Service Model for Integrated Hospital Discharge

DRAFT FOR DISCUSSION – March 2017

Executive Sponsor: Sally Morris, CE EPUT

Operational Lead: Pam Sabine, Director Essex Integrated Services

1. Context and purpose of paper

There has been a considerable focus of effort across provider organisations in the past several months, in order to maximise the opportunities for admission avoidance and smooth, safe and appropriate discharge pathways. The following actions/elements have been agreed by the system as required in any model for integrated discharge.

Elements agreed by system partners to be maintained within the Model

- A visible community & social care presence in the hospital to support crisis & quick decision making for IC; building organisational relationships via F2F communication.
- Support to the hospital in terms of "navigating" the beds; joint working between the hospital and all IC providers to facilitate smoother and timelier discharge.
- "Walk the wards" to assist in the clarification of information and identification of patients' discharge destination, when they are coming up to being MFD; supporting the facilitation of timely discharge.
- Liaison with Social Care for the provision of care packages and/or placements in the wider system to release capacity.
- All partners to attend daily discharge meetings with hospital staff.
- The wider sharing of information with local economy to support pressures in the acute hospital and improve flow via the daily conference calls.
- A reduction in the number of DTOCs and an overall improvement in patient flow.
- Improved joint working and more timely information for the hospital.
- Relationship-building and joint working with the residential care providers to maintain a more consistent approach towards timely assessment for admission and a more flexible stance towards eligibility.
- Decision on the role of SPOR going forwards: currently co-ordinates provision of capacity information for all 4 bed-based units twice daily (inc. Uplands and Priory).
- Direct involvement with commissioners and Uplands, to facilitate the inclusion of this private provider in the system, with the same boundaries and expectations as NHS providers.
- Daily F2F contact with the hospital; patient assessments completed where necessary to aid decision making.
- Direct involvement with managers in ECC and SBC social care services to review and where possible expedite delays from these bed based units to create capacity.
- A critical and visible link between the hospital, primary care and community services to plan patients' return home and better use the local community offer.

2. The Next Stage

The regional escalation forum requires partners to work together to design and implement an integrated hospital discharge service (IHDS). **The (now local) A&E Delivery Board** has tasked the **Discharge Management Group** to form a Task & Finish Group to design, agree and implement an Integrated Discharge Team involving all partners. The service model should ideally be agreed by the end of June 2017, to allow embedding and initial evaluation prior to the beginning of winter.

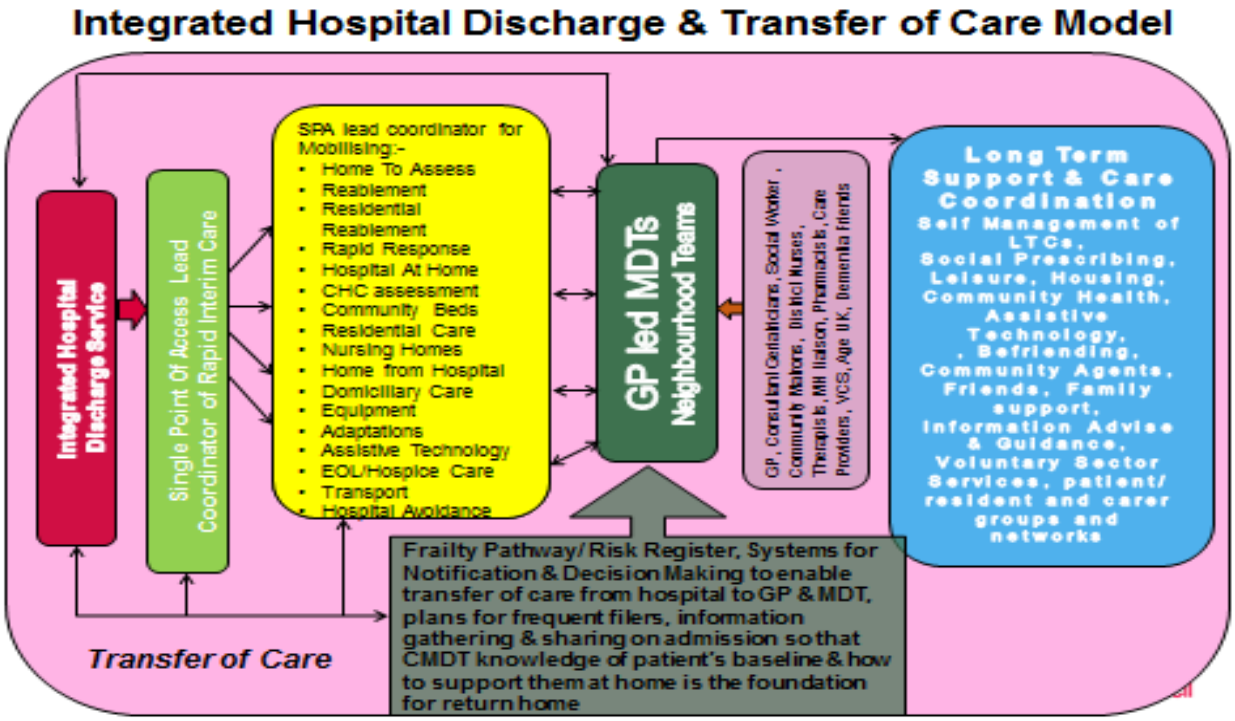
In addition, the 2017/18 SEPT and SUFHT CQUINs require coordinated action to achieve the necessary improvement in an integrated approach towards discharge.

3. Current Position

Over the past 6 months, SUFHT has implemented a number of initiatives which have proved successful in improving the discharge process to some extent. Equally, SEPT has increased the community presence within the hospital to support discharge planning and patient flow.

However, further improvement is expected at regional level and the diagram below illustrates that an IHDS is part of a wider whole system model for supporting patients out of hospital and helping them to remain independent at home. The plans for the IHDS need to be taken forward in conjunction with changes in the community services to make this new model successful.

The Integrated Hospital Discharge and Transfer of Care Model



4. Proposed Aims of an Integrated Hospital Discharge Service

The ultimate objective for the IHDS model will be to bring together all staff in the system, who are assessed as being integral to achieving a streamlined and effective transfer of care planning process for patients and carers, supporting wards and MDTs when there are factors that could lead to delay. It is important that the service includes everyone involved in the discharge planning/process to strengthen the capability to handle simple discharge in a streamlined and timely way. The system has agreed that there needs to be an improvement in the coordination of professionals, teams and services to focus on patients returning home, ensuring patients have the correct follow up assessment and care planned after an admission.

It is also important that the service focuses on developing and strengthening links with Primary Care, community services and neighbourhood/locality teams. This will ensure that the service provided to patients reflects their needs and is informed by a picture of their

baseline at home prior to admission. Community teams will need to contribute information, advice and support to the assessment, planning and transfer for patients.

The following points summarise the aims and purpose:

a) To provide clinical leadership and direction around discharge and transfer of care (ToC) for staff working across a range of provider organisations.
b) To provide the integrated health and social care support required to discharge patients with social and/or complex medical needs.
c) To minimise delays arising from problems with inter-agency liaison.
d) To focus decision-making with the patient and carers at the centre of processes.
e) To work with system partners to analyse trends e.g. frequent attenders, locality trends (SCCG, CP&R CCG, Neighbourhood/Locality Teams), reduction in bed use, increase in community care support packages.
f) To identify end of life patients who wish to be looked after at home and ensure that they receive expedited discharge with the right health and care support.
g) To ensure effective use of community services capacity and capability to manage patient need and risk at home.
h) To reduce the need for on-going packages of health and care through better use of rapid interim care services and assessment of long term needs in the right place at the right time i.e. at home or in the community
i) To improve patient and carer experience

4.1 Priority patients for the IHDS service.

Drafting a service specification and criteria will be a part of this project. As a guide, approximately 20% of all hospital in-patients are likely to be involved initially. The patient cohort will specifically be those who:

- Have ongoing health and social care needs
- Require community care services to be restarted or arranged
- Need reablement or interim care services at home or in step down/community beds
- Need to be discharged to a residential/nursing home on a temporary or permanent basis
- Require further assessment, review and coordination of care in the community from their GP and community multidisciplinary team
- Require access to specialist care at home (e.g. respiratory team)
- Have a history of recurrent admissions or failed discharges from hospital
- Require particular help to support themselves and/or their family through the planning and decision making process

Examples of typical scenarios which indicate the IHDS will lead on ToC and provide a positive impact for patients:

- A frail older person (75yrs+) with dementia living with an older carer who is struggling to sustain their caring role. Is not suitable for reablement but could either benefit from an intensive support and assessment at home to understand their needs and make decisions about long term care, or require placement.
- A working age adult (50yrs+) with multiple long term conditions whose wife recently left him, appears depressed and is unemployed. He is a frequent attender and does not appear to have a strong social network or be compliant with medicines or treatment being prescribed.
- An older person admitted from a residential care home who does not want to return as she feels the staff have been unfriendly and her room is unclean.

- A frail older person who is losing weight, not eating or drinking and no longer enjoys activities at her nursing home. She was admitted after a fall. There are some indications that she may be approaching end of life but there is no end of life plan.

4.2 Service Objectives

To facilitate a safe and rapid return home through multi-disciplinary and collaborative working between the discharge service at SUFHT, SPoR in the community (and wider community services) and primary care and neighbourhood/locality teams:

The service will do this using the following initiatives:

a) Establish an expected date of discharge (EDD) or transfer within 24-48 hours of admission.
b) Discuss expectation of return home and EDD with patient and family within 24-48 hours of admission
c) Involve patients, family members and carers in planning and decision making.
d) Connect with primary care and community MDTs at an early point in planning transfer of care for people with complex needs.
e) Restart packages of care and ensure care providers are clear about any change in needs or requirements to effect safe support.
f) Connect with the SPoR to coordinate the triage and prioritisation of referrals into rapid interim care services. The SPoR will function as one central point to coordinate and mobilise interim care services and ensure the patient is provided with the most suitable service to meet their needs and outcomes without delay.
g) Strengthen relationships, trust and joint working with care providers to facilitate ToC to care homes, interim care services (community beds/home) and domiciliary care.
h) Embed H2A as a practice to reduce demand for unnecessary hospital assessments and diagnostics.
i) Embed consistent culture and practice across providers to address risk aversion and build confidence to return patients home for further assessment and support.
j) To increase discharge at weekends by strengthening the quality and outcome of 7 day working.

4.3 Teams, Roles and Functions in the Integrated Hospital Discharge Service

Table 1 (page 5) includes the roles and functions delivered by the various providers that might be brought together under single leadership within the SUFHT IHDS service. Most roles and functions included already exist and are funded within the provider establishments. Several, however, are funded by the providers at cost in order to support the system. Posts that are new and require funding are highlighted in bold/italics.

Providers and commissioners in SEE have expressed their willingness to enter into detailed discussion with a view to designing and implementing an integrated service. The direction and coordination for all groups is one of the discussion areas, but clearly a service manager will be required. This does not impact on employment or line management. However, the provider organisation which “hosts” the manager for integrated discharge will have a coordination function for integrated hospital discharge that all system partners will need to commit to supporting via their staff.

Table 1 – functions, teams and roles within scope of the SUFHT IHDS – *these are suggested roles required to support the IHDS to be a success and meet the stated aims and objectives. This approach has been demonstrated as effective in other areas within the country. Discussion at the Discharge Management Group will refine the selection of the roles required. It is proposed that as a basis all roles within the provider partners which currently*

work in the discharge process should be brought together in one team, working to a single set of objectives.

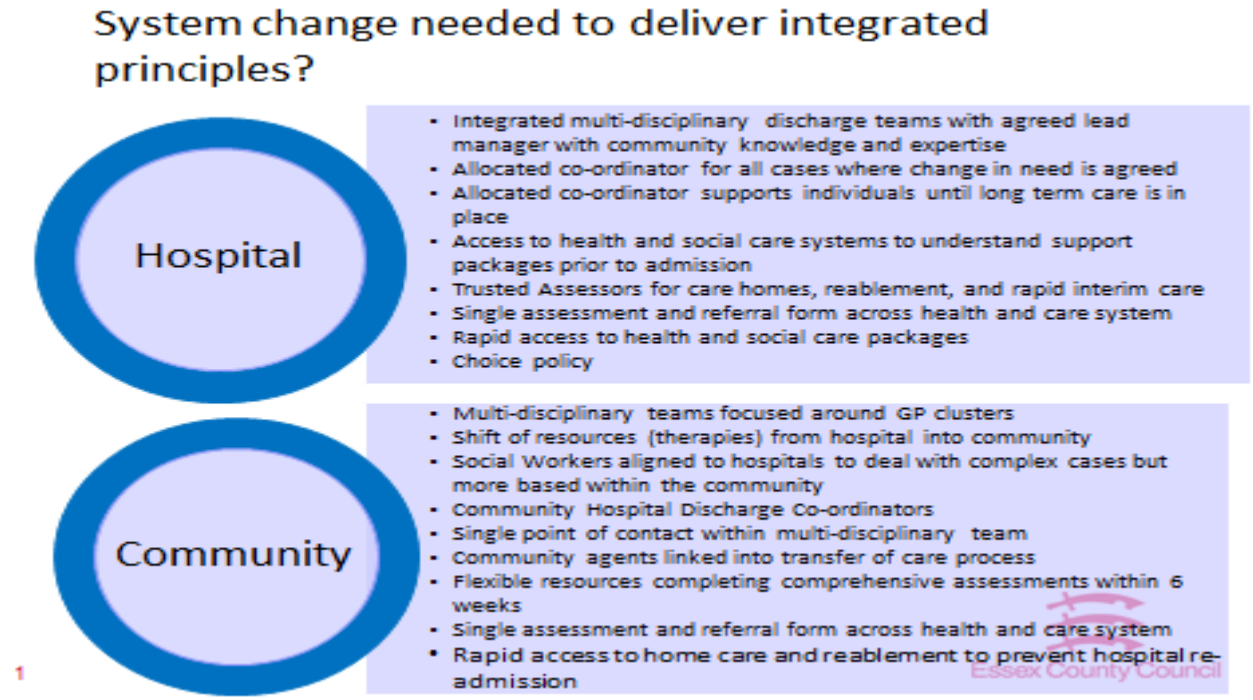
Provider	***Medical Sign off on TOC & Clinical Leadership***	***Assessment***	***Discharge Planning and Coordination***
SUFHT	*Consultant Geriatrician* *Ward medical cover*	*Therapies Manager* *OT's, PT's, SLT's* *Frailty Clinical Nurse Lead*	*Bed Manager* *Discharge Coordinators* *Pt Journey Coordinators* *Ward Clerks* *Pharmacy lead* *Hospital transport*
ECC		*Social Care Manager* *Hospital SW team* *Social care OT* *Progress chaser*	
SBC		*Social Care Manager* *Social work team*	
SEPT		*Integrated discharge practitioner (nurse or therapist)* *Integrated discharge therapist* *Community Matrons in-reach from community MDTs on sessional basis*	*Head of Intermediate Care* *Coordinators*
SEPT MH		*MH liaison nurse (over 65s)* ***New requirement - increase to 2 MH Liaison Nurses for Over 65s***	
Care Home		***Trusted Assessor Care Homes***	
CHC Assessors			

4.4 Aligned Services

- **SPoR:** In South East Essex, there are opportunities to enhance the Single Point of Referral (SPoR) in the community. The aim is to provide the lead coordination function for mobilising rapid interim care and community support services for patients leaving hospital, including the triage of referrals and prioritisation for care providers. This would aid patient flow and rapid ToC by ensuring best use of interim care and community capacity and matching the person to the right service. The SPoR can also assist two-way information gathering and sharing between hospital, GPs and community MDTs. Further discussions are needed to work up the detailed proposals and plans for enhancing the SPoR.
- CP&R CCG has agreed to coordinate a workshop to explore different models for the SPOR moving forwards. Representatives from all partner organisations will be invited.

- **Care Co:** Central to ensuring care close to home and reducing demand on hospital services are neighbourhood/locality teams and the Care Coordination Teams to coordinate care for those with complex needs, including frail older people and those with LTCs. Further work is needed to develop the systems, processes and connections required to enable transfer of clinical responsibility between hospital consultants and GPs and the MDTs.

The following are key changes required to delivering the integrated service model.



The system requires that the new service model described at point 3 is rapidly implemented (deadline June 2017). This requires rapid and concurrent mobilisation of the 3 key work-streams:

a. The creation of the Integrated Hospital Discharge Service itself – bringing together the provider functions and ensuring the changes in the hospital summarised above.

b. Making the changes to expand and strengthen the SPoR, to provide coordination of all community services supporting patients to remain at home, avoiding hospital admission and enabling patients to return home. This will include strengthening the coordination of the rapid interim care services and working with providers to ensure effective in-reach to pull patients out, within a home to assess approach.

c. Designing and building the connections between the Integrated Hospital Discharge Service, the Single Point of Access (Essex) and community services, and the arrangements for transfer of care from hospital to GPs and community MDTs.

The programme of work to address these priorities will be overseen and driven through the Integrated Discharge Task & Finish Group and the planning and design should be undertaken by operational representatives from all partner organisations. Work stream leads will be assigned for each of the areas. A project plan will be needed showing the milestones.

Also required is a decision about interim management of the service until a substantive manager is recruited and appointed. The interim post holder will need to work in close liaison with appropriate service leads in partner organisation. The CCGs will facilitate a workshop to commence work on the re-design, planning and implementation of alterations/enhancements to the Single Point of Access that are needed to coordinate the rapid interim care.

5. Links between integrated discharge and other services

The Integrated Hospital Discharge Service will need to have strong relationships and interface with the following other services and functions: TBC

6. Governance arrangements for Integrated Hospital Discharge

- The IHDS Task & Finish Group will provide updates to the local A&E Delivery Board and seek support as required, in respect of activity, performance, impact, and issues requiring engagement and action by providers and system leaders to drive improvement.
- The Discharge Management Group will note progress and issues as reported to them.
- Information governance: all service staff will ensure that patient information is safeguarded, taking account of:

  Confidentiality
  Caldicott Guardian
  Information sharing protocols/agreements
  Informed consent
  Record keeping protocols

7. Key Service Outcomes and KPIs – initial suggestions based on national work.

Performance indicator	Target	Reporting	Note
DTOC – number of people with a delayed discharge recorded as at the last Thursday of the month	2.5% of bed base	monthly	Bed base fluctuates & as beds are closed, DTOC % increases. This target will ensure consistent view of impact on DTOC regardless of bed numbers. Breakdown by reasons for delay will enable monitoring of impact on specific issues e.g. delays in TOC to care homes, delays awaiting CHC assessment
DTOC – number of delayed days recorded for the month attributed to SUFHT and to partners (by cause of delay)		Monthly	Steady reduction. Breakdown by reasons for delay will enable monitoring of impact on specific issues e.g. delays in TOC to care homes, delays awaiting CHC assessment
Permanent admissions into residential/nursing placements for Older		Monthly	ECC/SBC could provide the monitoring of this. An effective service will ensure a “return home first” approach for most

People (65+) per 100,000 residents			patients and reduction in placements.
Older people still at home ??? days after discharge from hospital into reablement/ rehabilitation services	Target to be agreed – either maintain steady state or % improvement	Monthly	Already collected. Discharge service will ensure access to reablement for those with potential for greater independence and confidence to remain at home.
Length of stay for people admitted over 7 days	Target to be agreed – e.g. % reduction or straight line reduction in LOS over 7 days	Monthly	
Readmission rates for over 75s	% reduction to be agreed	Monthly	
Number of routine discharges achieved before midday	35% discharges by midday	Monthly	Safer Bundle
Number of people discharged at weekends	80% of weekday rate	Monthly	Safer Bundle

It is suggested that we propose a two stage approach to the implementation of the IHDS.

1. The hospital team and the community team, along with social care, work together as one team under “umbrella” management
2. The staff within the two/three teams are moved into one team.

Actions:

1. **Information on current input/capacity:**

SUFHT: which staff work within their discharge process.

SEPT: staff working in the hospital and with roles and hours.

Social Care: staff working within the hospital, with roles and hours.

????Other agencies

2. T&FG determines ideal staffing cohort for service; identifies what is already in place (i.e. what is cost neutral) and what would need additional funding, plus impact on community/social care staff in terms of F/T involvement with the team.
3. Discuss interim leadership of team