Hospital Discharge

A review by the Social Services, Housing and Public Health Policy Overview Committee

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2016-2017

HILLINGDON
LONDON

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Chairman's Foreword

The number of people aged 65 years old and over in England is increasing, which with this changing demographic, is having an impact on the number of older people being admitted to hospital. This increased demand for health services, combined with reduced health funding is putting pressure on the health and social care system.

The aim of the review was to examine the discharge process from Hillingdon Hospital for the over 65s, in an attempt to look at ways of improving the process, both for patients, in terms of their care, and for the authorities in terms of increased costs from longer than needed stays in hospital.

Delays in discharging people from hospital who are medically fit adds increasing pressure on hospital bed provision, which impacts on residents who require beds for planned health procedures and those admitted through Accident & Emergency.

The review sought the views of the Council's Health and Social Care professionals, Healthwatch Hillingdon for the patient perspective and of health service partners. There are many initiatives which are already in place by organisations to improve the process of discharge from hospital and to make the process simpler and easier to understand for patients and their carers. The recommendations of the review aim to improve the process further.

I would like to thank officers for their support during the review, and also thank the witnesses and officers who assisted to help the Committee in preparing its findings for Cabinet.

Councillor Wayne Bridges

Chairman of the Social Services, Housing and Public Health Policy Overview Committee

Summary of recommendations to Cabinet

Through the witnesses and evidence received during the detailed review by the Committee, Members have agreed the following recommendations to Cabinet:

1	**a) That clear information about the discharge process is developed for, and with people admitted to hospital and their families, so that they know what to expect.** **b) That this information is provided to patients on admission, as agreed through a joint working policy.**
2	**a) That a joint working policy across all partners involved in the hospital discharge process is developed to clarify the roles and responsibilities of the appropriate teams within each organisation and to ensure consistency of approach.** **b) That briefings with staff across organisations on the content of the agreed joint working policy are undertaken.**
3	**That partners explore options for delivering a more integrated intermediate care service that ensures that people admitted to hospital are supported to go home by the most appropriate professional first time and that the number of hand-offs between different organisations is reduced.**
4	**That partners explore affordable options to enable people who are medically fit for discharge are able to step down from hospital without the need to be admitted to a care home.**
5	**That partners explore affordable options that will ensure an appropriate supply of care home places to address the needs arising from Hillingdon's changing population.**

6	**That partners explore affordable options for ensuring that people admitted to hospital and their families have access to advocacy to support them in making informed decisions about how their future care needs will be met, including the care setting.**
7	**That Healthwatch Hillingdon consider undertaking a further review of the patient experience of the discharge process at Hillingdon Hospital in a year's time.**
8	**That a progress report be provided to the Social Services, Housing & Public Health Policy Overview Committee six months after the implementation of the review's recommendations, that includes an update on the above recommendations as well as:** • **Number/% of Delayed Transfers Of Care in Hillingdon Hospital attributed to patient/family choice;** • **% of Continuing Healthcare assessments taking place in a hospital setting;** • **Number/% of patients discharged before midday 7 days a week.**

Background to the review

The objective of the review was to examine the discharge process from Hillingdon Hospital and how people are supported into the least restrictive care setting in order to maximise their independence and safely meet their needs.

The focus of the review was on Hillingdon Hospital where around 80% of the people admitted were from within the Borough of Hillingdon. Of those admitted as emergencies, almost 30% were of people aged 65 and over and registered with Hillingdon GPs. The Committee agreed that this age profile would be the focus of the review.

Reasons for the review and current position

There is a very high national profile regarding delays in hospitals being able to discharge people whose medical needs no longer require them to be cared for in a hospital setting.

During 2015/16 there were 50,696 admissions to The Hillingdon Hospitals NHS Foundation Trust's (THH) beds. Whilst 25,256 admissions were planned for (also known as elective procedures), 25,440 were admitted as emergencies (also known as non-elective admissions) and of these nearly 30% (7,593) were of people aged 65 and over registered with a Hillingdon GP.

Approximately 80% of the people admitted to THH are Hillingdon residents and for admissions of people aged 65 this was almost 83% being Borough residents. Other admissions come mainly from other parts of North West London. 85% of Adult Social Care hospital-related activity comes from Hillingdon Hospital and the remainder comes mainly from Northwick Park and Ealing Hospitals.

In 2015/16 there were 4,196 delayed days for Hillingdon residents and/or people registered with a Hillingdon GP aged 18 and over. Research shows that the longer an older person is in hospital not only are they likely to become increasingly confused but there is also an increasing risk of them contracting a hospital acquired infection. In addition, delays in discharging people who are medically fit or medically stable adds increasing pressure on hospital bed provision, which can lead to higher costs due to the necessity of opening escalation wards. This also increases hardship on other residents due to cancellation of planned health procedures as bed capacity is used to support admissions through Accident & Emergency.

Current context

The Committee was informed that changes in the levels of activity in the last two years had increased patients delayed transfer to care. Reference was made to research which showed that the longer an elderly person was in hospital, they were more likely to become increasingly confused, and there was also an increasing risk of them contracting a hospital acquired infection.

In addition, delays in discharging people who were medically fit added increasing pressure on

hospital bed provision, which could lead to higher costs.

The Committee was made aware that according to NHS England (NHSE), nationally everyday, more than 6,000 patients who were well enough to leave hospital were unable to do so because of insufficient local care models. With a 23% rise of delays in discharge nationally since June 2015, “joined-up care” remained the single most important feature for ensuring greater patient safety and efficient hospital discharge planning.

The National Audit Office (NAO) estimated the cost to the NHS of older patients in hospital beds, no longer in need of acute treatment, totalled £820 million every year. Longer stays in hospital also led to increased social care costs.

Evidence & Witness Testimony

Avoiding Hospital Admission

The Committee identified that the most effective method for addressing a hospital admission is to prevent it from occurring in the first place. The Committee was informed of the initiatives which were currently in progress, which are intended to achieve this and these included:

Development of an anticipatory model of care for older people - Under this new model older people identified as being at risk of hospital admission are invited into their GP surgery to explore completion of a care plan. The process if care planning is intended to identify what interventions may prevent an escalation of need. A multi-disciplinary team (MDT) approach for people with more complex needs, e.g. an approach that involves professionals from different health and care organisations, seeks to identify solutions that will prevent or delay further escalation of need and enable management of the person in their usual place of residence.

Better Care Fund Plan (BCF) - A key priority of Hillingdon's 2016/17 BCF is the prevention of admission to hospital and this is reflected in its eight schemes that look at issues such as addressing the needs of older people at risk of falls, stroke, dementia and/or social isolation, preventing admissions to hospital from care homes and supporting people at home who have had an escalation of need but do not require admission to hospital.

The Ideal Hospital Discharge Pathway

In December 2015, the National Institute of Health and Care Excellence published guidance on the transition between inpatient hospital settings and community or care home settings-for-adults-with-social-care-needs https://www.nice.org.uk/guidance/ng27. This identified the key components of good discharge practice as being:

a) Starting discharge planning early;

b) Maintaining the momentum of treatment while in hospital, e.g. increasing the number of people discharged before midday and at weekends;

c) Multi-disciplinary assessments between health and social care providers; and

d) Undertaking assessments of older person's long-term care needs in the most appropriate setting, ideally in their own home.

If local systems are working well then there will be low levels of delayed transfers of care and

also low levels of readmissions.

Delayed Transfers of Care (DTOC)

A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when:

a) A clinical decision has been made that the patient is ready for transfer; AND

b) A multi-disciplinary team decision has been made that the patient is ready for transfer; AND

c) The patient is safe to discharge/transfer.

Reference was made to the Care Act which set out a formal process for the notification of local authorities where a person with potential social care needs requires an assessment prior to discharge. This is the assessment notice and discharge notice process that was previously known as the 'section 2s' and '5s' process under the Community Care (Delayed Discharge) Act, 2003. The purpose of the discharge notice is to confirm the date of discharge. The Council can be fined where it is responsible for appropriate measures to facilitate a discharge on the discharge date not being in place. The Care Act makes fines discretionary and the Council is working with Hillingdon Hospital to establish a no fine agreement.

The Committee was provided with DTOC breakdown for 2015/16 and the Q1 2016/17 outturn position and in summary, in 2015/16 Hillingdon had the 12th lowest level of delayed transfers of care in London and the lowest out of the eight Boroughs in North West London. In Q1 2016/17 Hillingdon's position had changed to having the 13th highest in London and the fourth highest in North West London. A contributory factor to this revised position had been a change in reporting practice, e.g. reporting as DTOCs delays that do not fall within the DTOC definition and partners are currently looking at this.

Services Supporting Timely Hospital Discharge

The Committee was informed that there was a wide range of services currently in place to support discharge from hospital which comprised of home based services and bed based services.

These included the following:

a) Integrated Discharge Team

During 2015/16 an integrated discharge team was set up in the Acute Medical Unit (AMU) to identify adults with care needs as soon as they are admitted to hospital and to take a more proactive and joint approach between health and social care to discharge management. The team includes Hospital discharge coordinators, an occupational therapist, social workers and admin support. Social work staff within this team now actively visit other adult wards within THH seeking to identify people who may have social care needs in order to expedite the discharge

planning process.

b) Homesafe

This is led by Hillingdon Hospital through the Care of the Elderly Team (COTE). The service entails older people aged 65 and over who are admitted through the Emergency Department being screened and receiving a comprehensive geriatric assessment (CGA).

c) Community Homesafe

The nursing, therapeutic and care needs for people aged 65 and over who have undergone a CGA are met for up to 10 days by the Community HomeSafe clinicians (the service is provided by CNWL) to facilitate clinically appropriate and timely discharge from acute care. People with lower level support needs are referred to the Age UK Take Home and Settle element of HomeSafe.

d) Reablement

The Reablement Service is provided by the Council and is intended to assist people to learn or relearn day to day living tasks following an escalation of needs. The service is provided for up to six weeks and is non-chargeable. During Q1 2016/17 the Reablement Team received 227 referrals, and of these 176 were from hospitals, primarily Hillingdon Hospital. During this period, 102 people were discharged from Reablement with no ongoing social care needs.

e) Rapid Response

This service is provided by Central and North West London NHS Foundation Trust is based in the community and provides 'in reach' to the Emergency Department at THH. It provides nursing, therapeutic and care needs for up to 10 days and has a fast track referral process to the LBH to establish packages of care or reablement. In Q1 2016/17 the Rapid Response Team received 886 referrals and 56% (500) of these came from Hillingdon Hospital. The remaining 44% came from a variety of sources within the community, e.g. 19% (169) from GPs, 11% (99) from community services such as District Nursing and the remaining 13% (118) came from a combination of the London Ambulance Service (LAS), care homes and self-referrals. Of the 500 referrals received from Hillingdon Hospital, 340 (68%) were discharged with Rapid Response input, 138 (28%) following assessment were not medically cleared for discharge and 22 (4%) were either out of area or inappropriate referrals.

f) Hawthorne Intermediate Care Unit (HICU)

This 22-bed unit on the Hillingdon Hospital main site is provided by CNWL and provides short-term rehabilitation, typically for up to 6 weeks. Medical input is from the THH COTE consultants and the unit is staffed by a multidisciplinary team, including nurses, physiotherapists, occupational therapists, a ward pharmacist and an activities coordinator.

g) Bridging Care Service

This service is provided by Harlington Hospice and enables people with stable health needs to be discharged from Hospital pending an assessment to determine their ongoing care needs.

h) Franklin House Step-down beds

These beds are provided by Care UK for people who are medically stable and are a) on a rehabilitation pathway, need a bed-based service but are unable to weight bear for 3 weeks or more; or b) are undergoing an assessment for continuing healthcare (CHC) which has not yet been completed.

i) Cottesmore Step-down Flat

Run by the Council in Cottesmore House extra care scheme, this flat provides an alternative setting to a care home to enable older people to step down from hospital and relearn daily living skills before returning home. The stay in this flat is for up to six weeks.

j) Home Treatment Service

This service is provided by CNWL and is intended to support people with severe mental health conditions, including dementia, at home for up to 14 weeks.

k) Community Rehab

This service is provided by CNWL and comprises of nurses, physiotherapists, occupational therapists, speech and language therapists, dietitians and rehabilitation assistants.

l) Take Home and Settle

This service is provided by Age UK and is intended to take people home, get them settled in and provide support for three days after discharge.

m) Community Equipment Service

This service provides aids of daily living ranging from bath boards to electric hoists and is jointly funded by the Council and the CCG and is provided by Medequip Assistive Technology Ltd.

Preventative Initiatives

The Committee was informed that the most effective method for addressing hospital admission was to prevent hospital admissions from occurring in the first place. The Committee was made aware of a number of preventative initiatives such as the **development of an anticipatory model of care for older people**. This was where older people, who had been identified as being at risk of hospital admission, were invited into their GP surgery to explore the completion of a care plan.

This would identify any interventions which might prevent an escalation of need.

For people with more complex needs, a multi-disciplinary team (MDT) approach was taken. For example, an approach which would involve professionals from different health and care organisations, seeking to identify solutions which would prevent or delay further escalation of need and enable the management of the person in their usual place of residence. Reference was made to H4All (a consortium of local third sector organisations) who played a crucial role in this initiative.

A key priority of Hillingdon's 2016/17 Better Care Fund Plan (BCF) was the prevention of admission to hospital and this was reflected in its eight schemes that looked at issues such as addressing the needs of older people at risk of falls, stroke, dementia and/or social isolation, preventing admissions to hospital from care homes and supporting people at home who have had an escalation of need but did not require admission to hospital. This initiative involved cross over work with what was happening in GP surgeries.

Reference was made to the work of LondonADASS, who were working in collaboration with NHSE and the Local Government Association to support local systems to improve the performance of hospital discharges. The Hospital Admission and Discharge Pathways Network had been created which aimed at developing and sharing good practise in addressing delayed transfers.

Discussion took place on communications with the family of the patient and whether families were given details of options in terms of different care homes. The Head of Social Work reported that there was online information available for families and early discussions took place on patient pathways.

Clinical Commissioning Group (CCG)

The Chief Operating Officer from the CCG, informed the Committee that the Clinical Commissioning Group was a clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.

Commissioning was about getting the best possible health outcomes for the local population, by assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as hospitals, clinics, community health bodies, etc.

The Chief Operating Officer of Hillingdon Clinical Commissioning Group reported that there had been a 12% increase in the over 80s age group attending Accident & Emergency at Hillingdon Hospital. With an ageing population and the increase in the number of dementia cases, the planning of hospital discharges had become challenging. It was important that the needs of the patients were clearly identified and there needed to be a consistency of processes to enable all agencies to identify who was accountable for providing particular elements of care and support.

Care Planning was vital with an overarching Care Plan for each person. This required close working with social care professionals and the timely carrying out of processes.

The Committee was informed that as hospitals were busy, often there was reactive, rather than proactive responses to people's needs. The aim should be to work closely with partners to get patients home sooner and help combat the growing pressures the hospital was experiencing, which were being exacerbated by delayed transfers of care.

The transfer of care planning requirements should improve patient experience and quality of care and enable all medically fit patients to be discharged with appropriate care and support at home, wherever possible. This would reduce delayed transfers of care and lower the readmissions of patients.

Continuing Healthcare Team

The Clinical Team Leader for the Continuing Healthcare Team reported to the Committee that Continuing Healthcare (CHC) was the name given to a package of care which was arranged and funded solely by the NHS for individuals outside of hospital who had ongoing health care needs.

Adult Continuing Healthcare was provided when an individual had been assessed by a multi-disciplinary team and they had been deemed to have a primary health need. After this had been defined, a package of care would be developed.

The Committee was informed that continuing healthcare was available in any setting to meet assessed needs, including the patient's own home or a care home. Reference was made to assessments for continuing healthcare being triggered when a person was admitted to hospital. A person who was eligible for CHC would typically have complex health conditions and would be eligible for NHS care. If a person was not entitled to NHS care they would be eligible for means tested local authority social care.

Reference was made to the decision-making process which should always be centred on the person requiring the care. This meant putting the individual and their views about their needs and the care and support required at the centre of the process.

A Checklist Tool was used, which was a screening tool used to assess whether a full assessment of eligibility for continuing healthcare was required. Once the Checklist had been completed and it indicated that there was a need to carry out a full assessment of eligibility for NHS continuing healthcare, the individual completing the Checklist would contact the Clinical Commissioning Group (CCG) who would arrange for a multidisciplinary team to carry out an up-to-date assessment of the person's needs.

The Committee was informed that because hospitals were very busy, unfortunately it was inevitable that there would be delays. It was important that families of patients and the hospital

were involved in discussions regarding eligibility for care but that expectations of families should be managed due to issues of choice of care and the cost of care packages.

A lack of clarity for patients and their families about care choices, including the funding of care, was identified as a cause of some delays in discharge. It was recognised that this could be addressed by the availability of better information at an earlier stage in order to manage expectations. The Committee was informed that addressing this was included within the DTOC action plan for 2016/17.

The Committee was informed that eligibility criteria assessments had to be completed within 30 days, but disputes between parties sometimes resulted in delays. Making decisions on a relative with health needs was a stressful and upsetting time for family members, with disagreements sometimes taking place in relation to making the right health care choices for their elderly relative. The important role that Advocacy Services would play in the process was noted.

Hillingdon Hospital

The Committee received evidence from the Deputy Director of Nursing, the Director of Integrated Care and a Consultant Geriatrician from Hillingdon Hospital.

For the over 65s age group, the average length of stay in Hillingdon Hospital had increased when compared to 2015/16. The Committee was informed that a Discharge Task Force Programme had been implemented which was a dedicated “task force” group which would be focusing on improvement and transformation. This would undertake a forensic investigation of the discharge process for every ward at the hospital.

The Task Force consisted of 5 individuals, who were mainly drawn internally. Data was collected over 9 weeks and the hospital held a clinical summit reviewing the findings.

The Committee was informed that a number of actions had been taken to improve the efficiency of discharges from hospital. These included appointing patient flow coordinators to help with communication.

Also a trial had taken place on Fleming ward which involved the engagement of patients in managing their own discharge. One of the initiatives involved patients wearing their own clothes. This had a positive outcome with research showing that patients wearing their own clothes spent an average of 0.75 days less in hospital than patients wearing hospital clothes.

Reference was made to the **SAFER** and **Red to Green** schemes, which were two national tools which had been introduced to improve the flow of discharges. SAFER consisted of a Senior Review which was where all patients would receive a consultant review before midday.

All Patients would have an expected discharge date which would be based on the medical

suitability for discharge status agreed by clinical teams. **F** - **Flow of patients** would commence at the earliest opportunity (by 10am) from assessment units to inpatient wards. **E** – **Early discharge, 33%** of the hospital's patients would be discharged from base inpatient wards before midday. Medication to be taken home for planned discharges should be prescribed and with pharmacy by 3pm the day prior to discharge wherever possible to do so. **R** – **Review**, A weekly systematic review of patients with extended lengths of stay would take place to identify the issues and actions required to facilitate discharge. This would be led by clinical leaders and be supported by operational managers who would help remove constraints that lead to unnecessary patient delays.

The Red to Green scheme was used to signify progress on patient treatment and eventually discharge. A red day was what every patient started off on. Green days were when patients received interventions which supported pathways of care through to discharge, a day when all that was planned or had been requested, had taken place on the day it had been requested, which resulted in a positive experience for the patient. A green day was when a patient received care, which could only be delivered in hospital.

The Committee was made aware of a number of improvements which were being to the Discharge workstream:

- Redrafting of the hospital's Working Together leaflet to encompass all the above mentioned suggestions.
- The development of written information for patients and carers in relation to NHS Continuing Healthcare Assessments.
- The continuation of work in progress to review and revise discharge processes and procedures including prescribing and issuing of medication to take home and the format of Multi-Disciplinary Meetings to aid discharge planning.
- The development of an in-house survey to capture patient and carer feedback and satisfaction scores following discharge.
- Improvements made in relation to communication at patient's bed meetings, the introduction of virtual Multi-Disciplinary Meetings for Mt Vernon wards, the introduction of ward based medication to take home and therapy communication.

Central North West London (CNWL) NHS Foundation Trust

CNWL is an NHS provider of mental health, sexual health, physical health, addictions, eating disorder and learning disability services. The Borough Director and Head of Adult Services provided the Committee with information on CNWL's procedures for hospital discharge.

The Committee was informed that the needs of people with mental health issues were catered for by Liaison Psychiatry who saw patients who presented themselves at Accident & Emergency

with symptoms ranging from self-harm, suicidal ideation to psychotic symptoms. Patients were assessed and sign posted to other services. Patients were also seen in general hospital wards where again they were assessed, staff were advised and help was given with the discharge plan if their mental health needs dictated it.

The Clinical Health Psychology service helped patients who were having serious difficulty coping with an illness or a disability, which impacted on their lives. The Rapid Response Team (RRT) provided a rapid response, 7 days a week in A & E. Assessments were made of patients to facilitate their discharge home. Specifically in relation to patients over the age of 65, RRT

Clinicians attended wards to assess patients and if suitable for discharge, they were discharged under the care of RRT.

The Committee was provided with details of the Homesafe scheme which was commissioned to help facilitate early supported discharge, which included people aged 65 years and over. Through this service, patients had access to therapy, nursing and/or care support, including a night sitting service.

The Committee was informed that the following were areas which had been identified to improve discharges:

- Better information sharing through Information Technology. Sharing information would avoid duplication of assessments. It was important that the service had information of other health issues of patients they were treating with mental health issues.
- The development of 15 Care Connection Teams.
- Reviewing and improving the current Rapid Response Service.
- The establishing of a single point of access.
- Better integration of intermediate care services.

Healthwatch Hillingdon

The Chief Executive Officer of Healthwatch provided the Committee with a summary of the recent review which had been carried out by Healthwatch into hospital discharges from Hillingdon Hospital. The project aimed to gain an understanding of the discharge process from the perspective of the patient. It looked at what went well, and what did not go well.

The project focused on adults over the age of 65 and their experiences of being discharged from Hillingdon Hospital. The methodology of the review was split into three stages. Stage 1 involved 172 patients being interviewed and completing a survey on 17 different wards at the Hospital. Dependent on the condition of the patient, patient's advocates completed the survey.

Stage 2 involved interviewing patients 30 days after being discharged, in which they were asked for their experience of the discharge process and whether their post discharge care had been

adequate. 52 discharged patients/advocates completed the second survey.

Stage 3, Healthwatch met with over 20 organisations who commissioned, or provided care services within hospital and the community for the over 65s in Hillingdon. This stage helped the review to identify and understand the processes and procedures involved in hospital discharges, and the factors, barriers and enablers which contributed to providing patients with a safe Transfer from hospital to being cared for, out in the community.

The Committee was informed that generally the results showed that the over 65s had expressed an overwhelming feeling of pride in the NHS and hospital discharges. However, it was found that staff were working under intense pressure and that care could not always be delivered to the required standard. The review's findings were summarised into three categories:

Communication and Information

Communication between patients / carers and health professionals and the information provided, was sometimes poor. Reference was made to patients being unable to speak to doctors, patients not remembering what had been told to them, patients not knowing which medicines to take, who was coming to see them at home and how to arrange a private care home placement or a care package.

It was suggested that providing clear written information for patients / carers, would improve communication and improve outcomes for patients. It was also reported that the Trust's "Working Together" booklet should include a Patient Journey booklet which provided information for patients / carers.

Process and Procedures

The Committee was informed that the review highlighted that there was a marked difference in the discharge procedures on each ward which meant there were discrepancies on how patients were treated in terms of being prescribed medication and how transport was processed. Examples were given on how some patients had been left many hours without hot food and refreshments, either in the discharge lounge, in their beds or in the ward's day room. The recommendation of the review would be to standardise as far as possible the discharge process across all wards. A standardised process would help both staff and patients and improve the quality of care to patients.

Closer Integration and Joined up Working

There was a perception from patients that organisations did not appear to communicate well with each other or work closely enough. Examples of these were assessments being carried out separately by social services and hospital staff, not all relevant partners being invited to multi-disciplinary team meetings etc. It was important that all organisations were aware of each

other's services and that the effectiveness of the Joint Discharge team was maximised to its fullest. A possible solution could be a single point of access for discharge which would provide an information hub for professionals and provide integrated care for the patient. Discussion took place on the changing demographics of the population with an increasing number of dementia cases in the elderly age group. The number of these cases, made the process of discharge challenging.

Findings & Conclusions

From the evidence the Committee heard there were a number of issues and challenges that currently posed obstacles to a smoother discharge process and pathway in Hillingdon. There is currently inconsistency in how quickly the discharge planning process starts, which means that complexities about a person's personal circumstances and their health and care needs are not identified at an early enough stage to enable them to be discharged as soon as they no longer need to be in hospital. For example, a person requiring adaptations or with other complex accommodation issues that can take a considerable amount of time to resolve.

Assessment for continuing healthcare (CHC) may be triggered following a screening when a person is admitted to hospital. A person is likely to be eligible for CHC funding if they have a complex health condition that requires the intervention of a health professional. A person who is eligible for CHC will have all of their care needs met by the NHS. Delays in securing timely assessments is a contributory factor in delaying discharge and in freeing up step-down provision provided to facilitate discharge.

There needed to be an agreed policy and procedure that clarified the roles and responsibilities of all agencies involved in the discharge process.

There needed to be clear information for patients about what to expect so that health and social care staff give a consistent message to enable patients, their Carers and families to make informed choices. This would also help to address unrealistic expectations and could help to prevent difficulties later over choices that may or may not be available.

The alignment of consultant decisions with availability of medication and transport home was not consistently occurring across wards at Hillingdon Hospital. This was preventing some more timely discharges from hospital occurring.

One significant cause of delays in Hillingdon was an increasing reluctance on the part of care homes to accept people with more complex needs, particularly people with challenging behaviours. A contributing factor to this was the difficulties faced by care home providers, especially nursing homes, in securing and retaining suitably qualified staff.

From Healthwatch Hillingdon's Hospital Discharge Project and from the evidence submitted during the review, it is evident that communication is the key to the process of discharge.

Patient and carers need to be kept fully informed across the whole pathway to entering and exiting hospital. The communication has to be clear, easy to understand and given upon entry to

hospital. Patients are often unable to speak to a doctor, or due to their condition, have forgotten or become confused about what they have been told. This is vital, in particular with regard to medication which has been prescribed to patients when they leave hospital.

In addition good communication is needed on how to arrange a private care home placement, or care package. Evidence would suggest that by providing clear written information to inform patient/carers and support them to make decision and would greatly improve the discharge process.

Joint working is essential for the effective management of discharge from hospital. In some cases, decisions on the best care for an individual following discharge from hospital are based on a professional assessment of the patient's health, social care and housing needs. It is therefore important that the input from these professionals is coordinated effectively and promptly. Protocols and processes need to be joined up, consistent, sending the same message to patients, to ensure that clear information is given to patients.

Recognition was made of the requirement for a single point of access for discharge which would improve the communication to the patient / carer. The Committee was reassured that this was already being put in place across North West London and would greatly improve the process of discharge. It was acknowledged that joint and closer working would improve the process and maximise the use of resources and avoid duplication. Members acknowledged that hospitals were very busy places and health professionals had heavy and involved workloads, but the suggested improvements would ultimately improve the discharge experience for patients.

The Committee therefore recommend:

1	**a) That clear information about the discharge process is developed for, and with people admitted to hospital and their families, so that they know what to expect.** **b) That this information is provided to patients on admission, as agreed through a joint working policy.**
2	**a) That a joint working policy across all partners involved in the hospital discharge process is developed to clarify the roles and responsibilities of the appropriate teams within each organisation and to ensure consistency of approach.** **b) That briefings with staff across organisations on the content of the agreed joint working policy are undertaken.**

The Committee heard that that there is a large range of services delivered by different health

providers. This arrangement led to multiple transferring responsibility for care between organisations which sometimes meant that the needs of residents were not necessarily being addressed by the most appropriate professional first time.

Timely communication between organisations is needed, to enable a better integrated intermediate care service. Organisations who were providing care for an individual needed to be connected and there needed to be a joint way of keeping patients and their carers updated, informed and involved.

On that basis, the recommendation is:

3	**That partners explore options for delivering a more integrated intermediate care service that ensures that people admitted to hospital are supported to go home by the most appropriate professional first time and that the number of hand-offs between different organisations is reduced.**

The Committee heard from witnesses that once a person has been admitted to a care home they become institutionalised very quickly, which can result in a loss of independence and a shorter life span. In addition, family dynamics can also make it difficult to move a person into a less restrictive setting because of the view that their relative is safer in a care home. The conclusion was that the best option was to avoid a person being admitted into a care home at all if it could be avoided. On this basis, the recommendation is:

4	**That partners explore affordable options to enable people who are medically fit for discharge are able to step down from hospital without the need to be admitted to a care home.**

The Committee was provided with demographic information for the Borough which indicated that there were an increasing number of older people living in the Borough. With people living longer the incidences of people with dementia was on the increase, which was impacting on social and health care. This was likely to increase with Projecting Older People Population Information projections suggesting that the number of people with dementia was likely to increase by 14% to 3,133 between 2015 and 2020 and by 25% to 3,606 in the period between 2020 and 2025. This would be a challenge for the provision of health and social care services.

This changing demographics of the population of the Borough, and some of the complex care needs of patients, was a factor in the hospital discharge process.

Information was provided which summarised the profile of Hillingdon's current care home market

for older people.[1] The key headlines were:

a) As at 30 September 2016, Hillingdon had 49 care homes comprising of 1,482 beds.
b) There were 31 homes comprising of 1,353 beds for older people.
c) There were 16 nursing homes in Hillingdon comprising of 749 beds.
d) There were 18 care homes for younger adults comprising of 129 beds.
e) 45% of older people placements were of self-funders, which compared to an average of 30% for London.
f) Providers owning more than 40 homes nationally owned approximately 40% of the older people care home market in Hillingdon; 40% was also owned by providers owning between 2% and 5% of the older people market nationally.
g) 55% (27) of Hillingdon's care homes were in the south of the Borough, e.g. below the A40, but 52% (773 beds) of bed capacity is in the north of the Borough.

With the changing demographics of the population of the Borough it was important that there was an adequate supply of home places for those elderly people leaving hospital. All partners were asked to investigate all affordable options to ensure there were an adequate supply of care home places to meet the likely increased demand in the future. The Committee therefore recommend:

5	**That partners explore affordable options that will ensure an appropriate supply of care home places to address the needs arising from Hillingdon's changing population.**

An advocacy service is provided by an advocate who is independent of social services and the NHS, and who isn't part of the patient's family. An advocate's role includes arguing the case of the patient, and making sure the correct procedures are followed by health and social care services.

In the case of elderly vulnerable people, this is an important role, particularly during the stressful situation of being discharged from hospital. Being independent means they are there to represent the wishes of the patient without giving their personal opinion and without representing the views of the NHS or the local authority.

Local authorities fund advocacy services and the Committee agreed that partners should enable access to advocacy for the elderly admitted to hospital to help support them in making decisions in relation to their future care needs, after discharge from hospital.

[1] Based on report by Care Analytics Ltd for the Council in December 2015.

The Committee recommend:

6	**That partners explore affordable options for ensuring that people admitted to hospital and their families have access to advocacy to support them in making informed decisions about how their future care needs will be met, including the care setting.**

The Committee noted all of the work that was in progress and considered that it would be helpful if Healthwatch could revisit their review, as this would help to identify the extent to which the patient experience of the discharge process had improved. As a result, the following recommendation is made:

7	**That Healthwatch Hillingdon consider undertaking a further review of the patient experience of the discharge process at Hillingdon Hospital in a year's time.**
8	**That a progress report be provided to the Social Services, Housing & Public Health Policy Overview Committee six months after the implementation of the review's recommendations, that includes an update on the above recommendations as well as:** • **Number/% of Delayed Transfers Of Care in Hillingdon Hospital attributed to patient/family choice;** • **% of Continuing Healthcare assessments taking place in a hospital setting;** • **Number/% of patients discharged before midday 7 days a week.**

Terms of Reference of the review

The following Terms of Reference were agreed by the Committee from the outset of the review:

1. To gain a comprehensive understanding of current discharge activity in respect of the 65 and over population and focusing on Hillingdon Hospital.
2. To investigate best practice on what the ideal discharge pathway would look like.
3. To gather evidence from Healthwatch Hillingdon about the resident/patient experience of hospital discharge.
4. To explore the key issues and challenges that inhibits a smooth hospital discharge process and pathway.
5. To particularly examine the issues faced in meeting the needs of residents/patients with mental health needs and the impact on the broader discharge process.
6. To consider national and regional initiatives, e.g. London and North West London, being undertaken to improve the hospital discharge process and pathway.
7. To examine the work being undertaken by the Council and NHS and third sector partners to improve the resident/patient experience of hospital discharge.
8. To report to Cabinet any positive recommendations or conclusions arising from the review.

Witnesses and Committee activity

The Committee received evidence from the following sources and witnesses:

Witness Session **4 October 2016**	• Gary Collier (Health & Social Care Integration Manager) • Nina Durnford (Head of Social Work, Adult Social Care Services) • Dr Steve Hajioff (Director of Public Health)
Witness Session **2 November 2016**	• Gary Collier (Health & Social Care Integration Manager) • Nigel Dicker (Deputy Director Residents Services) • Nina Durnford (Head of Social Work, Adult Social Care Services) • Sandra Taylor (Head of Service - Early Intervention & Prevention) • Caroline Morison (Chief Operating Officer, Hillingdon Clinical Commissioning Group) • David Muann (Clinical Team Leader for the Continuing Healthcare Team)
Witness Session **14 December 2016**	• Kim Cox (Borough Director, Central North West London NHS Foundation Trust) • Claire Eves (Head of Adult Services, Central North West London NHS Foundation Trust) • Graham Hawkes (Chief Executive Officer, Healthwatch Hillingdon) • Melissa Mellett (Director of Operational Performance, Hillingdon Hospital) • Caroline Morison (Chief Operating Officer, Hillingdon Clinical Commissioning Group) • Vanessa Saunders (Deputy Director of Nursing, Hillingdon Hospital) • Julie Vowles (Consultant Geriatrician, Hillingdon Hospital) • Julie Wright (Director of Integrated Care, Hillingdon Hospital).