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ADULT CARE AND WELL BEING OVERVIEW AND SCRUTINY PANEL 18 JULY 2022

THE ROLE OF ADULT SOCIAL CARE IN COMPLEX HOSPITAL PATIENT DISCHARGES

Summary

1. The Panel has requested a Report on the role of Adult Social Care in complex hospital patient discharges.

2. The Strategic Director for People and the Cabinet Member with Responsibility for Adult Social Care have been invited to the meeting to respond to any questions the Panel may have.

Background

3. Panel Members will be aware of the current significant pressures on urgent care nationally and at the two Worcestershire Acute Hospitals, including ambulance handover delays, which is subject to ongoing scrutiny by the Health Overview and Scrutiny Committee (HOSC). This Report on the role of Adult Social Care in the process of complex hospital patient discharges has therefore been added to the Panel's work programme.

4. The Worcestershire economy sees a high number of people admitted to long term care from hospital which indicates it is an outlier and not compliant with national guidance where the expectation remains that 95% of people will be discharged home, with some 45% of those requiring support. Furthermore, 4% will access a short-term bedded facility for intermediate care before returning home, and only 1% will be accessing a care home directly from hospital.

5. The Worcestershire Health and Care System (Worcestershire Acute Hospitals NHS Trust, Herefordshire and Worcestershire Health and Care NHS Trust and Worcestershire County Council Adult Social Care) has come under increased scrutiny regarding Emergency Department performance and ambulance handover times. Whilst a proportion of this may be due to operational matters, a significant proportion are patients deemed medically fit for discharge. Delayed discharge can be due to several factors which can adversely affect flow through the hospital and availability of beds for those in Accident and Emergency/Medical Assessment Unit who need admission.

Complex Hospital Patient Discharges

6. There are two categories of hospital patient discharge:

- Simple Discharge – where a patient is discharged to their own home and will need little or no additional care once they leave hospital, for example, a

simple discharge is one that be carried out at ward level with the multidisciplinary team-this is often referred to as Pathway 0.

- Complex Discharge – where a patient needs more complex care after post-discharge from hospital, for example, funding issues, change of residence or increased health and social care needs.

7. No two weeks are the same regarding the numbers of patients supported by the Council with hospital discharges. Over the last two months, the total number of complex discharges supported by Worcestershire County Council from Pathways 1 to 5 are:

May-22: - 559
June-22: - 428

In comparison to simple discharges (Pathway 0): -

May-22: - 2985
June-22: - 2333

The Process

8. For all patients who are identified as requiring a complex discharge, details are entered onto a patient tracker to provide oversight to the Worcestershire System which enhances communication and discharge planning. For patients in community hospitals, information is captured and recorded for the right to reside, i.e. need to stay in hospital, and formal meetings are held twice weekly to track patient progress and discharge. Daily meetings are held regarding patients in Intensive Assessment Rehabilitation beds.

The Challenges

9. Prolonged stays in hospital often have a detrimental impact on patients, especially for those who are frail or elderly. Spending a long time in hospital can lead to an increased risk of falling, sleep deprivation, catching infections and sometimes a decline in cognitive and physical health needs. Despite this, nearly 350,000 patients spend more than three weeks in acute hospitals each year.

10. As the demand for urgent care increased in late summer 2021, a visit and subsequent report by Dr Ian Sturgess (Clinical Lead for NHS England and NHS Improvement) and his team recommended the development of an Integrated Intermediate Care Service across the community and social care to bring about better collaboration to reduce waste and the improved coordination of staffing and pathway resources, as well as reporting on patient demand in a single and accurate manner to support hospital discharge.

11. Ongoing system escalations led to the Chief Operating Officers across the Worcestershire System to immediately move to pilot this integrated way of working to ease the immediate urgent and emergency care pressures in September 2021.

12. Whilst Adult Social Care already provided support for hospital discharges via the Reablement Team (an overview of which is provided at **Appendix 1**) and the Onward Care Team (an overview of which is provided at **Appendix 2**), it was

accepted by System Leaders from the recommendations made by Dr Ian Sturgess that work between the Worcestershire System partners was being undertaken in isolation making the pathways (detailed at **Appendix 3**) difficult to navigate. There were delays in handovers, duplication of effort and separate reporting lines and accountability for health and social care staff regarding facilitating hospital discharges.

Areas to highlight

13. The main areas to highlight to the Panel are:

- An integrated Intermediate Care Service was formed as part of a trial with the aim of consistently, enabling more than 80% of patients discharged into reablement services to remain at home after 91 Days. The reablement service provided by Worcestershire County Council consistently exceeds this target for individuals over 65 years as detailed below, endorsing 'HomeFirst' is the best outcomes for individuals:

  Jan-22 - 87%
  Feb-22 - 84.5%
  March 22- 80.8%

  (Please note indicators are run in arrears to allow for purchasing to flow through the system)

- The Reablement Service has received a rating of 4.5/5 from people who have used the service and/or their family/carers
- The Onward Care Team (OCT) cluster model (dedicated staff identified to support early discharge planning) was launched in January 2022
- The Safe to Transfer (STT) approach and paperwork has been introduced. This focusses on describing care needs as opposed to prescribing needs and initiates a rapid response from the OCT who match the service response and pathway required to the request
- A performance dashboard is now in place, refining the demand and capacity data needed to support the service
- Structures have been reviewed and front-line teams have been aligned alongside Neighbourhood Teams which have resulted in increased flexibility and responsiveness
- A streamlined discharge, assessment and allocation process has been agreed, minimising the number of 'hand-offs' between teams. These updated processes have removed duplication and increased a timely response to individuals therefore improving patient experience.
- A single process for people to exit from Pathway 1 (PW1) support has been agreed, ensuring accountability and responsibility for delays in accessing on-going care. This has reduced delays for people exiting PW1 from Neighbourhood Teams thereby maximising team capacity
- The numbers of discharges to all pathways have either decreased or remained broadly level from that experienced pre-pilot, but the decrease is particularly marked for Pathway 3.

Issues for the Panel to Consider

14. The Integrated Intermediate Care Team has made a significant impact

regarding patient outcome and improved flow through the hospital of which Adult Social Care is an integral element. A formal review is being undertaken which will be presented in August 2022 to the Integrated Commissioning Executive Officers Group (ICEOG) which highlights the achievements (some of which are described above) and recommendations for a future service provision.

Purpose of the Meeting

15. The Panel is asked to:
    - Consider and comment on the information provided regarding the role of Adult Social Care in complex hospital patient discharges;
    - Agree any comments to be made to the Cabinet Member with Responsibility for Adult Social Care; and
    - Determine whether any further information or scrutiny on a particular topic is required.

Supporting Information

Appendix 1 – Overview of the work undertaken in the Reablement Service
Appendix 2 – Overview of the work undertaken by the Onward Care Team
Appendix 3 – Overview of the Discharge Pathways

Contact Points

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Background Papers

In the opinion of the proper officer (in this case the Assistant Director for Legal and Governance) the following are the background papers relating to the subject matter of this report:

Agenda and Minutes of the Health Overview and Scrutiny Committee on 9 May and 9 March 2022, 18 October 2021, 27 June 2019, 14 March 2018 and 11 January 2017

All agendas and minutes are available on the Council's website here.