and help improve the discharge process.

3.6 Home carers providing this service have received face to face training to ensure they have the right skills to encourage customers to undertake tasks for themselves. In the first instance home carers work with customers to ensure they can achieve the goals set out in their support plan such as making tea or a simple meal. Once these goals are achieved more challenging goals may be set or a decision may be taken that the customer has reached their reablement potential.

3.7 Customers are referred either from a community social work team or a hospital social care team when discharged from hospital. In November 2010 the Reablement Service became countywide and its current capacity is 40 referrals per week. They receive approximately 20 referrals a week from the north of the county and 19 a week from the south, but this can change day by day. There have been 300 customers since March 2010 but this is likely to increase now the service is countywide. During the adverse weather conditions in December 2010 the service experienced an increase in referrals which placed it under pressure to meet the extra demand. Adult Social Care recognise when they extend the criteria to enable more people access to the Reablement Service they will need to increase staffing capacity to ensure all those eligible can receive the service.

3.8 The unit cost of the service is around £29 per hour and employing more staff may increase these costs, but as an-invest-to-save-service the cost benefit is in the longer term. Currently 58% of customers do not require further care and it was considered important the reablement service was not seen as a cost cutting service, but as providing better outcomes. This supports the comparative research study conducted by Social Policy Research Unit (SPRU), University of York and the

Personal Social Services Research Unit (PSSRU), University of Kent[1], where they found the reduction in social care costs are almost entirely offset by the initial cost of the reablement intervention. They found over the course of a year the average total cost of social care services used by the reablement group was only £380 lower than the average cost of social care services used by the comparison group. They consider the potential for local authority to make significant savings may be limited. However if a whole systems approach was taken by the County Council and NHS Warwickshire where they work together to understand the impact of any changes in one organisation has on another could be beneficial for both social care and health in identifying potential savings that can be invested elsewhere.

Recommendation 1

The County Council and NHS Warwickshire to conduct a feasibility study to establish if a whole systems approach to the Reablement Service would reduce NHS costs to enable the PCT to provide funding to support this service.

3.9 On average it costs around £150 per day for basic social care but the level of care given is tailored to individual needs. For example two people could have the same condition such as a broken ankle, but one may take longer to recover or have further complications which will delay their recovery and therefore will cost more.

3.10 The SPRU & PSSRU study supported the positive impact the service had on the users' quality of life including social care related quality of life. They found it lasted up to ten months after receiving reablement, when compared to users of conventional home care services. The T&F Group recognise that Reablement Services should not be considered as a cost cutting service, but as a service that improves the quality of life for people so they can remain independent for longer.

3.11 Following the assessments and reablement support planning, customers are separated into 3 streams according to their needs. Stream 1 is for those that require a lower level of support to stream 3 where customers have more complex needs. Those customers requiring more complex needs are case managed by an Occupational Therapist to ensure any specialist equipment required is made available. It is usually quicker to provide a simple package than a more complex one, but it can be dependent on whether there is a carer available. The support plans are reviewed at 2 and 4 weeks and any goals achieved are signed off at the review stage. Customers can exit reablement at any stage within the 6 week programme if they have reached their reablement potential. At 6 weeks those ending the review and that are not FACs eligible at the end of the reablement programme are referred to an information service such as PHILLIS

[1] Home Care Re-ablement Services: Investigating the longer-term impacts (prospective longitudinal study), Social Policy Research Unit. University of York, 2010

(Promoting Health and Independence through Low Level Integrated Support).

3.12 There are a number of possible options if a customer's health deteriorates before the package ends and they are readmitted to hospital for more than 24 hours. A full assessment is carried out and another referral made by the ward to the Hospital Social Care Team. At the time of this review it was unclear whether customers would continue with the remaining weeks they have not used when they have recovered or whether the customer would have to pay if a new 6 week package was required. However, it was decided that if there were no significant changes to the health of the customer a reablement restart package could take place with the possibility of a Home Care Supervisor providing an assessment.

3.13 Councillors were informed that 80% of all customers by December 2010 were receiving Reablement Services prior to being assessed for FACs. Of these 61% of customers did not require ongoing support with the remaining 39% having a reduced level of ongoing support.

3.14 The Department of Health has provided additional funding to align local authority reablement services with health and intermediate care to reduce unnecessary hospital admissions. This is the next stage to be implemented.

3.15 A concern was raised that not all ward staff are aware of the Reablement Service and the benefits it can provide. However it is essential that if staff are made aware, they need to know which patients would be eligible to receive the service. For example a patient with complex medical needs including cancer was wrongly referred to the service when they were discharged, but they were too ill be able to get out of bed. The family had reported that palliative care was required, but this had not been passed to the Reablement Service. This poor referral not only caused the patient and family distress but delayed access to Macmillan Nursing Services.

3.16 The T&F Group agreed that the information relating to the Reablement Service needs to be well managed, in order to manage the expectations of the patient, their family and carers or waste valuable time and resources.

Recommendation 2

That hospital staff not directly involved with the Reablement Team are provided with information about the Reablement Service, but this is to be well managed to ensure they are aware of the service's prescriptive eligibility criteria so that any referral made is appropriate to the patient's needs. This could be a single point of access service, like a triage service, to ensure patients receive the right information and a service that is appropriate for their needs.

3.17 The PCT and the County Council are currently developing a Concordat for Reablement Services in the future, which includes plans to carry out assessments after discharge. The T&F Group consider this would be an ideal opportunity to include hospital discharge within this process and develop policy and procedures, for both, with performance measures/indicators to be used when commissioning services from providers to ensure reablement and discharge arrangements will continue to meet the future needs of Warwickshire residents.

Recommendation 3

That hospital discharge is included within the development of the Concordat agreement between WCC and NHS Warwickshire, which includes a review of the current policies and procedures and to continue the development of a set of key performance indicators, which can be used when commissioning services from providers to ensure the Reablement Service and discharge arrangements meet the future needs of Warwickshire residents.

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4. Hospital Discharge in Warwickshire

4.1 The Community Discharge Act 2003 reinforced the need for effective communication between the individual, family/carers and the multi-disciplinary team in the discharge plan. There are two notices which are used:

> ***Section 2*** *assessment notifications with a minimum of 3 days estimated discharge date should be sent as soon as possible after admission or before elective admission. This allows social work and multi-disciplinary colleagues to work effectively towards a timely discharge.*
>
> ***Section 5*** *discharge notifications gives notice of the confirmed multi-disciplinary decision that a patient is safe to discharge. This allows social services 24 hours to put services in place.*

4.2 The T&F Group were provided with details about the two types of discharge simple and complex/transfer of care. Simple discharge relates to patients who are discharged directly from A&E, ward areas or assessment areas to their home of residence. They have simple needs which do not require complex planning or delivery. Complex discharge or transfer of care is when several members of the multi-disciplinary team are involved with assessments to ensure safe appropriate and timely transfer. It requires coordinating services provided or commissioned by primary and secondary care which may involve home or site visits and the provision of specialist equipment.

4.3 There is an integrated discharge team at the University Hospital in Coventry and discharge facilitators at Rugby St Cross Hospital. There

are also two Age UK advisors that attend the University Hospital in Coventry two afternoons a week and Rugby St Cross one afternoon a week to provide information and advice to patients on what support is available on discharge. This was considered an example of good practice which was valued by both patients and staff.

Recommendation 4

All Hospital Trusts to approach Third Sector organisations such as Age UK or the Stroke Association to assess the benefits of having an advisor once a week to provide information and advice to patients on what support is available on discharge.

4.4 Hospital social care workers attend all the acute trusts and the community hospitals in the catchment area of Warwickshire but it can include hospitals such as Good Hope Hospital Birmingham, Alexandra Hospital Worcestershire and The Horton, Oxfordshire.

4.5 Concerns were raised with the T&F Group that currently when a social worker leaves, a replacement cannot be appointed due to a recruitment freeze. This was of particular concern in dealing with additional demands in the winter weather creates. Whilst due to budgetary pressures replacements cannot be appointed there needs to be strategies in place to be able to cope with these extra demands.

4.6 People attending hospital for either a 24 or 48 hour stay with an existing care package have been part of a pilot study where they have not been given an assessment. Normally they would have been given an assessment regardless of the existing package they may have which was counterproductive and not best use of resources. The main outcomes from this study has been a reduced the length of stay with the requirement for section 2 or section 5 notifications being avoided.

4.7 The changes with discharge planning in recent years have helped families become more aware of what is available which has reduced complications and resistance when relatives are discharged. However, there were still situations where families of patients that would be considered self funding could bed block because they did not want them to pay for their care. It was considered important that the patient, families and carers were involved with the discharge assessment process from the beginning to help prevent unnecessary delays. It was considered useful if families were made aware that a hospital is not an appropriate or safe place for their relatives to stay because of the high risk of contracting a hospital acquired infection or them becoming institutionalised and dependent on care services.

Recommendation 5

The County Council and the Hospital Trusts to work in partnership to consider how they can involve families from the onset of admission in the discharge planning process and use this process to raise awareness of the complications that can arise if their relative stays in hospital longer than necessary.

4.8 The UHCW is currently experiencing significant issues relating to delays in discharge which they need to address. The T&F Group learned that several factors can cause these delays such as matters relating to Sections 2 and 5 of the Community Care Discharge Act 2005, Continuing Healthcare (CHC) Assessments, prescribing medicines to take out (TTOs) or the refusal by families of patients that are self funding to take up placements in care/nursing homes. The Trust is currently looking at whether they could implement trespass laws such as Aintree University Foundation Trust and Southport & Ormskirk Hospital Trust are seeking to do, so patients can be removed into more appropriate care. However, there is guidance in the Department of Health's 'Choice Directive' where patients and families can go through consultation process to resolve any concerns they may have with the discharge arrangements. In the meantime Acute Trusts can make arrangements for patients to be placed elsewhere while the matter is being resolved.

4.9 The County Council can serve notices on families if they cause unnecessary delays by not actively taking up a placement when given their first choice for a care home.

4.10 Those patients without a family to act on their behalf are appointed an independent advocate. For those with mental health incapacity or impairment the County Council has a contractual arrangement with Independent Mental Capacity Advocate (IMCA). IMCA is governed by the courts and was established to help particularly vulnerable people following the Mental Health Capacity Act 2005.

Recommendation 6

NHS Warwickshire, the Hospital Trusts and the County Council to work in partnership to deliver the Continuing Healthcare assessment process and resolve matters relating to Sections 2 and 5 of the Community Care Act 2003. This should include the development of a strategic approach to reduce delays on matters relating to the prescribing medicines to take out (TTOs) and the taking up of placements in nursing homes.

Recommendation 7

When patients are admitted, the Hospital Trusts ensure patients and their families are made aware on how long they are expected to stay in hospital, when they would be expected to leave and what arrangements are made prior to discharge. If there is a complication where an agreement for discharge cannot be reached with the patients and their families all staff should be encouraged to follow the guidance relating to the Choice Directive (Department of Health 2003). This will hopefully ensure that the implementation of the trespass law to remove patients into more appropriate care is only used in exceptional circumstances.

4.11 Good discharge planning was considered essential in ensuring that a hospital is not placed in a situation where no beds are available for emergency admissions. When this occurs a bed crisis (level IV) is set in motion where requests are made for beds at other hospitals in the locality and in some situations further afield, the downside to this is not only patients being transferred further from their home and family, but it can often cause a ripple effect where bed shortages are created elsewhere.

4.12 Following a recent shortage of beds due to adverse winter weather George Eliot Hospital and NHS Warwickshire (PCT) have been working together on new arrangements to transfer patients into appropriate care. The PCT have used funds from Bramcote Hospital closure to spot purchased ten care home beds for patients being discharged from hospital to free up acute beds in the hospital and reduce delayed discharges. It was stressed that this service is very much a temporary arrangement (up to two weeks stay) and only one patient has remained in the nursing home longer than expected. When discharged the nursing home completes the patient's assessments before they are returned home. The West Midlands Strategic Health Authority's Performance Report shows that George Eliot Hospital's delayed discharge rate has been consistently lower than 5% for the past year.

Recommendation 8

NHS Warwickshire to ensure the Winter Plan is resilient to ensure resources are used in a co-ordinated way, such as the spot purchasing of care beds across the health economy to reduce delayed discharges. This would benefit all the hospital trusts including the West Midlands Ambulance Service by reducing delayed discharge rates, which will enable more acute beds to be available for emergencies.

4.13 South Warwickshire Foundation Trust identified that 25-30% of older people should not be in hospital. They were often admitted into hospital because there was no other place of safety. On occasions carers of relatives finding they cannot cope attend A&E hoping to get their relatives admitted. Currently social care workers are not part of

the A&E team, but if they were they could help reduce unnecessary admissions by arranging more appropriate care for the relatives or even respite care for carers. The T&F Group suggest a feasibility study is carried out to assess if incorporating social care (with training to support carers) as part of a hospital team at all hospital trusts could help reduce unnecessary admissions.

4.14 The UHCW's Accident and Emergency Department's - React Service provides a holistic assessment that has helped to reduce unnecessary admissions by approximately 20%. The team which has physiotherapists and Occupational Therapists check the patient's emotional and physical needs to assess whether they require a short term care package. The service is available from 9am – 7pm Monday to Friday and 9am - 4pm at weekends but the Trust would like to be able to extend the hours of this service. They also have an IT discharge planning tool 'Jonah' to help reduce discharge delays.

Recommendation 9

Sharing good practice and taking the University Hospitals Coventry and Warwickshire's React Service into consideration we recommend that all hospital trusts should incorporate social care within a hospital team to help reduce unnecessary admissions and these social workers to be trained to provide support for carers as well as those requiring care services.

4.15 SWFT also experience delays in trying to find the right care home or dealing with families' resistance to having their relatives transferred into care. Both NHS and adult social care staff at Warwick Hospital provide assessments prior to discharge, but there have been delays with those receiving end of life care. However the hospital is not considered an appropriate place for assessing patient's care needs or making the best use of their resources.

4.16 SWFT has been involved with the 'Cost of Frailty Pilot Project'. The principles of the project are:

- An assessment is done prior to the admission into hospital
- The patients are discharged and then assessed rather than assessed and discharged as done previously. It is accepted that there is a level of risk that could cause problems, but the intention will be to introduce policies to minimise this risk.
- Resources are required in the community but consider current arrangements are too compartmentalised which needs to change
- There will be an integrated health and social care from 1st April 2011 in Stratford and it is hoped that this will lead to a reduction in admissions of 2/3 per day. It is the intention that the single service in Stratford will be implemented elsewhere by the summer.

- Currently there are 50% referrals from the Ambulance Service and 50% from GPs. The Trust is working with GPs to ensure an assessment is carried out prior to admission. The GP Consortia have been very supportive.

4.17 The Trust considers this project has significantly improved partnership working with social care and the PCT but it still needs sign up from social care partners. WCC, Adult Social Care has confirmed it still requires work on the policies and procedures and may require resources to be moved around but this will require an agreement with NHS commissioners.

4.18 The UHCW are looking at admission avoidance by working with GPs and concentrating on care homes that send older people into hospital inappropriately such as reaching end of life when there is nothing that can be done to alleviate the inevitable. Their plans are to provide care staff with training and confidence to be able to care for patients with long term conditions and those with dementia when reaching their end of life. Last month the trust invited care home managers to the hospital and 40 attended. The outcome from the meeting is that they are very interested in taking up the UHCW's proposal for training care staff.

4.19 There is a similar project in Warwickshire where they are working to upgrade and improve the skills of care staff in 10 care homes. The County Council is considering whether extra funding for care homes to provide staff with extra pay if they agree to further training would be an incentive to improve their skills. The T&F Group learned that the Care Quality Commission will monitor the training to ensure the quality is consistent. Concerns were raised that although care home staff can be given this training there are circumstances where GPs will not attend a nursing home to deal with a patient with a urinary tract infection where they suggest an ambulance is called. It was proposed that a pilot study with GPs and nursing homes that are keen to be more proactive to look at best practice to reduce unnecessary hospital admissions.

4.20 The T&F recognise the work being undertaken by the acute trusts and the county council to improve training in care homes but consider there may be additional benefits if they worked in partnership.

Recommendation 10

(a)The County Council, NHS Warwickshire and the Hospital Trusts to work in partnership to develop and implement end of life care training packages for care home staff.

(b)This to include a pilot study working in partnership with a Care/Nursing Home and GPs to identify cases where hospital admissions could be avoided and examples of good practice. The aim will be to produce guidance on approaches that can be taken to reduce unnecessary hospital admissions, which can be implemented throughout the county.

Recommendation 11

The County Council and NHS Warwickshire as part of their commissioning arrangements with care homes ensure that their employees are encouraged or given incentives to participate in further training to help prevent unnecessary admissions into hospital or where medical invention will not improve or change the outcome for those reaching the end of their life.

4.21 Warwickshire County Council, NHS Warwickshire (PCT) and the Acute Trusts have agreed a discharge protocol to improve the inconsistent practices being experienced across the county. This discharge protocol covers a vast number of areas such as:

- Types of admission
- Assessment processes
- The definition of simple & complex discharge
- Discharge procedures
- Cross boundary referrals
- Housing
- Deprivation of liberty issues
- Abuse
- Procedures in dealing with patients refusing to leave hospital

4.22 It is hoped that there will be a significant improvement with the discharge arrangements in two years time. It was considered that the proposed changes will take that long to be fully implemented.

4.23 It is expected that the move to 'Virtual Wards' and the support being provided to help those with long term conditions could also reduce unnecessary admissions into hospital.

4.24 The Carers Strategy will enforce the policy of identifying carers to ensure they receive support, health checks and respite breaks. Carers will be able to access this support via their GP, Accident and Emergency Departments and other support agencies.

5. Continuing Healthcare Assessments (CHC)

5.1 NHS Warwickshire (PCT) has the responsibility for determining CHC eligibility and providing a package of care which can be very complex at times. The CHC team identify, commission and fund these packages of care to ensure they meet the needs of those that are eligible to receive this care.

5.2 In 2010 the CHC service was reviewed which identified the need to redesign the service and adopt a more strategic approach. They streamlined the process in order to release staff to reinvest time into the service elsewhere. There will be a transitional process to allow staff to implement the changes below:

a) A workforce options appraisal to centralise the administrative function, provide a single point of access, a resource for appeals and the provision of a duty clinician, fast track clinician, a duty manager and a complex case coordinator. The expected outcome from these changes will be a streamlining in the decision making process, the implementation of case management approach with identified caseloads, proactive links with named care homes and the splitting of geographical areas to clear backlogs.

b) A joint operational group was set up with Warwickshire County Council in January 2011 to agree joint policies and new ways of working. iExamples of policies recently agreed are CHC eligibility, funding process and the 29 day transfer of care.

c) A patient choice and resource allocation policy was approved by NHS Warwickshire in March 2011. This has been very helpful in setting up procedures and the legal requirements to agree a course of action in locating care settings which meet an individual's reasonable clinical needs.

d) A work stream was set up to review procurement arrangements looking at negotiations with main domiciliary providers to secure more competitive rates. The NHS West Midlands Framework for Care Homes was implemented by NHS Warwickshire in January 2011. Patients will be banded into the most appropriate tier of care rather than having individual care and are being provided with a choice of three care homes where possible. It is hoped that this will reduce delays in the patient and families having to identify a suitable placement.

5.3 A typical month's workload for the CHC team includes dealing with 125 new referrals, 40 fast track referrals for end of life care, approximately 150 changes of client circumstances, ad hoc reviews of complex cases in addition to the agreed monthly and annual reviews.

5.4 The current developments and priorities for 2010/11 were to ensure CHC is fit for purpose and there are agreed policies and procedures in place to ensure it is an efficient service that works within the strict financial constraints the NHS are facing. The areas identified for development in the next financial year for NHS Warwickshire are:

- To work with providers to support CHC training and an implementation of a model where providers will have more responsibility and ownership of the CHC assessment process and make eligibility recommendations.

- Will assume responsibility for WCC Funded Nursing Care from the 1st April 2011

- Negotiating with Warwickshire Community Health to case manage and review Fast Track clients (end of life care) to ensure timely allocation of

care packages by using Commissioning for Quality and Innovation (CQUIN). This is where commissioners reward excellence by linking the provider's income to the achievement of a local quality goal.

- Use the opportunity to tender for an out of hours service to ensure clients with complex needs are cared for in their own homes when tendering for domiciliary care

- Work with the County Council to implement the Care Funding Calculator. This is a tool that will provide greater transparency and information in negotiating the placement of clients. It is designed to provide cash efficiency gains by ensuring a fair payment level for residential and supported living placement.

5.5 The perceived challenge to implementing the changes outlined in the above section will be to work with partners collaboratively and to resolve the historical issues. Using senior managers rather than a panel to do the assessments has made the process much quicker and works well at South Warwickshire Foundation Trust. The plan is to role it out to the University Hospitals Coventry & Warwickshire and George Eliot Hospital.

5.6 The T&F Group learned that complex cases are those clients that require more case management are dealt with by those with the necessary experience to help clients such as those requiring ventilation or those that have behaviour issues relating to mental health concerns.

5.7 It was considered not appropriate for CHC assessments to be carried out in a hospital setting and it could be done elsewhere at a lower cost. The costs for NHS Warwickshire are comparatively higher than other areas of the county and it can take approximately half of the budget to provide CHC.

Recommendation 12

To test the suitability of providing assessments in a home setting the County Council and NHS Warwickshire invite the Borough and District Councils to look at whether future needs assessments including CHC assessments could be carried out at a lower cost in an alternative setting such as Extra Care Housing.

6. Patients' Views

6.1 As part of the scope the T&F Group wanted information on Warwickshire patients' experiences of the hospital discharge process which included their families. An NHS Warwickshire report 'Patients Views'[2] taken from NHS Choices, Patient Opinion and a consultation

[2] Patient Views: Insights from patients' experience of being discharged from hospitals across Coventry and Warwickshire during 2010 – Sheila Peacock, NHS Warwickshire

project involving older people provided the T & F Group with the following quotes from patients and their families:

"My husband found some difficulties over last minute discharge arrangements at rather unsociable hours"

"She was sent home with a dressing on her wound & there was no record of this on her discharge sheet. Her drugs were tipped into a huge plastic bag with no instructions on how they should be given, along with some of her belongings."

"Individually some of the staff were OK but most of the time communication problems between different departments caused a lot of concern. I was even sent home without a discharge letter and no aftercare."

"No notes or verbal guidance issued to me on discharge as to what I should expect, and what precautions to observe after an abdominal operation."

"The discharge process was fine but the aftercare from GP was non-existent. It might have been there if I'd asked for it but it wasn't proactive."

"I was kept in hospital an extra day because the surgeon was not available"

"The standard of care was excellent, I had major surgery, and could not have been better treated if I was in a private hospital. After I was discharged, I had a problem, I telephoned them, and asked if I could come over to the hospital – when I arrived there, they immediately dealt with my problem."

"Not discharged until fully recovered. 2 recalls before discharged. Very satisfied"

"After a recent hip operation, the SWAT team visited on 3 days to make sure everything was fine"

6.2 This report indicated that patients and their families had a mixed experience when discharged from hospitals across Coventry and Warwickshire. Some had a very good experience while others had or had known someone that had quite a bad experience. A common reason for dissatisfaction was the lack of communication between clinical staff and the patients and their families, including concerns with GP aftercare. There also appeared to be a correlation between the level of care given and the patients' physical and mental capacity. The feeling amongst relatives and friends was older people were not always cared for properly, because they were unable to understand, hear properly or speak up for themselves.

Recommendation 13

Patient findings from recent reviews indicate that communication is still the main concern for them. NHS Warwickshire in partnership with the County Council should actively seek ways to improve the lines of communication between clinical staff, the patients and their families.

Recommendation 14

The GP Consortia with NHS Warwickshire and the Hospital Trusts to review how discharge information is provided to NHS Community Services, including GPs, to enable them to be more proactive in providing aftercare.

7. NHS - Patient & Relatives Complaints

7.1 Following concerns raised in the recent Ombudsman Report[3] in February 2011 – 'Care and Compassion?' which looked at ten investigations into NHS care of older people the T&F Group agreed to review the complaints procedures of NHS Warwickshire and the Acute trusts in Warwickshire.

7.2 NHS Warwickshire looks at trend information when analysing complaints and if a problem reoccurs, they monitor these complaints. They also use patient surveys to obtain information on those services where there have been concerns, to monitor whether these have improved.

7.3 The UHCW with Coventry PCT and NHS Warwickshire have recently reviewed their complaints process and no potential issues were identified.

7.4 South Warwickshire Foundation Trust stressed the number of complaints (about 5 in total) are very small when compared to the several thousand patients they see each year. However all complaints are treated very seriously and are referred back to the speciality concerned. There is an integrated reporting process and patient stories are referred to the Trust's Board for consideration.

7.5 Unique complaints are looked at very carefully to establish if it is a one off complaint or whether it is something that is likely to occur again. If changes are considered necessary a new policy or procedure is put in place.

7.6 There are discharge facilitators at all the acute trusts to ensure that mistakes do not occur in relation to discharge. All the Trusts have an excellent Patients Advocacy and Liaison Service to act as an

[3] Care and Compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people, February 2011

intermediary between the patient, families and carers with the trust concerned to resolve any concerns or complaints they may receive.

7.7 After further discussion it was agreed that there was not always enough helpful information supplied to the patient or their families on discharge to alleviate any concerns they may have if there were complications or how to contact the hospital or GP. The T&F Group considered it was important that this information is provided to patients, families and carers to ensure they obtained the right support or care to help them remain at home and prevent unnecessary readmissions into hospital.

Recommendation 15

Hospital Trusts review the discharge information they provide to patient and carers to ensure patients are aware of who to contact to receive help if they have complications. This to include information about the support Age UK and other third sector organisations can provide.

To ensure all the recommendations, if agreed, are implemented the T&F Group want NHS Warwickshire, the Acute Hospital Trusts and the County Council to report back to Adult Social Care and Health OSC in six months time.

Recommendation 16

For all the responsible authorities such as NHS Warwickshire, University Hospitals Coventry and Warwickshire, South Warwickshire Foundation Trust, George Eliot Hospital and Warwickshire County Council to report back to Adult Social Care and Health OSC in six months time with their implementation plan for all the recommendations above.

8. Findings

The T&F Group reached the following findings:

8.1 The unit cost of Reablement Service is more than basic social care, but the benefit for users is in the longer term by enabling them to remain independent for longer so they can stay in their own home. The costs of Reablement are initially higher and the Social Policy Research Report commissioned by the Department of Health identified there are limited savings for social care in the longer term, but there may be more potential for savings to be made in health. It was considered important that ways were found to ensure the service remains sustainable and if a whole systems approach was taken by both adult social care and health (where each organisation understands the impact of any change they make has another) could help identify potential savings that could be made jointly. This could be reinvested in the service which will enable the service to develop to meet the likely

increase in demand when further changes are made to the eligibility criteria **(Recommendation 9.1).**

8.2 It was considered important that hospital staff not directly involved with the Reablement Team including relatives and carers were not only aware of the benefits of the Reablement Service, but of the prescriptive eligibility criteria to ensure any patient referral made to the service was appropriate for their immediate needs **(Recommendation 9.2).**

8.3 A Concordat to improve partnership arrangements is currently being developed by the County Council and NHS Warwickshire, but it was considered important that it went further than reviewing current policies and procedures, but continued to look at the development of a set of key performance indicators to be included in any contractual arrangements with providers to ensure the future needs of residents are met **(Recommendation 9.3)**.

8.4 Age UK advisors attend the University Hospitals Coventry and Warwickshire Trust two afternoons a week to provide discharge information for patients. This was considered an example of good practice which could benefit patients attending George Eliot Hospital and South Warwickshire Foundation Trust **(Recommendation 9.4).**

8.5 Although discharge planning in recent years have helped families become more aware of what is available there are still instances where bed blocking can occur. It was considered important that families and carers are involved in the discharge process from the beginning and are aware of the health complications that can occur if their relative stays in hospital longer than necessary **(Recommendation 9.5).**

8.6 Section 2 and 5 of the Community Care Act 2003 and CHC assessment process still causes the main delays with discharge from hospitals which needs to be resolved **(Recommendation 9.6).**

8.7 Bed blocking still causes problems for the hospital trusts therefore in addition to the information provided for patients it was considered important that hospital staff follow through the guidance relating to the Department of Health, 'Choice Directive' to ensure that the requirement to implement the trespass law is used as a last resort **(Recommendation 9.7).**

8.8 George Eliot Hospital worked with NHS Warwickshire to spot purchase care home beds to transfer patients to a care home to resolve serious bed shortages caused by adverse weather conditions in 2010. Their discharge rates being consistently lower than the other hospital trusts that serve Warwickshire and it was considered beneficial if these hospital trusts work with NHS Warwickshire in a co-ordinated way to implement this scheme **(Recommendation 9.8).**

8.9 The University Hospitals Coventry and Warwickshire's A&E Department have a React Service which takes a holistic approach when assessing a patient's needs to reduce unnecessary admissions

into hospital by approximately 20%. It was suggested if social care workers were part of the A&E Department at Warwick Hospital it could further reduce the number admissions **(Recommendation 9.9).**

8.10 (i)For those reaching the end of their life being admitted into hospital was considered not beneficial for either the patient or their families, but there were instances when this occurred, which was thought mainly due to insufficient training in end of life care in care homes. End of life care training packages are being developed, but these need to be implemented to reduce hospital admissions **(Recommendation 9.10a)**.

(ii)The T&F Group were also made aware that there were circumstances where a GP would not come out to a nursing home to deal with a patient with a urinary tract infection and they suggest an ambulance is called **(Recommendation 9.10b).**

8.11 It was considered important that care home staff were encouraged to take up training by giving them incentives such as an increase in pay **(Recommendation 9.11).**

8.12 There was an issue relating to the high costs of providing future needs assessments and CHC in a hospital setting where it could be possibly cheaper if it was provided elsewhere **(Recommendation 9.12).**

8.13 Communication between clinical staff, patients and their families is still a cause for concern. It can make a difference on whether the patient has a good or bad discharge experience **(Recommendation 9.13)**.

8.14 GP aftercare was another area where improvement in communication could be of benefit for the patient and their families **(Recommendation 9.14)**.

8.15 Some patients were provided with helpful information that ensured they knew who to contact if they had complications on discharge, but there were still instances where insufficient information was given which caused consternation for both them and their families. It was suggested that information from Age UK and other third sector organisations should be included, to help those that may not be eligible for health or social care packages **(Recommendation 9.15).**

9. Recommendations

The T&F Group made the following recommendations:

9.1. The County Council and NHS Warwickshire to conduct a feasibility study to establish if a whole systems approach to the Reablement Service would reduce NHS costs to enable the PCT to provide funding to support this service.

9.2. That hospital staff not directly involved with the reablement team are provided with information about the Reablement Service, but this is to be well managed to ensure they are aware of the service's prescriptive

eligibility criteria so that any referral made is appropriate to the patient's needs. This could be a single point of access service, like a triage service, to ensure patients receive the right information and a service that is appropriate for their needs.

9.3. That hospital discharge is included within the development of the Concordat agreement between WCC and NHS Warwickshire which includes a review of the current policies and procedures and to continue the development of a set of key performance indicators, which can be used when commissioning services from providers to ensure the Reablement Service and discharge arrangements meet the future needs of Warwickshire residents.

9.4 All Hospital Trusts to approach Third Sector organisations such as Age UK or the Stroke Association to assess the benefits of having an advisor once a week to provide information and advice to patients on what support is available on discharge.

9.5. Both the County Council and the Hospital Trusts to work in partnership to consider how they can involve families from the onset of admission in the discharge planning process and use this process to raise awareness of the complications that can arise if their relative stays in hospital longer than necessary.

9.6. NHS Warwickshire, the Hospital Trusts and the County Council to work in partnership to deliver the Continuing Healthcare assessment process and resolve matters relating to Sections 2 and 5 of the Community Care Act 2003. This should include the development of a strategic approach to reduce delays on matters relating to the prescribing medicines to take out (TTOs) and the taking up of placements in nursing homes.

9.7. When patients are admitted, the Hospital Trusts ensure patients and their families are made aware on how long they are expected to stay in hospital, when they would be expected to leave and what arrangements are made prior to discharge. If there is a complication where an agreement for discharge cannot be reached with the patients and their families all staff should be encouraged to follow the guidance relating to the Choice Directive (Department of Health 2003). This will hopefully ensure that the implementation of the trespass law to remove patients into more appropriate care is only used in exceptional circumstances.

9.8. NHS Warwickshire to ensure the Winter Plan is resilient to ensure resources are used in a co-ordinated way, such as the spot purchasing of care beds across the health economy to reduce delayed discharges. This would benefit all the hospital trusts including the West Midlands Ambulance Service by reducing delayed discharge rates, which will enable more acute beds to be available for emergencies.

9.9. Sharing good practice and taking the University Hospitals Coventry and Warwickshire's React Service into consideration all hospital trusts should incorporate social care within a hospital team to help reduce unnecessary admissions and these social workers to be trained to provide support for carers as well as those requiring care services.

9.10(a) The County Council and NHS Warwickshire and the Hospital Trusts to work in partnership to develop and implement end of life care training packages for care home staff.

(b) This to include a pilot study working in partnership with a Care/Nursing Home and GPs to identify cases where hospital admissions could be avoided and examples of good practice. The aim will be to produce guidance on approaches that can be taken to reduce unnecessary hospital admissions, which can be implemented throughout the county.

9.11. The County Council, NHS Warwickshire as part of their commissioning arrangements with care homes ensure they encourage their employees or give them incentives to participate in further training to help prevent unnecessary admissions into hospital or where medical invention will not improve or change the outcome for those reaching the end of their life.

9.12. To test the suitability of providing assessments in a home setting the County Council and NHS Warwickshire invite the Borough and District Councils to look at whether future needs assessments including CHC assessments could be carried out at a lower cost in an alternative setting such as Extra Care Housing.

9.13. Patient findings from recent reviews indicate that communication is still the main concern for them. NHS Warwickshire in partnership with the County Council ahould actively seek ways to improve the lines of communication between clinical staff, the patients and their families.

9.14. The GP Consortia with NHS Warwickshire and the Hospital Trusts to review how discharge information is provided to NHS Community Services, including GPs, to enable them to be more proactive in providing aftercare.

9.15. Hospital Trusts review the discharge information they provide to patient and carers to ensure patients are aware of who to contact to receive help if they have complications. This to include information about the support Age UK and other third sector organisations can provide.

9.16 For all the responsible authorities such as NHS Warwickshire, University Hospitals Coventry and Warwickshire, South Warwickshire Foundation Trust, George Eliot Hospital and Warwickshire County Council to report back to Adult Social Care and Health OSC in six months time with their implementation plan for all the recommendations above.

Scrutiny Review Outline **Appendix A**

Review Topic	**Hospital Discharges (delays and outcomes) and Reablement Services**
Panel/Working Group etc – Members	Cllr Compton (Chair), Cllr Tooth, Cllr Rolfe, Cllr Hazelton, Cllr Watson, Cllr Ashford
Key Officer Contact	Alwin McGibbon, Km Harlock, Caron Wiliams, Sheila Peacock, Zoe Bogg, Di King
Relevant Portfolio Holder(s)	Cllr Izzi Seccombe; Adult Social Care Cllr Bob Stevens, Health
Relevant Corporate/LAA Priorities/Targets	Corporate Priority 2 – Maximising independence for adults and older people with disabilities more choice and control in their life, the right help at the right time, easy access to information, advice, support and advocacy. • Supporting people to remain at home living independently • Decrease ongoing home care packages due to the introduction of prevention and early intervention including reablement • Narrowing the gaps and sustainable affordable services fit for the future.
Timing Issues	Reablement services became a countywide service at the end of November 2011. During the roll out process the referral criteria was extended to include hospital discharge. In addition there have been changes to the NHS Operating Framework which sets out clear expectations on what the NHS is required to deliver against 2010/11. £660,000 has been given to NHS Warwickshire to develop local plans in conjunction with WCC & Community Health Services to decide the best way of using this money to facilitate seamless care for patients on discharge to prevent avoidable hospital readmissions. It will be a few months before there will be information about reablement of hospital discharge patients and with this in mind it was thought appropriate to start this review in January 2011. This will enable the T&F Group to consider how the new ways of working and reablement will have on hospital discharge.
Type of Review	In depth review
Resource Estimate	If commissioned this review is likely to take somewhere between 3-4 months to complete the review i.e. up to having an agreed final report ready for submission to committee. This is potentially a complex review. A provisional estimate of scrutiny officer support is between 288 to 312 hours or 48-52 days depending on the actual methodology used by the review. This assumes a review planning meeting, 4 evidence sessions, evidence review meeting, meeting to develop conclusions and recommendations and between 4-5 local site visits (a best practice visit outside the county is not included). The resource estimate includes arrangements for meetings, research time, liaison and contact with witnesses and write up of evidence and the final report.

	The longer people remain in hospital the more dependant they become and the more difficult it becomes to rehabilitate back to independent living, creating an increased pressure on adult social care services. Getting people out of hospital and back into independent living at the earliest opportunity is cost effective for both health and adult social care services and a better outcome for the individual. Whilst it is important to ensure that discharges are timely, it is also fundamentally important to ensure that the outcome of the discharge is appropriate to individual needs. Government guidance states that no one should be admitted to residential care directly from hospital. Currently, it is thought that the numbers of people admitted to residential care direct from hospital in Warwickshire is too high. There is a need to ensure that health and social care services are working effectively in partnership to ensure timely discharges and appropriate discharge outcomes. Outturn performance for 2009/10 comments on two key areas for improvement
Rationale (Key issues and/or reason for doing the review)	We have missed our target to reduce the number of **delays of transferring patients from hospital to care**. This is an important partnership issue because although social care delays remain very low, delays that are the responsibility of the NHS make up over three quarters of the outturn for this indicator. Positive work has been undertaken with acute hospital trusts to identify and resolve delays across the health and social care system; both at an operational and strategic level such as transforming community based services. This is an important measure because it can impact on some of the most vulnerable and frail people in the County, who are caught up in the complex issues involved. The Adult Social Care & Health **'Reablement'** service is now a countywide service. The service has been designed to help people to regain the skills and confidence they need to live independently at home, particularly after an illness or spell in hospital. With the revision to the NHS Operating Framework 2010/11 and the funding allocation provided to the PCT to develop local plans does provide seamless care for patients to prevent avoidable admissions. It is essential that Adult Social Care works with colleagues in the PCT and the Community Health Service to ensure the reablement service forms part of a single or coordinated intermediate care service.

Objectives of Review (Specify exactly what the review should achieve)	1) To establish how effectively health and social care services are working in partnership to ensure timely discharges and appropriate discharge outcomes 2) To identify the factors which cause delays in discharging people from hospital and lead to inappropriate discharge outcomes and to consider the effectiveness of any plans/actions which have been taken to address the issues. 3) To identify the barriers to improve hospital discharges (process and outcomes) and the affordable options or solutions which would enable improved outcomes for people 4) To assess the impact the reablement service can have on hospital discharges and outcomes using the joint care pathways process. 5) Review the proposals for the new reablement service 6) To identify whether there are inequalities across the county, differential waiting/assessment times or differential outcomes. 7) To identify whether there are areas where improved working with partners could improve the outcomes for people and reduce demands on resources 8) To reduce the number of delayed discharges from hospital 9) To reduce the number of people admitted directly to residential care from hospital 10) To understand the NHS Operating Framework 2010/11 11) To understand Continuing Health Care (CHC) requirements 12) To understand the needs of carers, as well as patients, on discharge 13) To understand the NHS patients complaints procedures following concerns raised by Ombudsman Report Feb 2011
Scope of the Topic (What is specifically to be included/excluded)	<u>Include</u> The following is included in the scope of the review: • The views and experiences relating to delayed discharges of the three Acute Trusts that serve Warwickshire residents • The information provided by Adult Social Care, NHS Warwickshire and Acute Trusts should be evidence based - not anecdotal. <u>Excluded</u> The following falls outside the scope of the review: • Specific conditions that may cause admissions to hospital • Past services apart from acknowledging examples of best practice that may be appropriate to consider • Services provided by Coventry & Warwickshire Partnership Trust
Indicators of Success – Outputs (What factors would tell you what a good review should look like?)	• Recommendations accepted and implemented to deliver improvements
Indicators of Success – Outcomes (What are the potential outcomes of the review e.g. service improvements, policy change, etc?)	• Recognisable improvements in discharge processes and outcomes • Reduction in number of delayed hospital discharges • Reduction in number of people admitted to directly to residential care from hospital • Set of Health Indicators to measure hospital discharge & reablement process • Fewer people requiring ongoing care • Fewer admissions/readmissions

Other Work Being Undertaken (What other work is currently being undertaken in relation to this topic, and any appropriate timescales and deadlines for that work)	New Reablement Service Review of Continuing Health Care (CHC) Discharge Planning – CQUIN Adult Social Care Transformation Plan Hospital Discharge Protocols

Appendix B

Glossary of Terms

A&E	**Accident and Emergency**
CHC	**Continuing Healthcare**
FAC	**Fair Access to Care**
GP	**General Practitioner**
NHS	**National Health Service**
PCT	**Primary Care Trust**
PHILLIS	**Promoting Health & independence through Low Level Integrated Support**.
PSSRU	**Personal Social Services Research Unit**
SPRU	**Social Policy Research Unit**
SWFT	**South Warwickshire Foundation Trust**
T&F	**Task and Finish**
TTO	**To Take Out (medicines)**
UHCW	**University Hospitals Coventry & Warwickshire**