

**DERBYSHIRE COUNTY COUNCIL
IMPROVEMENT AND SCRUTINY COMMITTEE – HEALTH**

30 November 2015

Report of the Director of Legal Services

Review of Acute Hospital Discharge Process – Progress Report

1. Purpose of the Report

To inform Members of the progress of the review of Acute Hospital Discharges.

2 Information

Since the last meeting of the Committee the review working group has met with officers of the Council's Adult Care Department and staff at Chesterfield Royal Hospital.

Meeting with Adult Care Department Officers

The review working group met with Andrew Milroy, Assistant Director, and Tanya Henson, Group Manager, of the Council's Adult Care Department. In advance of the meeting the officers had supplied Members with a briefing paper which set the current discharge processes and improvements that had recently been achieved by collaborative work with NHS partners. This paper also set out the potential development opportunities which the Adult Care team has identified and also the challenges envisaged in working with numerous partner agencies. The meeting used this as the basis for a more detailed discussion and the following issues were noted;

- It was considered that the challenges facing the NHS and their partners, particularly in respect of winter pressures, were increasing every year. This was due to an aging population and financial pressures faced by the NHS service providers and the County Council.
- Members discussed their findings following a meeting at Derby Royal Hospital (DRH) with Lee Doyle (Gen Manager responsible for the Discharge process) when it had been noted that considerable improvement had been made in respect of the internal communication process. This had been achieved predominantly through the introduction of an "intelligent" whiteboard system which automatically communicated with all appropriate staff when a patient was ready to leave acute care.

- As well as the good internal communication systems (such as the one in place at DRH) there also needs to be good communication with partners who have to put measures in place for discharged patients.
- It was noted that Derbyshire County Council had been identified as an exemplar of good practice in that no patient had been delayed from discharge from acute care due to lack of funding being in place for their follow on care. The Council has an excellent record of assisting patients in accessing – and funding - their appropriate after-care needs. This had also been highlighted at the meeting with DRH.
- DCC's Adult Care Department has produced a leaflet for patients and their families on what to expect whilst in acute care – and upon discharge.
- The meeting with DRH made reference to some discharge delays being created by patients' families who were slow to arrange alternative accommodation for their relatives on leaving acute care. It was agreed that this did occur but not sufficiently frequently to make a huge difference to the discharge process as a whole.
- Examples of initiatives to enable speedy discharge processes were discussed, including Doncaster Royal Infirmary's "Discharge to Assess" policy. This entailed moving the patient from the acute ward to an assessment setting to enable their needs to be considered prior to them being fully discharged. This worked successfully providing there was capacity in the final destination, whether that was returning to the patient's own home (with care packages in place if necessary) or to a suitable care home setting.
- The Council's Adult Care Department was working to mitigate problems of delayed discharge from acute care to residential care homes through negotiations for contract renewals with private care home companies. Reference was made to the potential for Acute Hospitals to offer financial to care homes to accept a patient as swiftly as possible. The working group Members had concerns over this initiative as, although it may be cost effective for the Acute Hospital, it may not necessarily be in the patients' best interest and, in extreme cases, could compromise patient safety.
- The following points were highlighted as having the potential to improve/speed up the discharge process;
 - The increase in Hospital consultants being present 7 days per week
 - An assessment process beginning prior to patients being referred or admitted to Acute Care – or as soon as possible if taken in on an emergency basis – so that "exit strategies" can be planned as soon as possible. This should provide patients with a plan, shared with their family members, which explains their discharge from acute care and how their needs will be addressed at that stage.

- Developments under transformation programmes such as the 21C Care agenda aim to provide a more seamless care pathway in local communities and this should take into account the transfer of patients across different care requirements.
- Social worker placements in GP practices to identify social care needs and to support patients either through the Acute Hospital care process – or to help prevent them being referred to acute care in the first place.
- The use of “MARAC” style processes (Multi Agency Risk Assessment Conferences) for the most vulnerable patients to include input from all relevant stakeholders in a patient’s care, such as GPs, Housing providers, Adult Care services, care home managers. These may prevent a patient having to be admitted for acute care, or assist in the discharge process by having care in place at the appropriate time.
- A change of culture within health and social care provider organisations which embraces flexibility to suit the needs of each patient/client.

At the conclusion of the meeting it was agreed that the Adult Care officers would be invited to contribute to the formation of the review recommendations and their briefing paper would help inform decisions on the recommendations to be developed.

Members requested that feedback on the progress of work with the Acute Hospitals be provided to the working group via the Improvement and Scrutiny Officer.

Meeting with Chesterfield Royal Hospital (CRH)

The working group met with the following staff at Chesterfield Royal Hospital;

Debbie Eardley - General Manager, Medical/Emergency Care (M/EC) Division
 Sally Wilson - Matron, Clinical Operations, M/EC Division
 Rachel Whyman – Head of Nursing, M/EC Division
 Warren Hutson – Discharge Co-ordinator, M/EC Division

The Health Scrutiny Committee representatives explained the background to their review of the discharge process from acute hospital services and that the meeting with the staff of Chesterfield Royal Hospital was one of a series with stakeholders to discuss their experiences and opinions of the process to discharge patients from acute care.

The Hospital representatives outlined their roles and the acute care discharge process at Chesterfield Royal Hospital was discussed. It was noted that;

- An assessment of each patient was undertaken by a multi-discipline team on the acute care wards. As well as the appropriate health professionals, teams would include County Council social care staff if care packages were needed to ensure a patient could be discharged safely.
- The discharge teams were endeavouring to identify any social care needs as soon as possible – preferably as soon as a patient was admitted to acute care – as this would prevent any delays when a patient was ready to leave acute care.
- At the time of discharge, the ward sister would make a patient referral to their local community nurse and other carers as appropriate.
- The Hospital used a Discharge Checklist and a copy of the form would be supplied for the information of the working group Members, along with the associated information booklet.
- The Hospital and the Council's Adult Care team were endeavouring to improve their joint working arrangements and this was progressing well with the use of the "First Response" system.
- The Hospital and its partners had, for the past few months, used a "Discharge to Assess and Manage" programme where professionals such as therapists, nursing teams and adult social care service staff assessed patients in their own homes, thereby giving a real picture of their capabilities and needs.
- It was considered that the local Community Hospitals were crucial in helping patient transition and freeing up acute care beds.
- Hardwick CCG had, last winter, introduced the incentive scheme where Care Homes were offered £100 to take a discharged patient at an appropriate time and help prevent delay. The review working group Members asked if this approach could potentially compromise the interests of the patients but it was noted that there had been relatively little take-up of the incentive by local Care Homes and patient safety and wellbeing had not been compromised.
- There is a national Re-Admissions process which monitors patients who are re-admitted to acute care within 30 days of being discharged previously for the same condition. This had not been a huge issue for Chesterfield.
- There had been occasional instances of "inappropriate" admissions by local GPs where it would have been better for a patient to have care in the local community rather than admission directly to acute care. This was specific to a number of GP practices and it was noted that many were very good at assessing the best route of care and monitoring the progress of their patients who had been referred to acute care or other care services.
- Community Matrons were very useful for acute care providers and the development of the Community Matron facility would assist with an efficient discharge process.

- Chesterfield Hospital had a transitional ward and a discharge lounge which helped considerably in freeing up acute care beds. The hospital also used a “white board” system similar to that demonstrated to the review working group at Derby Royal Hospital to inform all health professionals of the status of each patient and ensure that everything was in place for their discharge from acute care. The aim is to have at least 60 – 70% of patients going home in the mornings.
- A proportion of patients admitted to Chesterfield Royal acute care were from outside the county, predominantly the Sheffield area. This presented an additional challenge in liaising with other service providers, such as adult care services, in the neighbouring Authorities. Debbie Eardley undertook to supply the working group with the percentage figure of patients from outside the county boundary.
- Transport to home was mostly good and it was very helpful to have a volunteer scheme to ensure patients’ homes were warm and there were basic provisions of food and drink etc. Access to a handyman service for minor alterations to patients’ homes could also accelerate their return home.
- It was considered that Care Homes could do more to support acute care hospitals in accepting patients more speedily. It would benefit the review working group to consider the systems and processes of the local Care Home sector to ascertain if improvements could be made to their part in the process. Additional information on this aspect could be gained from Jim Connolly (Director of Nursing) at Hardwick CCG.
- The hospital was about to begin (2 days after this meeting) a training and education programme on the discharge process for all its staff so that anyone connected with a patient would understand their role in working towards an efficient discharge from acute care.

Future Evidence Gathering

Future meetings of the review working group will include local care home managers, volunteer support groups and the local CCGs who commission acute care and follow-on services.

3. Considerations

In preparing this report the relevance of the following factors has been considered: financial, human relations, legal and human rights, prevention of crime and disorder, equality and diversity, environmental, health, property and transport considerations.

4. Officer’s Recommendations

The Committee is requested to note the progress of the review of the Acute Hospital Discharge process.

John McElvaney
Director of Legal Services