Update on Discharges from University Hospital Southampton

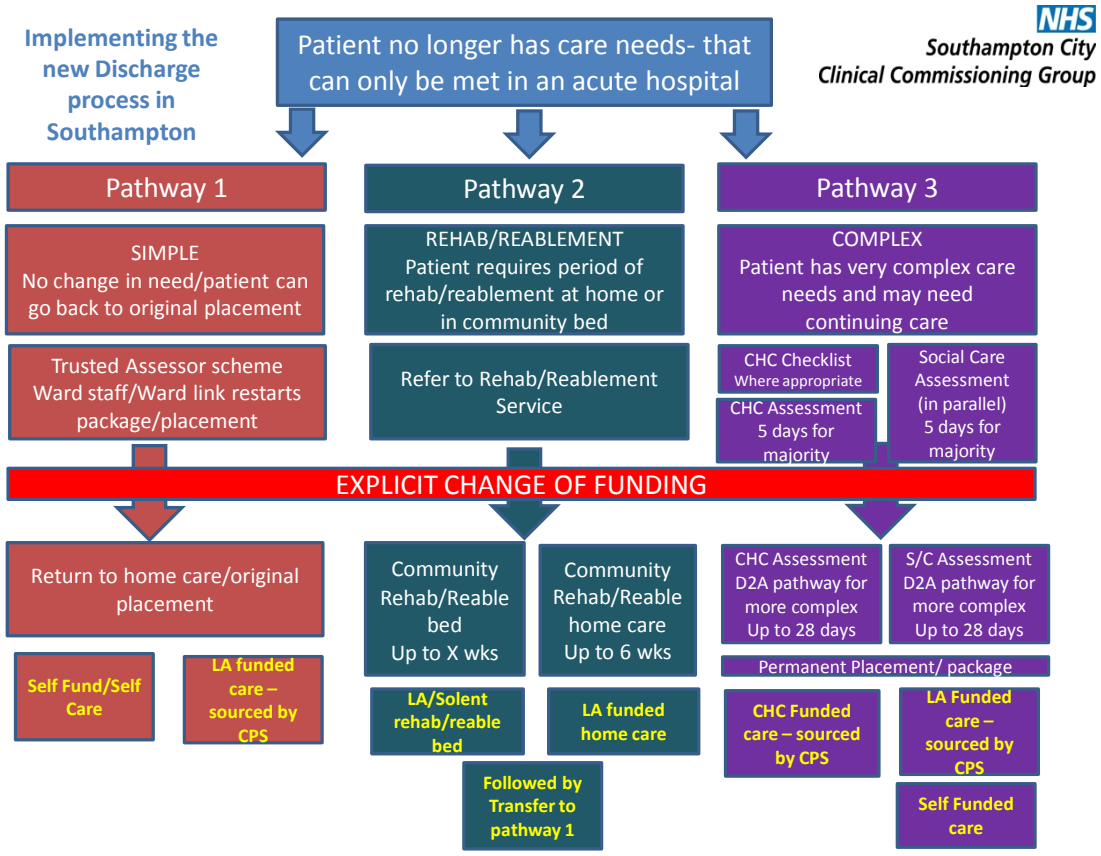
Southampton City Council Health Overview and Scrutiny Panel

Every day approximately 10% of the patients discharged from University Hospitals Southampton need some kind of further support to enable them to go home, be transferred to an interim bed or moved permanently to a residential or nursing home. The other 90% go home with normal levels of support from their GP or the district nursing team. This 10% translates into about 20 patients a day being discharged with ongoing support; half of these are Southampton residents. Currently about 180 patients (out of 1,000) from Southampton and Hampshire are somewhere in this process and just under half of these will have been waiting for more than three days for this transfer to occur. These patients may be in any of the three pathways shown below and not all will have or require social services input.

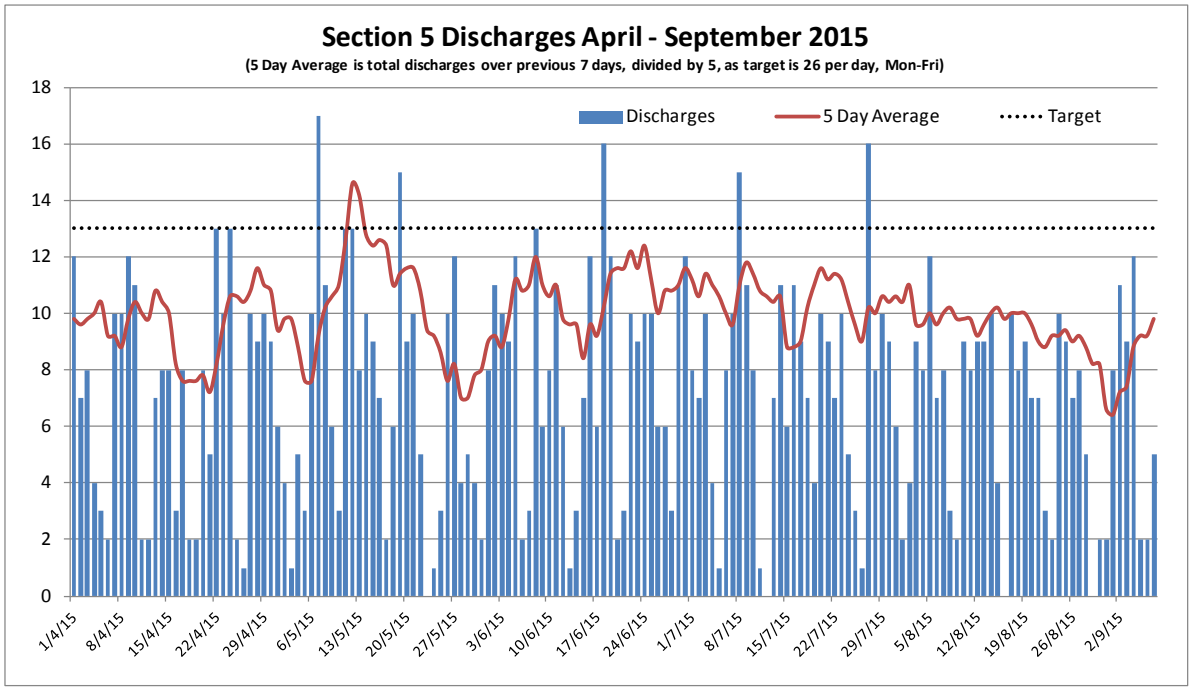
In an effort to reduce the overall numbers of patients waiting for discharge to be arranged the Hampshire and Southampton health and social care systems have committed to increase the number of these discharges from 20 to 26 per day (13 for Southampton residents).

If the health and social care system can deliver this it will make a real difference to patient care. Not only to the patients who are transferring to other care settings but to the patients who cannot be admitted for their elective surgery and for the patients waiting for admission in the emergency department. The Hospital runs at over 98% occupancy so every extra patient that transfers really counts.

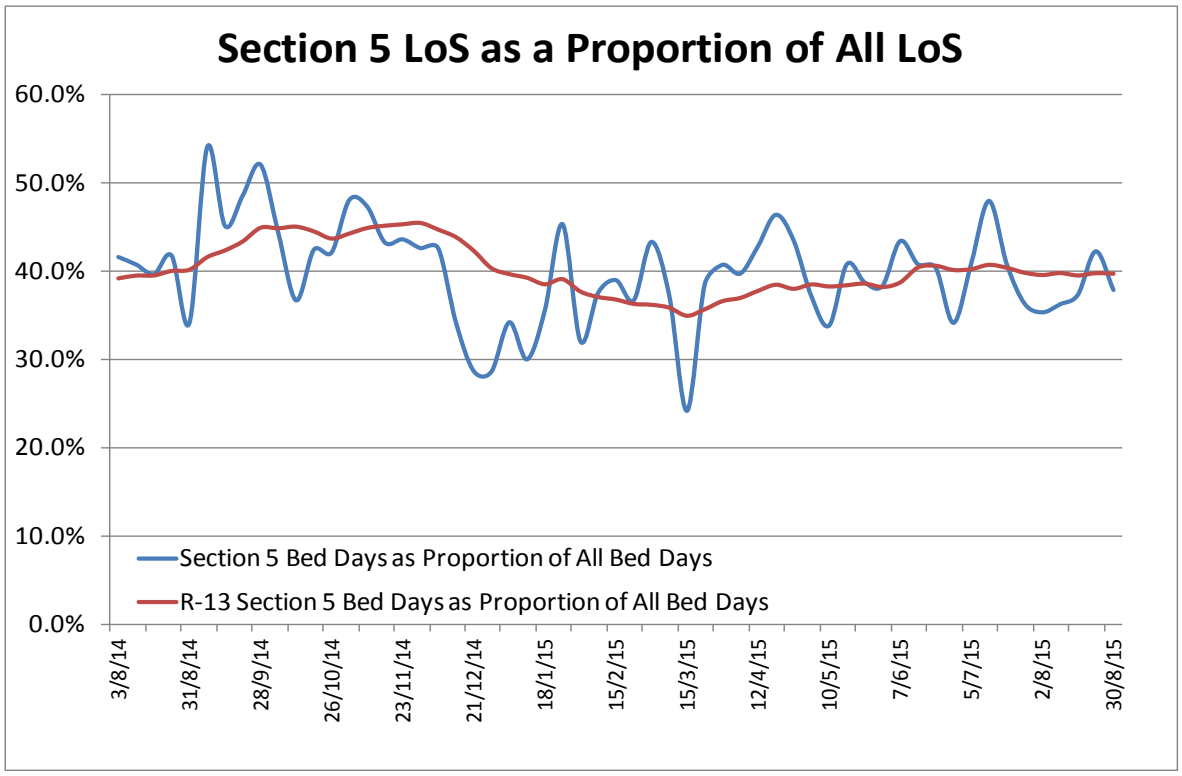
The possible pathways for discharge from Hospital are shown below:



The actual number of discharges against the 13 per day for Southampton patients are shown below, the 13 per day has not been met since May 2015:



Based on the current information fed into our systems the time taken to transfer a patient from an acute hospital bed is just over 10 days on average from the time they are declared medically fit. This can extend a patients stay by 40%. The table below, which includes an analysis of all delays, generated by all causes, this includes awaiting Continuing Health Care Assessments (CHC) and delays associated with Family choice. This demonstrates some of the fluctuations in the process which our teams are jointly teams working on to improve and shorten.



Over the last few months a lot of work has been undertaken to improve the flow of patients in across the system for the City. The system has been working together to reduce the time the patient spends in Hospital for three reasons:

a) There is significant evidence that patients physically deteriorate whilst in Hospital resulting in a loss of physical functioning, independence and quality of life; this may mean that an individual's care needs are higher when they leave Hospital increasing costs for the individual or the state.
b) Often these patients become unwell again during a Hospital stay if this is prolonged
c) Other patients with acute health care needs cannot access Hospital services in a timely manner

The process to discharge this group of patients may be considered in four steps:

- – identify there is a need and what type of care is suitable - assessment
- – agree who is paying for any ongoing care – self, NHS or Social Services
- – organise the care for this patient and agree the price - self, NHS or Social Services
- – transfer the patient when the care is available

The people involved in these decisions will include the patient, the family, the doctors, nurses and therapists, the social care team, the commissioners of services (the payer) and the provider of the services. For some patients this decision is relatively simple, for others very complex.

Examples of each pathway is set out below:

Pathway 1 – these are patients that after a short illness or injury can return to their normal place of residence with the same level of support that is currently in place. This can range from care at home

or care in a nursing home paid for by Adult social care, the patient or the CCG. If everyone agrees the care needs haven't changed (including the provider of that care) then the patient can return. At the moment the social care team are involved in making these assessments, particularly for care package restarts, in the future this role will be shared across heath and social care through trusted assessment.

Pathway 2 – the Hospital recommends a short period of physical rehabilitation in the Community beds at the Royal South Hants Hospital for a patient with a broken limb or with other rehab needs after a fall. This will help the patient become stronger and more mobile to achieve as much independence as possible when they return home. People involved are the patient, family, Hospital team (mainly therapy led), Solent community provider team who will assess the patient for suitability and Solent team who deliver the care. In this instance there is no discussion about funding as health pay for this care. This is fairly simple pathway and patients normally transfer out of an SGH bed within 1-2 days. This is a real improvement and Solent should be congratulated for their efforts.

Pathway 3a**–** The Hospital, patients and family feels the patient has some additional needs that need to be supported so they can return home. It is decided some ongoing personal care would be helpful which can vary from once a day to four times a day with up to two carers at each visit to help move and support the patient. The patient has to be financially assessed as personal care is not covered by the health budget and social care can only pay if the patient in unable to pay for themselves. Once the financial assessment is complete a domiciliary care organisation is organised (from the new framework) who may accept the patient on a written referral or may want to assess the patient to ensure they can meet their needs. Once agreed the care package will commence once they are sure they can meet the patients care needs every day. This is currently taking an average of 3.9 days to commence once a care provider has been chosen (July 15 figures, down from 7.4 days in April). This is a significant improvement and SCC and the Integrated Commissioning Unit should be congratulated.

Pathway 3b – Working with the Patient and the Family it is decided that the patient can no longer safely live in their previous accommodation (this may be their home, a residential home or a nursing home who can longer meet the patients care needs) and therefore needs a new care home on leaving Hospital. These are the most complex patients who take the longest to assess to determine who should pay for care and to find new placements for. Normally this pathway accounts for 30 patients per month from Southampton and usually involves in-depth clinical and financial assessment. The patient and family then need to select somewhere to live that is convenient and affordable to the payer. The new care provider will themselves assess and must accept them which is often not straightforward. Once a care provider is found they will set a timescale for when they will accept the patient. These pathways run into weeks and months; self funding patients are generally the most straightforward and patients eligible for CHC funding (who are by their nature the most complex patients) take the longest.

The work undertaken by the local system to improve each of these pathways is in four parts:

a) **break down the barriers between Health and Social Care** to create one service to reduce duplication of services (there are a number of examples of this including from creating one manager for the Hospital discharge Bureau to proposals to merge social care and health provision for patients who need reablement)

b) **increase care for patients at home to reduce the chance of an admission to Hospital**, this includes the creation of teams of health and social care staff who work in localities within Southampton to ensure good, joined up, health and social care on an everyday basis and increased care when the patient is more unwell working, anticipatory care planning with shared IT records to navigate through the health and social care and present Hospital admission

c) **encourage people to maintain their independence** either through targeted interventions (reducing falls through an exercise programme or support to help stay physically and mentally active.)

d) **Following Hospital admission ensure the care needs assessment and placement processes are as simple as possible and the capacity is available** to ensure the patient is home as soon as possible – the rest of this paper focuses on this element as a, b, and c are covered in the Better Care Fund Plan

The Assessment and Placement Process

The Hospital, CCG and the Adult Social Care team are working very hard to try and provide assessment and placement for up to 200 patients at any one time of which Southampton residents make up 50%. This is an ever changing list of names with c20 new patients added each day to the list of people who need support on discharge or to be transferred to another care provider. One member of staff described this as 'running to stand still'.

A number of things are happening to improve this:

1) The introduction of trusted assessment to share the burden of the work across health and social care and reduce duplication

2) UHS has invested in new staff (12) to increase its capacity to complete assessments and coordinate care from an early stage in admission and to support both health and social care teams

3) both Health and Social Care are creating links to the wards in the Hospital to identify and support patients earlier on the journey rather than starting this intervention when the patient in medically fit

4) The system has jointly agreed a new manager for the service has been appointed

5) The Hospital IT system is being enhanced to make it more user friendly and compliant with the 2014 Care Act

6) There is a refreshed Choice Policy which sets out clear expectations for patients and families on the choice of future care being agreed between the leaders within the integrated discharge bureau

7) Improved and quicker access to Domiciliary Care Packages, including complex packages

8) SCC continues to invest in Social work capacity in the Hospital Discharge Team through placement of locums

9) Despite the finical pressures faced by the Council SCC is not allowing finance to be an issue in delaying a discharge

10) The rehab and Reablement plan recently approved by SCC's Cabinet for detailed public will continue to develop this model, and phase three of the overall plan will look at simplifying the discharge pathway

11) Southampton City Council are currently working with our partners, including UHS to explore different models to reduce all DToCs, and reducing excess bed days

12) Southampton City Council continues to fund additional locum staff to support the team, and offers an enhanced service over seven days. We have increased our staff ratio over the weekend. This includes, in E.D, AMU and the discharge bureau itself.

Available Capacity

Capacity to accept these transfers of care can be an issue. The supply can be limited by workforce or market forces or the care provision does not meet the patients needs.

Six things are happening to improve this:

a) The new domiciliary care framework is increasing the coordination and availability of carers with a reduction from 7.4 days for a care package to start to 3.9 days in July 2015. There is still more to do in this area especially for patients who need the most complex care packages.
b) Increasing social services and health's ability to respond to patients who need short term support (rehabilitation and reablement) through the proposed integration of services
c) Increased support to nursing homes to ensure high quality care is available and ensure homes are able to accept new residents in a timely manner
d) Introducing and encouraging 7 day working for Hospital staff, Social Care staff, contracted providers and directly run services. Discharges are highest in the week and drop at the weekend; this should even out and increase the flow.
e) The Hospital has introduced discharge to assess pathways this for some patients using its own domiciliary care provider and, assisted by SCC a social worker, which means that more timely and accurate assessments can be made in the patient's home. This has been introduced as a pilot and has been very effective.
f) The use of bridging services, both the Hospital and Council provide these services until the domiciliary care provider is available to pick up that care. The need to make use of this sort of service will diminish as the new approach to Domiciliary Care continues to deliver benefits for the whole system.

Conclusion

Safe and timely discharges remain our priority, as a system we will continue to work with our commissioning colleagues to ensure that Nursing, Residential and Domiciliary care is provided and available in a timely fashion and together we will ensure that health and social care work in partnership with these providers to facilitate a smooth discharge and handover of care. It is fundamental that these services are in place and that discharges are not put on hold while care is being sourced. Good progress in a number of areas and some pathways for patients in Southampton

are significantly better. The actions in place within the action plans as outlined will start to address some of the other changes needed within the next three months as the winter approaches.

However the Panel should be aware there remain significant risks and concerns in the short and medium term.

In the short term it is important to note that the Council's Social Care budget is currently projected to be overspent by £ 2.9 m which, amongst other factors, is being driven in meeting the needs of the older population. Additionally, the Hospital is overspent by a predicted £9.6m and is failing to reduce the length of stay for patients. Moving to 13 per day would help reduce this impact as more beds would be released.

In the long term the population being looked after is ageing data analysed by the Hospital Discharge team for instance suggests that. on average, patients are two years older now before nursing home/ social services care is required) and becoming more dependent; the strategy of keeping increasingly dependent older people at home, whilst supported, is likely to result in increased hospital readmissions and a frailer hospital population needing recurrent social input . This dependency means we have to design care services that are able to meet the needs of patients which especially includes ensuring the availability of complex care packages at home (2 carers visiting four times per day and overnight care) and ensuring the availability of nursing home placements which are able to fully meet the very complex needs of the population who eventually cannot be managed at home; including those with challenging dementia, and respiratory needs plus 1:1 care.

There is also a significant workforce risk in the short and medium term. Care workers and Nursing staff are in short supply. Southampton has been better than other areas in Hampshire at recruiting staff but this may not last. It is therefore vitally important that we continue to focus on making every contact count (reducing unnecessary overlap and duplication) and making these roles as attractive and as rewarding as possible.

Recommendations

1. The Panel is asked to note the positive work which has been undertaken across the system since HOSP last considered this matter and the improvements which have been made.
2. The Panel is asked to support the move to achieve 13 per day as this will allow more operations to be performed this winter and better access from the emergency department for those patients needing beds.
3. The Panel is asked to review progress against the action plan in three months time.