Item No 8

Adult Social Care and Health Overview and Scrutiny Committee

5th September 2012

Hospital Discharge and Reablement

Recommendations

(1) It is recommended that the Overview and Scrutiny Committee consider and comment on the progress made within Social Care and Support in improving hospital discharge planning and continuing to improve delayed transfers of care.

1.0 Introduction and Key Issues

1.1 The People Group within Warwickshire County Council is responsible for the timely discharge of a customer from the following services:

- An acute bed within one of the hospitals – George Eliot Hospital, St Cross, South Warwickshire Foundation Trust, University Hospitals Coventry & Warwickshire (including St Cross Hospital)
- Other bordering acute hospitals e.g. Worcestershire
- Coventry and Warwickshire Partnership Trust acute in-patient beds.

1.2 The Community Care (Delayed Discharges) Act 2003 introduced responsibilities for the NHS to notify social services of a patient's likely need for community care services on point of discharge and to give 24 hours' notice on actual discharge. The Act also required Local Authorities to reimburse the NHS trust for each day an acute person's discharge is delayed where the sole reason for that delay is the responsibility of social services either in making an assessment for community care services or in providing those services. The Acute Trusts in Warwickshire agreed that they would not seek to pursue reimbursements, however, out of county hospitals made no such undertaking.

1.3 NHS Trusts provide weekly and monthly data to the Strategic Health Authority on all delays (either attributable to NHS ongoing care, social care or both) where a patient continues to occupy a bed after their confirmed discharge date.

1.4 The NHS Vital Signs on Delayed Transfers of Care and the Local Authority performance indicator NI131 measure all delayed transfers of care (acute and none acute) per 100,000 population.

1.5 February 2012 through to April 2012 saw unprecedented levels of activity in all the Acute Trusts serving Warwickshire residents with significantly

higher numbers of people presenting at Accident and Emergency and high numbers requiring a hospital admission. In order to improve patient flow, the Strategic Health Authority introduced further targets to improve discharges. Each hospital was given a target that comprised a number of "simple" cases that needed to be discharged each day and a smaller number of "complex" discharges. (Complex discharges included all supported discharges where an individual required Intermediate Care, Reablement or a Support Package). Warwickshire County Council achieved their targets in all three Trusts.

1.6 Very few delays are attributable as a result of delays in undertaking social care assessments, however, some of Warwickshire's more rural areas do present challenges when sourcing packages of care. Health colleagues are responding to health related delays, such as Continuing Health Care (CHC) assessments, mental health assessments and placements in NHS funded facilities. These all account for a higher number of bed days lost. Overall, the number of delayed transfers of care in Warwickshire has significantly improved, although further work is needed to match and exceed the performance of our comparators. There is strong joint commitment to deliver this.

1.7 Warwickshire Corporate Business Plan Measures for delayed transfer of care performance statistics are as follows, and are based on a national definition from the Adult Social Care Outcomes Framework (ASCOF):

Definition	**2011/12 outturn**	**Q1 outturn**	**2012/13 Predicted outturn**	**2012/13 target**	**2011/12 shire average**	**2011/12 England average**
Delayed transfers of care - **ASCOF 2C All Delays**	17	15.1	14	13	11.3	9.8
Delayed transfers of care - **ASCOF 2C Those attributable only to Social Care and those joint with health (exclude health only delays)**	7.4	4.9	4.5	4.0	4.1	3.8

ASCOF 2C (as shown above) is a measure of the total of all the different sorts of delayed transfers of care. It is the average number of delayed transfers of care (for those aged 18 and over) on a particular day, taken over the year and expressed per 100,000 of the population. The different reasons for a delayed transfer of care have been nationally defined and are:

- Awaiting completion of assessment (can be the responsibility of either health, social care or both)
- Awaiting public funding (can be the responsibility of either health, social care or both)

- Awaiting further non-acute NHS care (only the responsibility of health)

- Awaiting residential home placement (can be the responsibility of either health, social care or both)
- Awaiting nursing home placement or availability (can be the responsibility of either health, social care or both)
- Awaiting care package in own home (can be the responsibility of either health, social care or both)
- Awaiting community equipment and adaptations (can be the responsibility of either health, social care or both)
- Patient or family choice (can be the responsibility of either health, social care or both). This is the situation when a patient and family are taking time to decide which care home to move to, and the person remains in hospital while this is happening.
- Disputes (can be the responsibility of either health, social care or both)
- Housing for patients not covered by the NHS and Community Care Act (only the responsibility of health).

1.8 Warwickshire is striving to meet the aims of the 'Caring for our future: reforming care and support' Social Care White Paper, which sets out the vision for a reformed care and support system.

The new system will:

- focus on people's wellbeing and support them to stay independent for as long as possible
- introduce greater national consistency in access to care and support
- provide better information to help people make choices about their care
- give people more control over their care
- improve support for carers
- improve the quality of care and support
- improve integration of different services

This new system focus within the White Paper can be evidenced through the growing agenda between WCC and health partners. The main priorities that are currently underway for improving hospital discharge processes and the role of community support and assessment require a change in culture in the role of the acute hospital. Warwickshire is aiming to reduce hospital average lengths of stay and ensure that hospital is only utilised as a place to 'get treated'. As soon as a patient is clinically safe to be discharged, the journey of active convalescence and rehabilitation for the customer should take place out of the hospital environment, where the individual is central to the support service that they are being offered. The setting that the customer moves to after hospital, which will be their own home wherever possible, will be where they engage in their full assessment of needs / risks, which will identify the long term care and support which they need (if any). In addition to reducing the length of stay that a person remains in hospital, this will also reduce the overstatement of needs that often occurs in acute settings, when people are assessed at their most vulnerable, in an unfamiliar environment. Additionally,

it facilitates a more relaxed and appropriate environment to engage with carers and families, to enable informed long term care decisions to be made.

1.9 Following on from the Reablement and Hospital Discharge Task and Finish Group that took place in July 2011, a number of developments that were identified within the implementation plan, to improve hospital discharge and to maximise the use of the reablement service, are currently underway. This has focused partnership working between the acute hospitals, health community services and WCC to achieve the best outcomes for the customer at point of exit from hospital. The Service Manager Lead for Hospital Social Work Teams and the Service Manager Lead for Reablement Services have been working with health colleagues to agree a more co-ordinated approach to discharge planning and reducing lengths of stay in an acute medical setting.

2.0 Developments In Progress

2.1 Against a background of a series of early service integration pilots in Warwickshire, senior leaders from Warwickshire County Council, South Warwickshire Foundation Trust, NHS Warwickshire PCT and South Warwickshire Clinical Commissioning group met to discuss the way forward towards integrated / aligned services for older people. The outcomes of these discussions lead to the development of a shared purpose for integrated working.

The foundation of the new model of aligned working is defined by the development of three new 'Discharge to Assess' pathways. The aim is to establish three clearly understood pathways of care. A patient is identified for the appropriate pathway, which will depend on the complexity of need of the patient. (See Appendix A for a diagrammatic view).

The scoping work has identified the following *Shared Purpose Themes*, which we are following as we develop the new services:

- Focus on developing and implementing a complete 'Discharge to Assess' model for patients in hospital, as part of a vision to develop and deliver aligned care.
- This development process should be 'bottom-up' including patients and staff.
- The outcomes of the individual patient pathway must be recorded so that data is available to evaluate outcomes and further refine the model.

Pathway 1 – supported discharge home

This pathway will be utilised when it is identified that services can be provided which enable a safe hospital discharge for a person's return home. The majority of arrangements/services to deliver this pathway (e.g. the '5 a day' project) are already in place. Our objective is to achieve a

flow of 30 new patients a week moving to CERT/IMC for South Warwickshire and a flow target will also be set for Reablement Services.

Pathway 2 – 'Discharge to assess' where home is not an option at the point of discharge, but permanent residential care is not inevitable

This pathway should be used for individuals who cannot return home, even with availability of any of the services available in 'pathway 1'. These patient situations can be considered as medium to high complexity (or, in social care terms, 'critical' levels of need / risk). Patients will be discharged to a bed-based facility able to provide intermediate type care for a period of around 2 - 6 weeks. The anticipated exit route from the pathway is either back home (with support if needed), or to residential care. The patient will have given consent to care and support provided, along the journey.

Pathway 3 – 'Discharge to assess' to nursing home, where patient needs are very complex and where Continuing Health Care (CHC) eligibility is a possibility

This is a new pathway for Warwickshire. Patients will be discharged to a commissioned nursing home for a period of around 4 – 6 weeks. During this time, patients will be offered an environment in which to recuperate / rehabilitate as far as possible, and will be assessed for CHC eligibility. Patients assessed as eligible for CHC funding will have their long term care arrangements organised during the stay. Individuals assessed as eligible for WCC social care and support (nursing or otherwise) will have their long term care arrangements organised by an allocated Social Worker. Self-funders will be appropriately supported to identify their long term care arrangements. The patient will have given consent to care and support provided, along the journey.

Entry into the pathways will be determined by a mixture of the trusted assessment tool (outlined in section 2.2) and professional judgement, in discussion with the patient and their carers. An assessment will be applied to the customer when their acute medical phase is over and will lead to the most appropriate care setting (ideally in the person's home) being selected and accessed in a timely way. These pathways reflect ongoing assessment and support in the right place, at the right time, rather than being assessed in crisis, which may lead to creating an overstatement of dependence on community resources.

Scoping work has identified the following benefits:

- Clear and understandable pathways for all stakeholders, including patients, carers and referrers.

- A service that is timely – leading to best outcomes.
- No-one in hospital (or any of the short term rehabilitative / intermediate care services) any longer than needed – smooth 'flow' of people moving through services, without 'bottlenecks'.
- No-one makes a long term decision about their care whilst they are in hospital (unless in exceptional, appropriate circumstances).
- Decisions about long term care are made in an improved environment, with more time for engagement with carers, families and loved ones.
- More people will be able to return to their own homes to resume more independent lives. The risk of creating dependency will be minimised. (Currently, of the people who access pathway one, 16% have a need for additional support services after the period of rehabilitation / recuperation).
- Standardisation of care pathways and improved professional understanding will reduce duplication in assessments and inputs, reduce variations in practice, reduce time spent (by both patients and clinicians) in navigating a complex system, and therefore overall improve efficiency and productivity.
- These pathways are designed to deliver care close to home and to optimise health and social inclusion for vulnerable older adults. This has been identified as strategically important to clinical commissioning groups (CCG's) across Warwickshire, and the people they serve.
- A system that is transparent.
- A system that is operationally and financially sustainable with risk and remuneration clearly identified / linked for organisations.
- A system that deliberately helps its constituent members with their challenges and a culture that takes responsibility for people that are referred.

The work to date has seen significant improvements in the number of people supported who remain in their destination (usually in their own home) 91 days post discharge from hospital. This is evident within the Corporate Business Reporting for Q1:

Definition	**2011/12 outturn**	**Q1 outturn**	**Predicted outturn**	**2012/13 outturn**
%customers not needing social care 91 days after reablement	62%	55%	63%	63%

The % of customers requiring social care services 91 days post reablement for quarter 1 currently sits at 55%. This is lower than the agreed target. This may be due to the increased eligibility within reablement that has resulted in more complex customers being offered the service. Therefore the customer is likely to require an ongoing package of care following their reablement input. However, it is evident that the package of care is significantly reduced as a result of having received reablement.

2.2 Each acute trust discharge liaison team within the acute hospital or the Intermediate Care Team based in the community will use an electronic assessment tool with the customer. This approach is being developed so that health and WCC can use the same assessment process for a customer at their point of discharge from hospital. The staff member and the customer work together to answer a number of questions within the tool, which will determine which community based service the customer requires at their point of exit from an acute hospital stay or after a period of intermediate care. This trusted assessment should maximise timely discharges, as the outcomes and the content of the assessment (a pre-determined question set) will always be consistent. There will be little requirement for the service that the customer is being referred onto to chase for additional information before they can accept the customer, as the information will already be available within the electronic assessment tool. This initiative is called the Electronic Common Assessment Tool (eCAT). It is proposed that this will be rolled out within South Warwickshire Foundation Trust by October 2012. Ongoing review and monitoring will take place to ensure that the process is safe and effective. A countywide roll out of the eCAT within the acutes should be achieved by the end of the financial year.

2.3 All hospital discharge coordinators based within the acute wards will have the ability to refer directly into reablement using the trusted assessment tool (eCAT). Workshops are taking place throughout July and August 2012 to ensure the discharge teams have adequate knowledge and confidence regarding reablement eligibility. This will assist with timely discharges, as health colleagues will be able to refer directly into the reablement service.

2.4 Reablement Community Care Workers (CCW) are situated in the 3 acutes and work alongside the Hospital Social Care Team to maximise discharges into reablement for a more coordinated approach to discharge. The CCW is also used as a useful resource for the social work team to ensure customers that are considered for reablement are eligible for the service. This in turn will assist with timely discharges to the appropriate service area.

2.5 Since 8th May 2012, the South Warwickshire Foundation Trust Community Emergency Response Team (CERT) can refer directly into the reablement service. This ensures that the CERT capacity and flow remains focused on hospital discharge cases. After the 72 hours of CERT service the customer (if eligible) can move directly to reablement. Reablement respond within two hours of receipt of the customer referral and the service may start immediately using the trusted assessment documentation from CERT. Shared risk assessments are also being developed, so that the customer does not receive duplicate assessments from different organisations.

2.6 Some spare capacity within Warwickshire County Council's residential homes has temporarily been utilised to provide 'Moving on Beds'. These

are a resource for people who no longer require an acute hospital stay, but may benefit from a short period of residential care, with therapeutic input where needed, to enable them to return home. The outcome of this temporary arrangement will be evaluated and a refined model will become a crucial part of the discharge to assess pathway development outlined within section 2.1 of this report. Discharge co-ordinators based within the acutes are able to identify people that may benefit from this resource. The Residential Care Home Managers are committed to responding within two hours and admitting to the relevant home the same day where it is reasonable and safe to do so.

2.7 George Eliot Hospital and South Warwickshire Foundation Trust now have ward attached social workers to jointly agree estimated dates of discharge in a Multi-Disciplinary meeting and to improve communication between the ward and the social work team. This has led to better understanding from ward staff in what is categorised as a delay either to health or social care.

2.8 A dedicated social worker has been introduced at South Warwickshire Foundation Trust to ensure assessments are completed when a social worker may be absent and ensures discharges are not delayed. This ensures flow is not affected from reduced staffing levels within social care.

2.9 Where vacancies occur these are quickly filled and additional social workers were recruited in October 2011 to meet the increased demand that the winter months bring. We are currently scoping whether additional staffing will be required for winter 2012/13 to assist with potential winter pressures.

2.10 A fast track process has been introduced, to quickly discharge patients who were already in receipt of a package of support prior to their hospital admission and could be discharged with the same level of support without further social work assessment. Discussion with the individual, their family or carer and existing care provider are central to this process to ensure the views of all involved are taken into consideration and a safe discharge is arranged.

2.11 The Service Manager lead for Hospital Social Work Teams attends a monthly strategic meeting at George Eliot Hospital where issues are discussed relating to discharge. A similar meeting at South Warwickshire Foundation Trust also takes place, which the Reablement Service Manager attends. This ensures a joined up approach to discharge protocols and allows us to problem solve any key areas that may be contributing to delays in discharge. Similar meetings are held with UHCW and out of county hospitals.

2.12 There is good communication and relations between senior social care and Health managers and a joint approach to problem solving takes place, particularly where complex issues have been identified and a multi-disciplinary approach is required to ensure the customer receives tailored support.

2.13 All decisions for the Council funds required are made within two hours of request. This enables practitioners to secure the identified resource. All discharges referred into the reablement service are responded to within two hours of receipt of referral.

2.14 Colleagues in Strategic Commissioning are immediately alerted to provider (domiciliary or residential / nursing) resource deficiencies or quality issues within the external market. This enables commissioners to speak to external providers about the potential for additional capacity being made available and to work with them to improve standards of support where required.

3.0. Next steps

3.1 The formal project structure is being developed for the delivery of the 'Discharge to Assess' model. The key aspects of this pathway will be in place by November 2012.

3.2 Development of an Arden Cluster-wide performance database is being developed to enable stakeholders (acute, health community services and social care) to understand the performance and outcomes of the 'Discharge to Assess' system, in relation to discharges, admissions and flows. This database will be available by November 2012 and will give a more accurate picture of the activity, performance and outcomes across the whole of Warwickshire.

3.3 A review has taken place regarding CERT direct referrals into the WCC Reablement Service and lessons learned are being used to roll out the referral pathway countywide. Ongoing review will take place every three months to ensure the direct referral route remains effective.

3.4 Reconfiguration of the South Warwickshire Foundation Trust Hospital Social Care Team and the WCC Reablement Service is taking place to align with the Discharge to Assess pathways by November 2012. This will support the customer to make decisions about their future at the right time and in the right place. This will also ensure that we are as prepared as possible for the demands of the 2012/13 winter pressures.

Background Papers

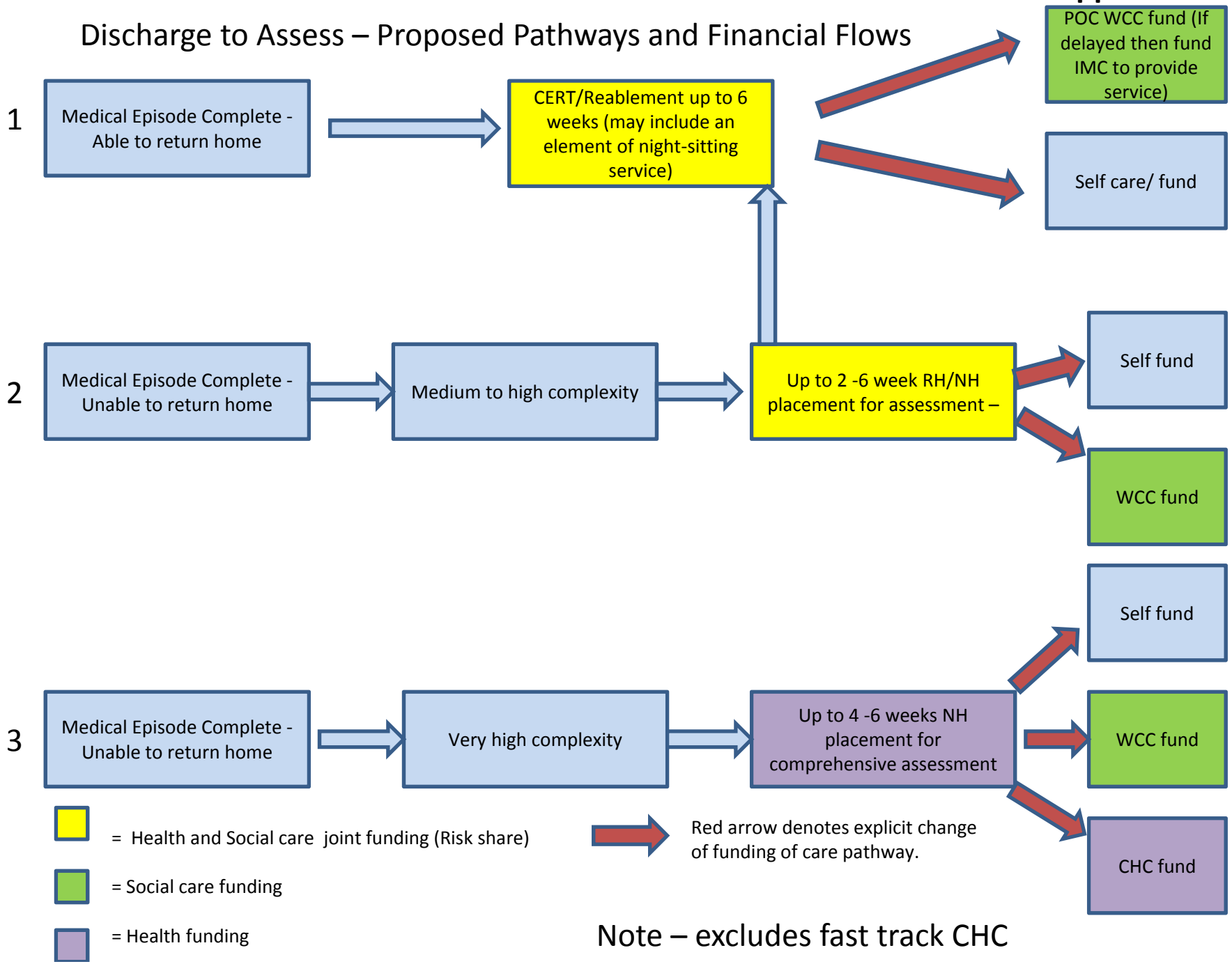
1. Reablement: Data on demand. October 2011
2. Reablement Evaluation. July 2011
3. Task and Finish Group. Reablement & Hospital Discharge May 2012

	Name	**Contact Information**
Report Author	Zoe Bogg / Di King	01926 731078 / 413311
Head of Service	Jenny Wood	01926 742962
Strategic Director	Wendy Fabbro	01926 742967
Portfolio Holder	Cllr Mrs Izzi Seccombe	01295 680668

South Warwickshire

Appendix A

Discharge to Assess – Proposed Pathways and Financial Flows



Note – excludes fast track CHC