Update on Discharges from University Hospital Southampton – January 2016

Southampton City Council Health Overview and Scrutiny Panel

Introduction

Since our last update in October 2015 a considerable body of work has been undertaken internally within the Trust and externally in collaboration with commissioners, community providers and the councils in relation to discharge. This has been centred on the following pathways (*Figure 1*) which involve the wider multidisciplinary teams (doctors, nurses, therapists, social work) working in collaboration with patients and their relatives; the associated decision making processes may be straightforward or very complicated.

If the health and social care systems can continue to make the same strides towards improving flow and discharge 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.

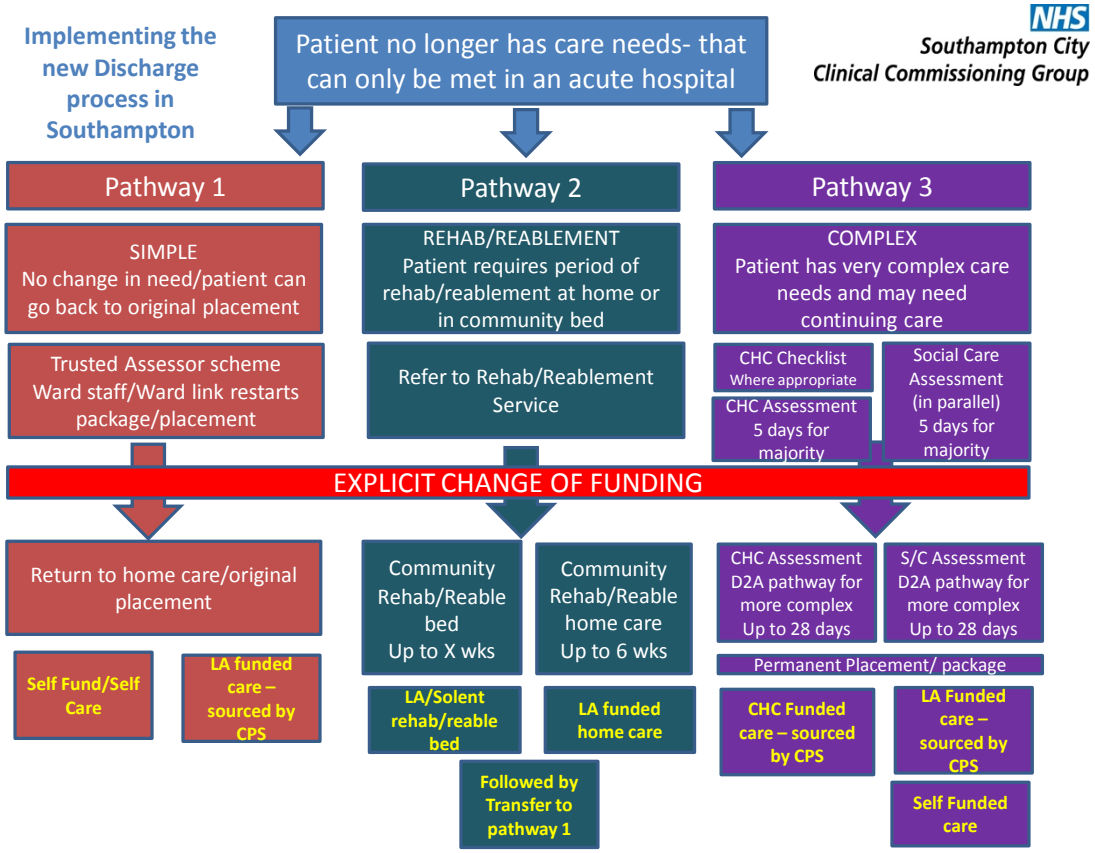


Figure 1: discharge pathways out of hospital

Details of work undertaken / ongoing

Work to improve flow of patients through these pathways across the system has continued over the autumn and winter months. This has previously been divided into four parts – the below section summarises progress in each of the categories.

a) Break down the barriers between Health and Social Care to create one service to reduce duplication of services

- Appointment of Integrated Discharge Bureau Operational Manager role, who commenced in November 2015. This post holder has operational responsibility for staff from all partner organisations within the IDB at UHS and is charged with bringing the organisations together under one operational framework.

- Restructure of the UHS IDB team including introduction of Discharge Officer roles to be the main liaison between the wards and the staff in the IDB. This team is almost fully recruited to and feedback so far from ward staff and IDB staff has been positive.

- Complete revision of the complex discharge process driven by the Care Act 2014, developed in the IDB and focussing on front loading the discharge process to start planning for discharge earlier in the admission. Supported by a redeveloped single IT workflow management system.

- Progress towards creating a merged health and social care provision for patients who need reablement services. Southampton City Council (SCC) and Solent Health Care Trust have worked together and recruited a new integrated Management team for a combined Rehabilitation and Reablement Team. The co-location of seven front line services will start to take place from mid-February 2016 and a final report recommending adoption of the wider integration plan will be taken to Cabinet in the February cycle.

- The Trusted Assessment principles are agreed across the local system, with good progress towards an agreed competency framework and training programme. This is aimed to increase the number of people who can complete work across health and social care.

- Ward link system is starting to embed and relationships building between staff and their ward link colleagues. The SCC team within the IDB are constant and stable, enabling team relationships to build and be sustained. This 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. All new SCC employees recruited into the Hospital Discharge Team (HDT) are employed using a contract which makes provision for seven day working to help facilitate timely discharge.

b) Increase care for patients at home to reduce the chance of an admission to Hospital

- 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 through targeted interventions

- Progress towards creating a merged health and social care provision for patients who need reablement services as described elsewhere in this report.

- The Hospital has extended its discharge to assess pathway pilot in Medicine for Older People – using our own domiciliary care provider to discharge patients home with a care package to meet immediate needs, and assessing the patients ongoing needs in their own environment. So far this has been very successful in reducing patient length of stay, and reducing the overall size of the care package required at the point of discharge from the service. It receives positive feedback from patients.

- UHS and SCC have also worked closely with our partners at Solent to review the inpatient rehabilitation pathway.

d) Following Hospital admission ensure the care needs assessment and placement processes are as simple and clear as possible and capacity is available to ensure the patient is home as soon as possible

- The Managing Complex Discharge Policy has been further strengthened and agreed at a system wide level. The policy sets out clear expectations and acceptable timescales for patients and families on the choice of future care, starting from admission and going as far as compulsory discharge from the Trust. There have now been a small number of test cases where using the later stages of the policy has been effective in facilitating discharge from the Trust.

- UHS has also overhauled it continuing healthcare (CHC) assessment process and assembled a new team to lead continued improvement. We are now working much more closely with our CCG partners to manage the process, and as a result we are now able to put far fewer patients through the process unnecessarily. This not only reducing the length of time that a patient has to stay in hospital for the full assessment process to take place, but reduces workload on the ward staff and the IDB team. Social services provide a vital input to this assessment process and SCC has been responsive to the changing timescales. The time to complete the process has reduced from 6 weeks to around 10 days on average.

- Improved and quicker access to Domiciliary Care Packages, including complex packages. 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 residents who need the most complex care packages. The ongoing partnership working which is part of the Cities better care fund (BCF) activities will seek to improve performance in this area even further. The Integrated Commissioning Unit (ICU's) Care Placement Team (CPT) continues to make securing timely packages of care its top priority. In the longer term SCC will be developing a new Extra Care Housing Strategy designed to help individual remain independent at home for longer thus reducing the pressure on UHS.

Despite the significant financial pressures faced by the Council, through the work of the HDT, SCC continues to carry out needs based assessments which are designed to facilitate timely. This ensures that the Council continues to ensure that the availability of funding is not a barrier to discharge.

- The integration of services increase social services and health's ability to respond to patients who need short term support (rehabilitation and reablement) through the proposed integration of services. As the integration agenda moves forward it is envisaged that this will see an increase in the availability of rehabilitation services through increased use of the new Domiciliary Care contracts.

- We continue to use 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.

26 per day target (13 for Southampton)

In our last paper we reported that approximately 10% of patients that are discharged from University Hospitals Southampton need some kind of further support to enable them to go home – this translated into about 20 per week day. 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 and ongoing commitment increase the number of these discharges from 20 to 26 per week day (13 per weekday for Southampton residents).

26 discharges per weekday equates to 130 per week. In line with the national direction of travel we need to ensure that complex discharge is also delivered over the weekends – if we adjust the target over 7 days, this would mean we would need to be discharging 18.6 patients per day on average (9 per day for Southampton residents).

Performance against this target over the last 6 months has been improving and is approaching 9 per day within the Southampton system:

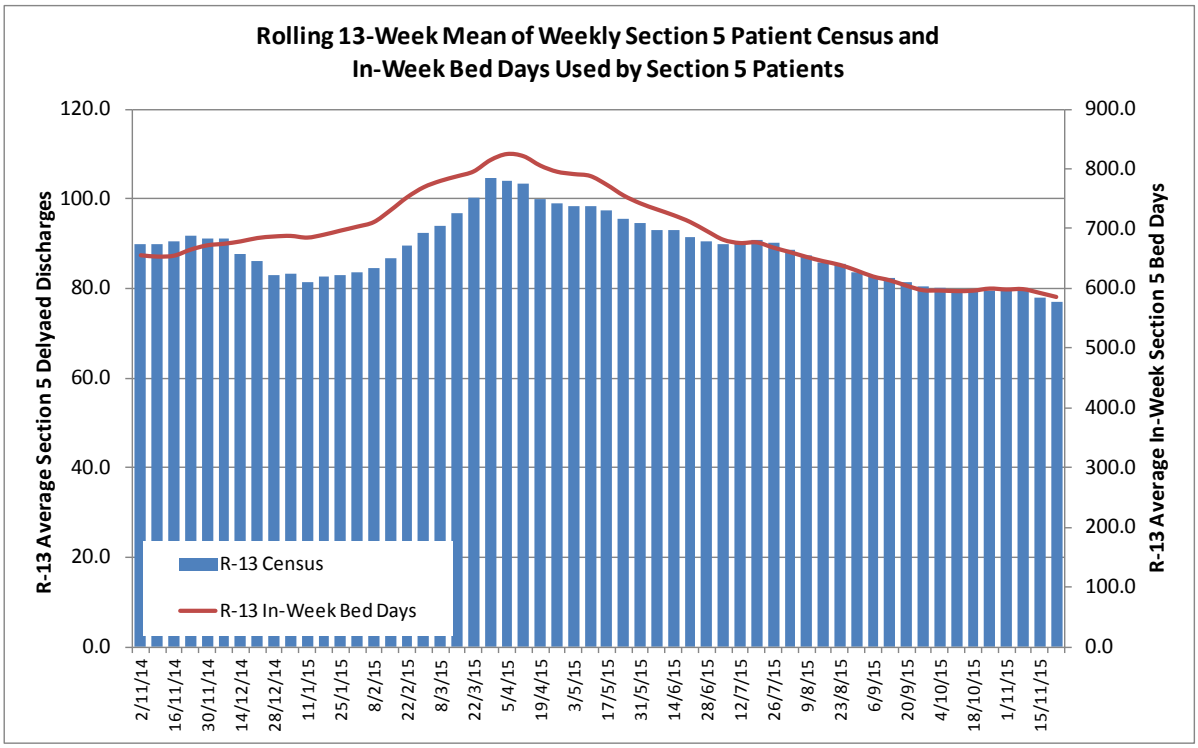
	Jul	Aug	Sep	Oct	Nov	Dec†
Average Complex Discharges per day	**13.9**	**12.5**	**14.3**	**14.2**	**14.8**	**16.4**
Southampton system	7.8	6.8	7.4	7.6	8.0	8.4
Hampshire system	5.7	5.3	6.6	6.2	6.3	7.3

Weekend Days	8	10	8	9	9	6
Week Days	23	21	22	22	21	18

(Data taken from daily manual count of complex discharges – un-validated; †up to 24/12/15)

Parity does not exist between the Southampton and Hampshire systems due to different processes and commissioning arrangements.

The number of lost bed days due to delays for Southampton patients are shown below. It appears we are making good progress towards reducing the number of lost bed days since the peak in April this year, and the trend continues downwards. .



Improved flow and discharge contributes to our hospital alert status and, therefore, our ability to provide higher quality care; a summary is shown below:

Cancellation Month	Number of cancelled operations	Alert status			
		Black Alert	Red Alert	Amber Alert	Green Alert
Sep-14	65		38	22	
Sep-15	75		39	21	
Difference	***10***	***0***	***1***	***-1***	***0***
Oct-14	115	1	60	1	
Oct-15	57		43	19	
Difference	***-58***	***-1***	***-17***	***18***	***0***
Nov-14	76		60		
Nov-15	47		23	26	11
Difference	***-29***	***0***	***-37***	***26***	***11***
Dec-14	90	32	25		5
Dec-15	tbc		8	19	35
Difference		***-32***	***-17***	***19***	***30***
Total Difference	***-77***	***-33***	***-70***	***62***	***41***

September status was almost identical when comparing 2014 and 2015, but since October (when a number of changes were made) our alert status and cancelled operations has been significantly improved each month.

Continuing healthcare processes

It is important that we get continued healthcare right. This means identifying the people who are eligible for healthcare funding in the community but not delaying discharge by performing too many assessments, unnecessarily, in hospital.

It is locally and nationally recognised that the threshold of the CHC checklist is set at a low level of tolerance. For this reason many people will “check in” for a full application to be put together, but in reality a very low percentage of these people will be eligible for CHC funding at the end of the process. This process of pulling together a full application has historically been lengthy and resource intensive, and may mislead patients and families into thinking they are eligible for funding.

UHS has worked with our local partner CCG’s and local authority to introduce a simplified decision tool / process at the ward level, in an effort to reduce the number of patients we are “checking in” for a full assessment where it is very unlikely that they will be eligible for funding at the end. This has been largely successful in reducing the overall number of assessments completed and improving the conversion rate for those assessments into funding eligibility.

This new process ensures that those we do checklist are those that are likely to be eligible for funding, thereby puts less patients through the process unnecessarily. For Southampton, we have been supplied the data which suggests that the number of patients being agreed as positive has gone up slightly over the last 6 months. The % agreed as eligible of the total applications put forward (both yes and no ratifications) has also increased from 8 to 29% over the same time frame.

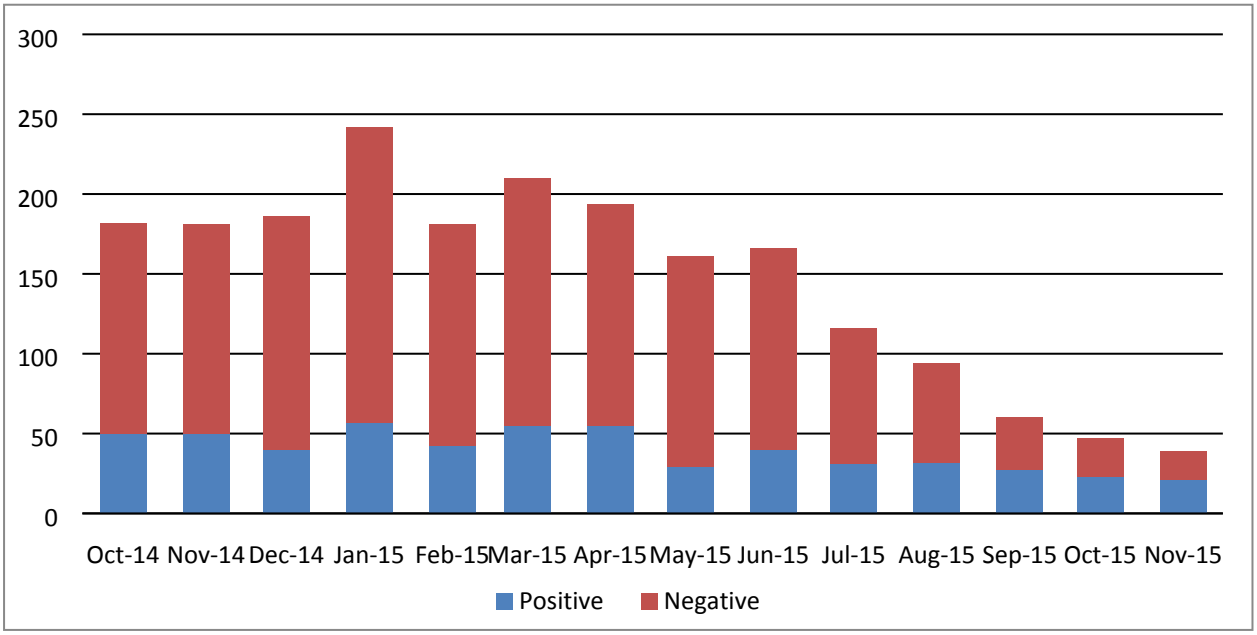


Figure 2: Number of CHC checklists undertaken broken down by outcomes

Time to wait for domiciliary care

It is really important that domiciliary care in the community is arranged in a timely manner to avoid unnecessary hospital delays. We have seen considerable improvements within the Southampton system over 2015 although more work and a demonstration of sustainability is still needed. Larger packages of care remain challenging to source. As highlighted elsewhere in this report this sourcing is a priority for the Councils CPT.

To illustrate this we have chosen a random day – Wednesday 19th November 2015 – and looked at the snapshot data for that day. Please note that this is data taken from our Complex Discharge Database and is only as good as the data entered. We are currently completing a joint review of patients discharged over the last 6 months to 4 times a day double up packages of care, to look at key timescales. ASC teams and in particular the HDT are participating fully in this review.

	Hampshire	**Southampton**
Number of patients awaiting a Social Services funded care package	13 – 7 inpatients, 6 on UHS@Home	7 – all inpatients, 0 on UHS@Home
Range of length of wait (from date of Section 5 to date of census)	3 - 189 days	5 – 22 days
Average wait (from date of section 5 to date of census)*	28 days	9 days

* Data ratification required by SCC.

Time to wait for rehabilitation beds

Flow into rehabilitation beds is also important and working well within the Southampton system. Again, for illustration purposes, we have chosen a random day – Wednesday 19th November 2015 – and looked at the snapshot data for that day. Please caveat that this is data taken from our Complex Discharge Database and is only as good as the data entered.

	Hampshire	**Southampton**
Number of patients awaiting a Rehab Assessment	19	3
Range of length of wait (from date of Section 5 to date of census)	1-19 days	1-2 days
Average wait (from date of section 5 to date of census)	8 days	1 day

Conclusion

Good progress has been made in many areas towards improving safe and timely discharge from hospital - the joint work we have put in is starting to show its results in terms of the increasing numbers of discharges and improved operational position at the hospital. We continue to develop the system complex discharge action plan in response to challenges as they arise. The Southampton system appears to be performing better than the Hampshire system.

The Panel should be aware that there are still significant risks and challenges as we move forward.

Capacity within domiciliary care agencies to support large package of care continues to be an issue which delays discharge for a number of patients. Partnership work to address this is ongoing and all stakeholders across the system continue to work to fully establish the three pathways described on page two of this report.

In the short term it is important to note that the Council's Social Care budget is currently projected to be overspent by £ 3.4 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 note the specific issues of large packages of care and increasing funding pressures.

3. The Panel is asked to review progress against the action plan in three months time.