



## **SCRUTINY TASK & FINISH GROUP**

### **DISCHARGE FROM HOSPITAL REVIEW**

#### **Report and Recommendations**

**July 2013**

## CONTENTS

| <b>Titles</b>   | <b>Page Nos.</b> |
|---|------------------|
| Members of the Review Group   | 2                |
| List of Advisers/ Witnesses   | 2                |
| Chair"s Foreword  | 3                |
| Summary and Recommendations   | 3 - 7            |
| Background  | 8                |
| Purpose   | 8                |
| Objectives  | 8                |
| Expected Outcomes   | 8 & 9            |
| Methodology   | 9                |
| Key Areas Examined  | 9                |
| Summary of Evidence/ Conclusions and Recommendations/ Advice  | 10 - 22          |
| <b>Appendix A</b><br>The 10 Steps – „Ready to Go“ (DH 2010)   | 23               |
| <b>Appendix B</b><br>Extract from report, ‘ <i>Strategy for Improving Integration of Care Pathways to support discharge from hospital</i> ’, presented to the Discharge from Hospital Review meeting on 30/5/13 | 24 & 25          |

## Members of the Review Group



**Councillor Gale**  
(Chair)



**Councillor J. Davies**



**Councillor A. Khan**



**Councillor D. Moles**



**Councillor D. Worthing**



**Mr Alan Fletcher**  
(Healthwatch, Luton)

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## List of Advisers/ Witnesses

| <b>Officers</b>   | <b>Titles</b>   | <b>Organisations</b>               |
|---|---|------------------------------------|
| - Ross Brand  | General Manager - Beds & West Herts   | East of England Ambulance Service  |
| - Mike Dolan<br>- Maud O'Leary<br>- Lisa Levy<br>- Michele Marvin<br>- Bert Siong | - Housing Manager<br>- Head of Adult Social Care<br>- Press & Public Relations<br>- Senior Consultation Officer<br>- Democracy & Scrutiny Officer | Luton Borough Council              |
| - Declan Jacob  | Director of Mental Health Beds and Luton  | South Essex Partnership Trust      |
| - Carol Hill<br>- Helen Miller  | - Accountable Officer<br>- Strategic Implementation Manager, Long Term Conditions   | Luton Clinical Commissioning Group |
| - Linda Sharkey   | Luton Community Service Manager   | Cambridgeshire Community Service   |
| - Karen Ward<br>- Marilyn George  | - Operations Director<br>- Integrated Operations Manager  | Luton & Dunstable Hospital         |



## CHAIR'S FOREWORD

This review provides an excellent example of Health Scrutiny and Health and Social Care Partners working together to examine and identify ways to improve services and patients' experience. Although services were under scrutiny, I was gratified to see partners' willingness to engage and provide information on areas of concerns and actions being taken to address them. In a way, the review was „pushing at an open door“, with little or no dispute about areas for development.

I would like to thank all witnesses who provided evidence to inform the review. Special thanks to representatives of voluntary groups and members of the public who contributed. Although few in numbers, their evidence was relevant and welcomed. Thank you also to all members of the review group and all the officers involved from the NHS and the Council, whose contributions were invaluable in making the review a success.

I am pleased to present our conclusions, recommendations and advice, which I hope will be appropriately considered, adopted and noted to improve services. I look forward to partners' responses to them and to the review of progress in due course.

Councillor Keir Gale  
Chair

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## SUMMARY AND RECOMMENDATIONS

- (i) The review set out to assess and identify the needs of Luton patients treated locally or in hospitals outside Luton and review provisions to meet those needs, in terms of the level of integration between services to prevent admissions/ re- admissions, ensure a smooth discharge process and good quality of care after discharge.
- (ii) The expected outcomes at Section 4 of the report are a set of aspirations of the desired state. The findings of this review identify services are generally performing well, but where they are not, there is an acceptance of the fact and steps are being taken to ensure good patient experience.
- (iii) As will be demonstrated in the various conclusions throughout the report, services are aware about the key issues and are taking steps and introducing measures in all areas to make improvements.
- (iv) Through the following recommendations, the review is intent on ensuring services maintain their momentum, as well as consider actions in some areas to make improvement.

**List of Recommendations:** (Paragraph numbers are as in the body of the report for ease of reference)

## **7.1 Admissions/ Discharges and Quality of Care after Hospitalisation**

- 7.1.a NHS Partners and LBC Adult Social Care and Housing services are commended for their efforts and recommended to keep up the momentum to improve joined up working and integration to address areas for development, relating to early intervention/ prevention, management of the discharge process from hospital and quality of care after hospitalisation to prevent/ avoid/ minimise re-admissions.
- 7.1.b The review strongly supports the vision for an integrated community service working in partnership with primary care and adult social care, which services are recommended to continue pursuing, as likely to be the answer to many of the current problems in the system.
- 7.1.c The reviews strongly supports the work of the Integrated Discharge Team and contributing partners are recommended to continue with its development and strengthening to work to its full potential, as it is considered an excellent resource to improve patients' experience of the discharge process.

## **7.2 Capacity of Community Service**

- 7.2.a The review commends services for taking steps to increase capacity in community services to deal with growing demands through integration and are recommended to continue developing such initiatives as the single point of contact, the crisis response team supporting acute care at home and the triage system for dealing with „on the day“ urgent calls.
- 7.2.b Luton CCG is recommended to consider and take steps in their „Healthier Luton“ commissioning decisions, to help address the resource implications for community services, of the shift of some services from hospital to community settings.
- 7.2.c The review supports and encourages the initiative to commission the voluntary sector to deliver appropriate parts of services to help boost community capacity to prevent admission and support discharges.

## **7.3 Intermediate Care**

- 7.3.a It is recommended that relevant partners review whether the provision of rehabilitation beds/ places for the hospital to discharge patients to is adequate to meet demand and take steps to manage the appropriateness of placements to prevent prolonged bed blockages.

## **7.4 End of Life Care**

- 7.4.a The review commends Luton CCG for making additional investment in palliative and end of life care, and recommends services to work together to improve patients' choice and experience in this sensitive area.
- 7.4.b It is recommended that services, particularly LBC Adult Social Care work with residential/ care homes to help and support them overcome barriers to receiving patients back at weekends and after 4.30 pm, as well as to prevent avoidable admissions in the first place.

## **7.5 Care Provisions for Luton Patients Admitted to Hospitals outside Luton**

7.5.a For Luton patients admitted to out of area hospitals, resulting from an emergency and not planned as part of ongoing treatment, Luton CCG is recommended to lead on the development of a joint protocol with the appropriate hospitals, to include as follows:

- Processes for effective communication;
- Agreed timescales for notifying services of imminent discharges, that allow sufficient time to put in place the appropriate care arrangements;

An arrangement for the ambulance service to share their electronic attendance records for patients they transport to out of area hospitals, to assist with tracking and care provision

## **7.6 Out of Hospital Strategy/ Frequent Attendees**

7.6.a The review supports and commends Luton CCG's Out of Hospital Strategy to avoid admissions and provide care for patients within community services and its approach to reduce multiple admissions and recommends it continues investing in the current initiatives, which appear to be leading to positive outcomes.

7.6.b It is recommended that the apparent high incidence of multiple admissions to hospital for age group 55-59, a matter beyond the remit of the current review, be referred to the Council's Overview & Scrutiny Board for inclusion on its Health & Social Care Review Group work programme for review in due course.

## **7.7 Joint Protocol for the Discharge of Homeless Patients**

7.7.a The review commends officers, particularly from LBC Housing Needs Team, the L&D Hospital and SEPT for developing the Joint Protocol for the discharge of homeless/ mental health patients, considered a good practice to smooth the discharge process and meet the housing needs of these vulnerable groups following hospitalisation.

7.7.b It is recommended that the Integrated Discharge Team, in co-ordination with the LBC Housing Needs Team, ensure the Protocol for the discharge of homeless/ mental health patients is robustly implemented, to identify and deal with the housing needs of homeless/ mental health patients in good time prior to discharge to reduce delays and ensure post discharge care is appropriately catered for.

## **7.8 Patients' Experience of Discharge from Hospital**

7.8.a It is recommended that the L&D Hospital takes all necessary steps as follows:

- to ensure their Pharmacy significantly reduces the time it takes to dispense patients „to take away“ prescriptions, in line with best practice elsewhere, to avoid the unacceptable delays between the time patients are informed they are fit for discharge and the actual time they are physically able to leave hospital;
- to ensure clinicians, particularly doctors“ co-ordinate their approach to complete electronic discharge letters at the time patients are informed they are fit for discharge, to reduce any delay in prescriptions reaching the pharmacy, which apparently adds to patients waiting time;

7.8.b It is recommended that the Integrated Discharge Team take the necessary steps to co-ordinate and oversee discharge planning to ensure appropriate equipment are provided where needed and suitable transport arranged to minimise risks to patients.

- 7.8.c The L&D Hospital is commended for the introduction of the Patients Experience Call Centre and recommended to continue to use this initiative as an early means of identifying and addressing problems and learning lessons to improve services.
- 7.8.d The Luton Adult Safeguarding Board is recommended to maintain oversight of safeguarding issues relative to discharge from the L&D Hospital.
- 7.8.e Accepting there are risks associated with reliance on patients using their own medicine at home, it is recommended that Luton CCG and the L&D Hospital consider what, if any, changes could be made to the prescribing policy to make the system more flexible to cater for patients already in treatment and whose prescription remained unchanged.

## **7.9 Integration of care pathways to support discharge from hospital**

- 7.9.a It is recommended that NHS Partners and LBC - ASC work together with cross boundary equivalent partners to consider the diverse proposals to develop a strategy for improving the Integration of care pathways to support discharge from hospital as follows:
  - 4.1 Explore the possibility of providing a jointly resourced social work service with Central Bedfordshire to cover weekend work;  
(Notes: Dependent on appropriate clinicians being on duty at the L&D Hospital to discharge patients)
  - 4.2 All patients eligible for community care to go through Care Track to determine the cost of health and social care services required to keep them safely at home in the community;
  - 4.3 The L&D Hospital and CCS should explore developing a feedback loop/ discharge user group to gather factual information on difficulties caused by discharges occurring late in the day;
  - 4.4 Explore the benefits of ASC Reablement and CCS Rehabilitation staff working closer together to develop focus and skills;
  - 4.5 Commissioners should explore further whether there is a need to increase capacity of Reablement Services accessed from the hospital;
  - 4.6. Commissioners (Luton CCG and LBC - ASC) should consider reviewing the number and focus of the block purchased nursing beds.
  - 4.7 Luton CCG needs to ensure that sufficient nursing capacity is commissioned to carry out CHC assessments;
  - 4.8 LBC- ASC commissioners should consider whether there is evidence to support increasing the capacity/ number of the 3 Step Up/ Step Down flats;
  - 4.9 Look at discharge in the context of the following:
    - i. The increases in admissions and reasons why;
    - ii. The potential for providing additional short term clinical and nursing support to some groups of patients in their own homes, to prevent admission to hospital in the first place;
    - iii. Services accepting recent assessments of patients already known to services to cut out duplication in referral process and save time;

- iv. How IT systems used by different agencies could be integrated to avoid breakdown in communication.
- 7.9.b To improve the integration of care pathways to support discharge from hospital, it is recommended that relevant NHS Partners and Luton - ASC ensure the ten steps outlined in the Department of Health guidance, „Ready to Go“ (see Appendix A) are (or have been) implemented to improve quality of service and patients“ experience;
- 7.9.c It is recommended that NHS funding issues to meet demands for Continuing Health Care Assessments, which is beyond the remit of the current review be referred to the Council“s Overview & Scrutiny Board for inclusion on its Health & Social Care Review Group work programme for review in due course.

## **7.10 Quality Assurance and Performance Monitoring Procedures**

- 7.10.a It is recommended that all services work in partnership to develop and implement an integrated quality assurance and performance monitoring system that sets agreed standards for the discharge process and quality of care after discharge and provides a procedure that enables performance to be monitored on a daily basis to allow for problems to be identified and addressed as close to real time as possible.

## **7.11 Mental Health/ Learning Disability**

- 7.11.a SEPT is commended for developing the Liaison Psychiatry Service with the L&D Hospital and recommended to ensure the service was appropriately implemented and resourced to develop its full potential to meet the often missed psychological needs of patients admitted to hospital with physical illnesses, prevent admissions and support timely discharge.
- 7.11.b The review commends SEPT for providing two specialist nurses dedicated to cater for the interest and needs of vulnerable adults with learning disabilities admitted to hospital, and recommends services ensure appropriate cases are identified and brought to their attention to avoid any such users being missed.

## **7.12 Responding to the Discharge from Hospital Review Group Recommendations**

- 7.12.a It is recommended that NHS partners, LBC Adult Social Care and Housing services and the Luton Adult Safeguarding Board respond to the Health & Social Care Review Group, on how they intend to deal with the report and recommendations of the Discharge from Hospital Review Group within 28 days of receipt.
- 7.12.b It is recommended that NHS partners, LBC Adult Social Care and Housing services and the Luton Adult Safeguarding Board (as part of its annual update to HSCRG) provide a progress report on those recommendations that are accepted, to a future meeting of the Health & Social Care Review Group at a date to be determined through negotiation.

## 1. **BACKGROUND**

- 1.1 Discharge from hospital is a health and social care partnership priority policy area, linked to the local priority outcome: *'Healthier and more independent adults and older people'*.
- 1.2 The topic was identified for examination for a number of reasons, including:
- The increase in emergency admissions to hospitals;
  - The apparent lack of a joined-up approach from services to manage the discharge process and post-discharge care;
  - Concerns relating to the capacity of community services to support acute care out of hospital;
  - National media interests of incidences of inappropriate discharge from hospital.

## 2. **PURPOSE**

- 2.1 The review set out to examine partnership strategy and performance issues relating to admissions and discharges from hospital, so as to understand Luton patients' needs and identify policy and practice issues and concerns and their effects primarily on patients' experience and to advise/ make recommendations for improvements.

## 3. **OBJECTIVES**

- 3.1 The main objectives of the review were:
- To assess and identify the needs of Luton patients treated locally or in hospitals outside Luton and review partnership strategies and action plans to meet those needs, in terms of the level of integration between services to minimise unplanned admissions/ re- admissions and to improve quality of care at discharge and after hospitalisation;
  - To review partnership quality assurance and performance monitoring procedures and actual performance relating to hospital admissions/ re-admissions and quality of care at discharge and after hospitalisation, to ensure appropriateness for continuous improvements;
  - To advise/ make recommendations to improve patients' experience of the discharge process and quality of care after discharge.
- 3.2 The review did not consider discharges from mental health units, discharges relating to children and discharges relating to pre-planned care.

## 4. **EXPECTED OUTCOMES**

- 4.1 The outcomes expected were as follows:
- The needs of Luton patients have been clearly identified;
  - Patients are aware of and understand what they can expect;
  - Health and Social Care partners have an integrated discharge policy to provide high quality of care to improve patients' experience;

- Health and Social Care partners have an appropriate integrated quality assurance and performance monitoring procedures to ensure continuous improvements;
- Performance indicators are showing positive signs of improvements.

## **5. METHODOLOGY**

- 5.1 Representatives from Luton Clinical Commissioning Group (CCG), Luton & Dunstable (L&D) Hospital, Cambridgeshire Community Service (CCS), South Essex Partnership Trust (SEPT), East of England Ambulance Trust (EEAST), Luton Borough Council (LBC) Adult Social Care (ASC) and Housing actively supported the review by providing information and personal contributions at meetings of the Group.
- 5.2 A member of the former Local Involvement Network (LINK), now Healthwatch Luton, was co-opted on the Group.
- 5.3 Diverse voluntary sector organisations were given the opportunity to comment and provide evidence. The review received inputs from Age Concern Luton, Luton Headway, Mencap, and NOAH Enterprise.
- 5.4 A number of guidance/ strategy documents/ reports were reviewed and/ or provided background information. These included Department of Health guidance, Luton Joint Strategic Needs Assessment, Luton CCG's Out of Hospital Strategy, Protocol dealing with housing needs of homeless patients discharged from hospital, services" strategy documents and action plans.
- 5.5 Public engagement was undertaken through appeals for information by two press releases, two local radio interviews, over 300 letters to residents on the Council's consultation database and online. Discharge information from patients" experience surveys provided to the review by the L&D also attracted radio and TV interests and coverage. Feedback from the public on the review was minimal, although relevant and supportive of the areas of concerns identified.

## **6. KEY AREAS EXAMINED**

- 6.1 The Group met on five occasions between February and June 2013 to consider evidence. Members also gathered evidence outside the formal meetings, visiting the L&D Hospital and Cambridgeshire Community Service and interviewing a key witness. The following areas were examined:
  - Admissions/ Discharges and Quality of Care after Hospitalisation;
  - Care of Luton residents admitted to hospitals out Luton;
  - Luton CCG's „Out of Hospital Strategy 2013/14 - 2017/18;
  - Protocol on housing needs of homeless patients discharged from hospital;
  - Strategy for improving patients" experience of discharge from hospital;
  - Issues relating to frequent attendees to hospital;
  - Strategy for improving integration of care pathways to support discharge from hospital;
  - Performance Management and Quality Assurance Processes;
  - Issues relating Mental Health patients admitted to Acute Hospital.

## 7. SUMMARY OF EVIDENCE/ CONCLUSIONS AND RECOMMENDATIONS/ ADVICE

### 7.1 Admissions/ Discharges and Quality of Care after Hospitalisation

- 7.1.1 As the number of admissions has an impact on the discharge process and aftercare, the review was encouraged to hear of early intervention and prevention initiatives, such as, the community health and social care teams and the Clinical Navigator Nurse Service pilot, to identify those at risk of avoidable admission and to take steps to manage them in the community. However, there remains a need for greater joined-up working between services to ensure users are properly informed and sign-posted to access the appropriate care service. This area for development has been recognised and services are already introducing measures to address it.
- 7.1.2 The review was informed of and supports the idea of an integrated community service working in partnership with primary care and social care as the likely answer to many of the current problems in the system, for example, through investment in the joint Reablement Strategy to increase community capacity.
- 7.1.3 The review was also informed of and considers the multi-agency Integrated Discharge Team, based at the L&D hospital an excellent idea to improve patients' experience of the discharge process and aftercare. Partners are urged to ensure the team is appropriately resourced and supported to work to its full potential.

| Recommendations/ Advice |   | Agencies Involved   | Lead Agency  |
|-------------------------|---|---|--|
| 7.1.a                   | <p>NHS Partners and LBC Adult Social Care and Housing services are commended for their efforts and recommended to keep up the momentum to improve joined up working and integration to address areas for development, relating to early intervention/ prevention, management of the discharge process from hospital and quality of care after hospitalisation to prevent/ avoid/ minimise re-admissions.</p> <p><b>Action required:</b> All services to note and continue with current initiatives.</p> | <ul style="list-style-type: none"> <li>• Luton CCG</li> <li>• LBC - ASC</li> <li>• LBC Housing</li> <li>• L&amp;D Hospital</li> <li>• CCS</li> <li>• SEPT</li> <li>• EEAST</li> </ul>   | <ul style="list-style-type: none"> <li>• Luton CCG</li> </ul>        |
| 7.1.b                   | <p>The review strongly supports the vision for an integrated community service working in partnership with primary care and adult social care, which services are recommended to continue pursuing, as likely to be the answer to many of the current problems in the system.</p> <p><b>Action required:</b> All services to note and continue with current initiatives.</p>  | <ul style="list-style-type: none"> <li>• CCS</li> <li>• LBC - ASC</li> <li>• LBC - Housing</li> <li>• Luton CCG</li> <li>• L&amp;D Hospital</li> <li>• SEPT</li> <li>• EEAST</li> </ul> | <ul style="list-style-type: none"> <li>• CCS</li> </ul>              |
| 7.1.c                   | <p>The reviews strongly supports the work of the Integrated Discharge Team and contributing partners are recommended to continue with its development and strengthening to work to its full potential, as it is considered an excellent resource to improve patients' experience of the discharge process.</p> <p><b>Action required:</b> Contributing partners to note and continue developing and strengthening the Integrated Discharge Team.</p>  | <ul style="list-style-type: none"> <li>• L&amp;D Hospital</li> <li>• CCS</li> <li>• LBC ASC</li> <li>• SEPT</li> </ul>  | <ul style="list-style-type: none"> <li>• L&amp;D Hospital</li> </ul> |

## 7.2 Capacity of Community Service

- 7.2.1 It is noted Community Nursing services are under great pressure from growing demands arising from the number of referrals and severity and complexity of needs. Some of the causes of this increase are also believed to be linked to the current drive to move care from the acute hospital to the community, to relieve urgent care pressures and reduce costs.
- 7.2.2 The review is concerned about whether community services can absorb the additional pressures without extra resources, but is impressed with the steps they are already taking to deal with the issue through integration and such initiatives as the single point of contact, the crisis response team to support acute care at home and the triage system for „on the day“ urgent calls. The review is also encouraged to note the commissioning of the voluntary sector to deliver appropriate parts of services, which no doubt also helps enhance capacity.

| Recommendations/ Advice |  | Agencies Involved   | Lead Agency   |
|-------------------------|--|---|---|
| 7.2.a                   | <p>The review commends services for taking steps to increase capacity in community services to deal with growing demands through integration and are recommended to continue developing such initiatives as the single point of contact, the crisis response team supporting acute care at home and the triage system for dealing with „on the day“ urgent calls.</p> <p><b>Action required:</b> Community services to note and continue with current initiatives.</p> | <ul style="list-style-type: none"> <li>• CCS</li> <li>• LBC - ASC</li> <li>• SEPT</li> <li>• Luton CCG</li> </ul> | <ul style="list-style-type: none"> <li>• CCS</li> </ul>       |
| 7.2.b                   | <p>Luton CCG is recommended to consider and take steps in their „Healthier Luton“ commissioning decisions, to help address the resource implications for community services, of the shift of some services from hospital to community settings.</p> <p><b>Action required:</b> Luton CCG to consider and address when making commissioning decisions.</p>  | <ul style="list-style-type: none"> <li>• Luton CCG</li> </ul>   | <ul style="list-style-type: none"> <li>• Luton CCG</li> </ul> |
| 7.2.c                   | <p>The review supports and encourages the initiative to commission the voluntary sector to deliver appropriate parts of services to help boost community capacity to prevent admission and support discharges.</p> <p><b>Action required:</b> Luton CCG to note, consider and address when making commissioning decisions.</p>   | <ul style="list-style-type: none"> <li>• Luton CCG</li> <li>• CCS</li> <li>• LBC - ASC</li> <li>• SEPT</li> </ul> | <ul style="list-style-type: none"> <li>• Luton CCG</li> </ul> |

## 7.3 Intermediate Care

- 7.3.1 The review notes issues around and the lack of provisions of rehabilitation beds to provide step up and step down care and places for the hospital to discharge patients to. It considers there is a need to review provisions, as well as prevent inappropriate placements, which could potentially block beds for prolonged periods of time and affect already stretched capacity to meet demands.

| Recommendations/ Advice |  | Agencies Involved  | Lead Agency   |
|-------------------------|--|--|---|
| 7.3.a                   | <p>It is recommended that relevant partners review whether the provision of rehabilitation beds/ places for the hospital to discharge patients to is adequate to meet demand and take steps to manage the appropriateness of placements to prevent prolonged bed blockages.</p> <p><b>Action required:</b> Relevant services to review adequacy of provisions of and appropriateness of placements into rehabilitation beds/ places.</p> | <ul style="list-style-type: none"> <li>• LBC ASC</li> <li>• LBC Housing</li> <li>• CCS</li> <li>• SEPT</li> <li>• Luton CCG</li> <li>• L&amp;D Hospital</li> </ul> | <ul style="list-style-type: none"> <li>• LBC ASC</li> </ul> |

## 7.4 End of Life Care

7.4.1 In relation to palliative and end of life care, the review shares services' concerns that more deaths are taking place in the hospital than at patients' preferred place of care in the community and at home. The review is encouraged to hear of the additional investment Luton CCG is making in this very important area to improve patients' choice and experience.

7.4.2 The review heard evidence of residential/ care homes' reluctance to take patients back following admissions to hospital at weekends and after 4.30 pm, a practice considered unhelpful as it has obvious impact on timeliness of discharge and patients' choice and experience. These homes have an important role to play and should be taking all necessary steps, to help services improve discharges, patients' choice and experience, as well as help to prevent avoidable admissions in the first place from, e.g. falls, urinary tract infections and dehydration.

| Recommendations/ Advice |  | Agencies Involved   | Lead Agency   |
|-------------------------|--|---|---|
| 7.4.a                   | <p>The review commends Luton CCG for making additional investment in palliative and end of life care, and recommends services to work together to improve patients' choice and experience in this sensitive area.</p> <p><b>Action required:</b> Luton CCG to note and continue with current initiatives.</p>  | <ul style="list-style-type: none"> <li>• Luton CCG</li> <li>• CCS</li> <li>• LBC - ASC</li> <li>• L&amp;D Hospital</li> </ul> | <ul style="list-style-type: none"> <li>• Luton CCG</li> </ul> |
| 7.4.b                   | <p>It is recommended that services, particularly LBC Adult Social Care work with residential/ care homes to help and support them overcome barriers to receiving patients back at weekends and after 4.30 pm, as well as to prevent avoidable admissions in the first place.</p> <p><b>Action required:</b> LBC Adult Social Care to address with residential/ care homes.</p> | <ul style="list-style-type: none"> <li>• LBC - ASC</li> <li>• CCS</li> <li>• L&amp;D Hospital</li> </ul>                      | <ul style="list-style-type: none"> <li>• LBC - ASC</li> </ul> |

## 7.5 Care Provisions for Luton Patients Admitted to Hospitals outside Luton

7.5.1 The Review heard there was a gap in care provisions for Luton patients admitted as emergencies to hospitals outside Luton, when they are discharged and repatriated to Luton. The review was informed of the key contributing factors, which led to the following conclusions:

- There is a lack of communication about Luton patients admitted to outside hospitals as emergencies (unplanned) and discharged, with local services not being notified, particularly where continuing care at home or in the community is required;
- There is no Single Point of Access for managing Out of Area Discharges and co-ordinating the appropriate care packages;
- These patients and their carers are not fully aware of how to access support required following hospital discharge;
- There is a need to carry out holistic needs assessments on patients being discharged from specialist hospitals to ensure the appropriate care package is provided.

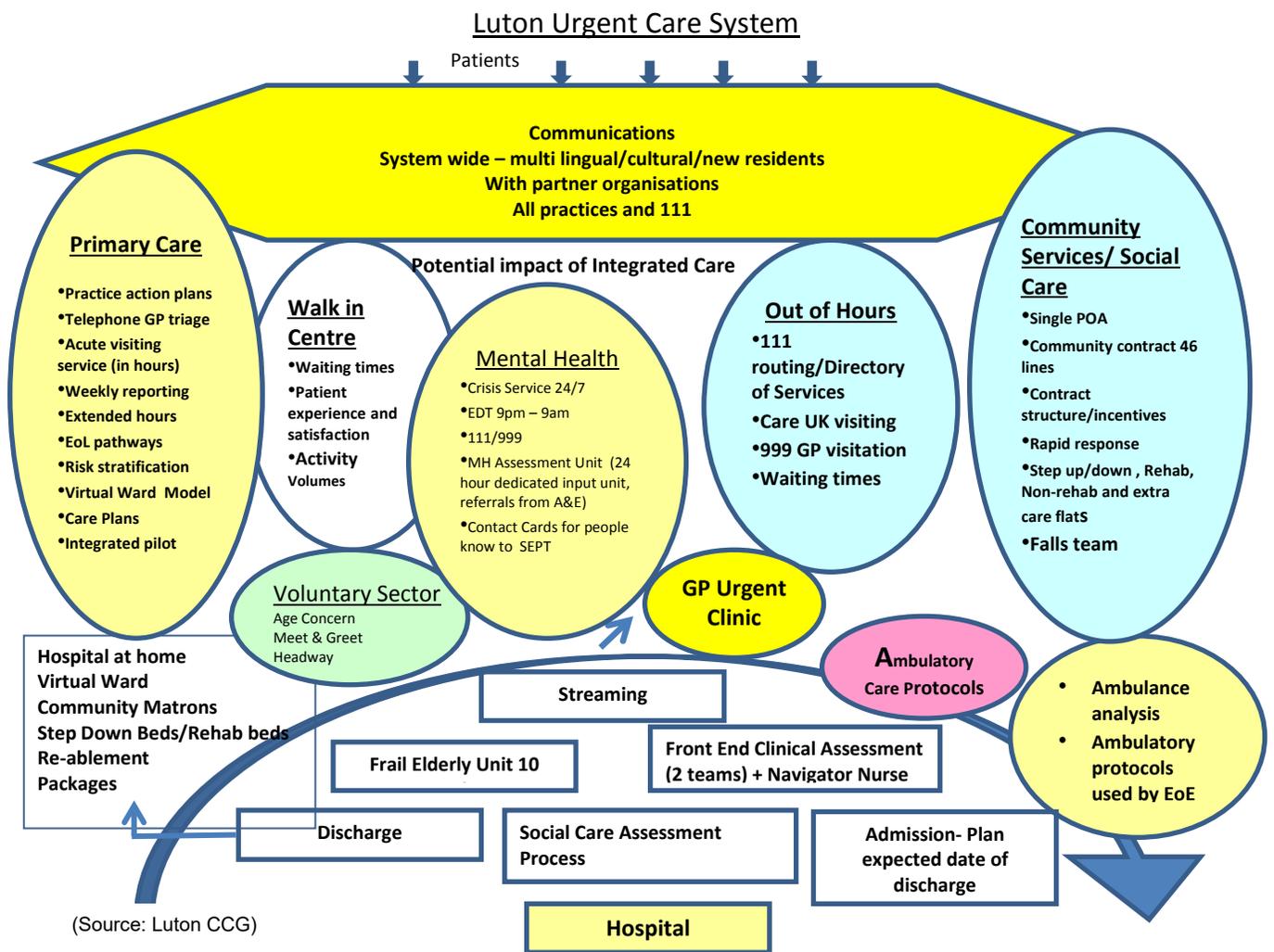
7.5.2 The review heard a suggestion from the Ambulance service that it might be possible for emergency ambulance crews to share their electronic attendance records for when they transport patients to out of area hospitals to assist with tracking and care planning if required. This is considered a good idea worthy of further consideration.

| Recommendations/ Advice |  | Agencies Involved  | Lead Agency   |
|-------------------------|--|--|---|
| 7.5.a                   | <p>For Luton patients admitted to out of area hospitals, resulting from an emergency and not planned as part of ongoing treatment, Luton CCG is recommended to lead on the development of a joint protocol with the appropriate hospitals, to include as follows:</p> <ul style="list-style-type: none"> <li>• Processes for effective communication;</li> <li>• Agreed timescales for notifying services of imminent discharges, that allow sufficient time to put in place the appropriate care arrangements;</li> <li>• An arrangement for the ambulance service to share their electronic attendance records for patients they transport to out of area hospitals, to assist with tracking and care provision.</li> </ul> <p><b>Action required:</b> Luton CCG to lead on the development of the joint protocol.</p> | <ul style="list-style-type: none"> <li>• Luton CCG</li> <li>• Out of area Hospitals (to be identified)</li> <li>• EEAST</li> <li>• CCS</li> <li>• LBC ASC</li> <li>• L&amp;D Hospital</li> </ul> | <ul style="list-style-type: none"> <li>• Luton CCG</li> </ul> |

## 7.6 Out of Hospital Strategy/ Frequent Attendees

7.6.1 From media coverage of urgent care issues nationally, the review was aware of significant pressures on the system in some parts of the country, with some A&E Departments struggling to cope with demands. The review was reassured by Luton CCG that the urgent care system in Luton was functioning well, with the hospital meeting its 4 hour target to see patients at A&E

7.6.2 The review also accepts Luton CCG, working with partners, was investing in a range of initiatives to prevent admissions to hospital, as depicted in the Urgent Care System diagram below.

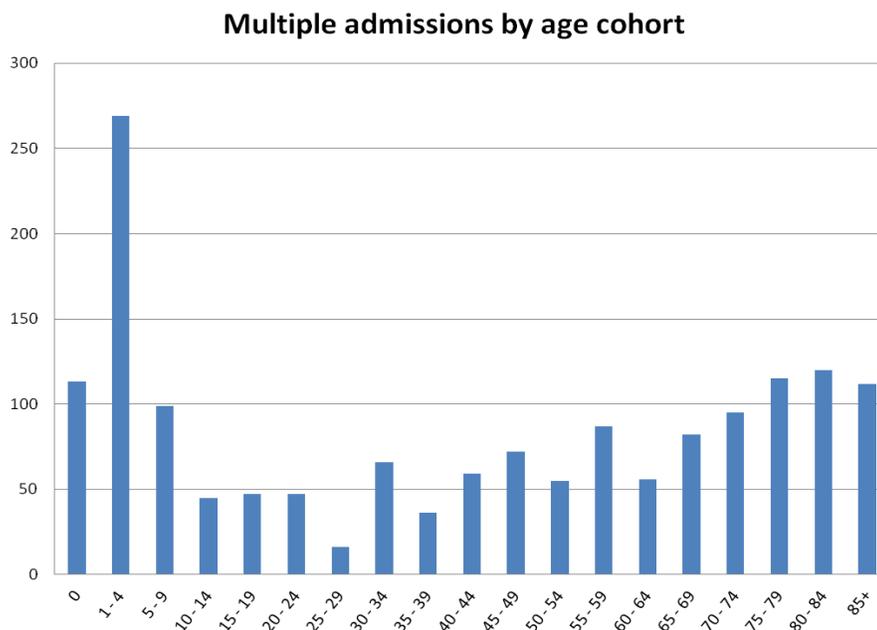


7.6.3 In relation to frequent attendees or multiple admissions, the review was presented with information on the current situation. As would be expected, it is clear from the age cohort chart below, the highest number of multiple admissions is for age range 1 – 4. Interestingly, although there were the expected increases in multiple admissions for age groups 65 and over, it was noted the increases were only moderate. It was suggested and the review accepts this could be linked to local early intervention and prevention initiatives having some success in managing older people in the community and preventing avoidable admissions.

7.6.4 The review was reassured Luton CCG had a range of initiatives to deal with the small, but significant group of patients who are considered as frequent attenders to hospital, including the following:

- Paediatric Advanced Nurse Practitioner/Rapid Response
- Risk profiling Directed Enhanced Service
- Long Term Conditions Hub and Stable Angina Clinic
- Urgent Care Dashboard
- Primary Care Investment Scheme
- Clinical Navigation Team
- End of Life Care support
- Working with and engagement with public, patients, carers

7.6.5 From the same age cohort chart, the review also noticed and was concerned about the reason behind the high incidence of multiple admissions for age group 55-59. As this matter was considered beyond the scope of this review for further examination, the Group agreed to refer it to the Overview and Scrutiny Board, with a request for it to be included on the work programme of its Health and Social Care Review Group (HSCRG) for review in due course.



(Source: Luton CCG)

| Recommendations/ Advice |   | Agencies Involved  | Lead Agency   |
|-------------------------|---|--|---|
| <b>7.6.a</b>            | <p>The review supports and commends Luton CCG's Out of Hospital Strategy to avoid admissions and provide care for patients within community services and its approach to reduce multiple admissions and recommends it continues investing in the current initiatives, which appear to be leading to positive outcomes.</p> <p><b>Action required:</b> Luton CCG to continue investing in current initiatives to avoid admissions and provide care for patients within community services.</p>   | <ul style="list-style-type: none"> <li>• Luton CCG</li> <li>• LBC - ASC</li> <li>• CCS</li> <li>• SEPT</li> <li>• EEAST</li> <li>• L&amp;D Hospital</li> </ul> | <ul style="list-style-type: none"> <li>• Luton CCG</li> </ul>                         |
| <b>7.6.b</b>            | <p>It is recommended that the apparent high incidence of multiple admissions to hospital for age group 55-59, a matter beyond the remit of the current review, be referred to the Council's Overview &amp; Scrutiny Board for inclusion on its Health &amp; Social Care Review Group work programme for review in due course.</p> <p><b>Action required:</b> LBC Overview &amp; Scrutiny Board to refer incidence of multiple admissions to hospital for age group 55 - 59 to its Health &amp; Social Care Review Group for review in due course.</p> | <ul style="list-style-type: none"> <li>• LBC Overview &amp; Scrutiny Board (For attention of: HSCRG)</li> </ul>  | <ul style="list-style-type: none"> <li>• LBC Overview &amp; Scrutiny Board</li> </ul> |

## 7.7 Joint Protocol for the Discharge of Homeless Patients

7.7.1 The review considered a draft of the Joint Protocol developed to address the housing needs of homeless/ mental health patients in hospital, prior to their discharge to help smooth the discharge process and prevent delays. The review was impressed with and considers the protocol to be a good practice to meet the housing needs of these vulnerable groups following hospitalisation. The review believes its success will depend on robust implementation by the Integrated Discharge Team, working closely with LBC Housing Needs Team.

| Recommendations/ Advice |   | Agencies Involved  | Lead Agency  |
|-------------------------|---|--|--|
| 7.7.a                   | <p>The review commends officers, particularly from LBC Housing Needs Team, the L&amp;D Hospital and SEPT for developing the Joint Protocol for the discharge of homeless/ mental health patients, considered a good practice to smooth the discharge process and meet the housing needs of these vulnerable groups following hospitalisation.</p> <p><b>Action required:</b> Integrated Discharge Team and LBC Housing Needs Team to note.</p>  | <ul style="list-style-type: none"> <li>• LBC Housing Needs</li> <li>• L&amp;D Hospital</li> <li>• CCS</li> <li>• SEPT</li> <li>• EEAST</li> </ul>                    | <ul style="list-style-type: none"> <li>• L&amp;D Hospital</li> </ul> |
| 7.7.b                   | <p>It is recommended that the Integrated Discharge Team, in co-ordination with the LBC Housing Needs Team, ensure the Protocol for the discharge of homeless/ mental health patients is robustly implemented, to identify and deal with the housing needs of homeless/ mental health patients in good time prior to discharge to reduce delays and ensure post discharge care is appropriately catered for.</p> <p><b>Action required:</b> Integrated Discharge Team and LBC Housing Needs Team to implement.</p> | <ul style="list-style-type: none"> <li>• LBC Housing Needs</li> <li>• L&amp;D Hospital</li> <li>• CCS</li> <li>• LBC ASC</li> <li>• SEPT</li> <li>• EEAST</li> </ul> | <ul style="list-style-type: none"> <li>• L&amp;D Hospital</li> </ul> |

## 7.8 Patients' Experience of Discharge from Hospital

7.8.1 Although relatively few patients/ public responded to the media appeal for information of their experience of discharge from hospital, their evidence identified similar issues obtained from other sources. Their feedback suggests quality of care received was good or excellent, but highlighted some similar issues with the discharge process. Problems cited included long delays due to waiting for hospital „to take away“ prescriptions (TTAs), inadequate transport, lack of co-ordination and breakdown in communication.

7.8.2 The review received overwhelming evidence that one of the main reasons patients are kept waiting, often for 4 hours or more, before they are able to leave hospital after being informed they are fit for discharge, is the inordinately long time it take to complete the whole process of prescribing, receiving, dispensing and delivering TTA"s.). This would appear to be linked to pressures of volume and procedural inefficiencies, including delays in doctors completing the electronic discharge letters. The review acknowledges the hospital is aware of this problem and is working with its Pharmacy to deliver improvements through a „TTA“ project. The project is looking for radical ways to improve the prescribing process turnaround time, including use of the

Ward Daily Discharge List and the roving pharmacist model. A patient information leaflet is also in use to manage patients' expectation of the discharge process.

7.8.3 The L&D Hospital has set up a Patients Experience Call Centre to survey patients within 48 hours of discharge, to ensure problems are identified early and addressed and lessons learnt are picked up and acted on to improve services. The review considers this initiative as a good practice.

7.8.4 The review received information on the L&D Hospital patients' experience audit covering a three month period. The audit reinforced some of the problems already identified. The hospital carried out further analysis into 9 incidences where safeguarding concerns had been raised. The analysis concluded as follows:

- No specific ward involved;
- Breakdown in verbal communication appeared to be a theme;
- Record keeping was variable;
- Discharge letters could be improved;
- External providers' assessments of patients not always well communicated with ward staff;
- Safe Discharge is the responsibility of all professionals and not just that of the Discharge Officers.

7.8.5 The review considers negative incidents were few in numbers relative to the average 105 daily discharges, but all concerned, not least the hospital itself, agrees even one negative incident is one too many. The review accepts a series of actions were being taken, including implementation of the „perfect day“ initiative to increase the opportunity for integrated working to minimise future negative occurrences.

7.8.6 The review received evidence from the Chair of the Luton Adult Safeguarding Board, which has oversight of all adult safeguarding matters for the area. Given negative safeguarding occurrences in hospitals are of national interest, the review was content to support the Safeguarding Board „s continued oversight of the safeguarding performance of the L&D Hospital. The review was informed safeguarding issues were also regularly monitored by the hospital's Board.

7.8.7 Relative to TTA prescriptions, the review heard evidence from several sources of patients being kept waiting for TTA medications they were already taking and had stock at home. The review was informed of the hospital's contractual obligation to dispense prescribed medicines for discharged patients to last them for two weeks. The rationale for this practice is understood, but its rigid application is considered partly wasteful as it ignores patients who were already on those medicines and had stocks at home.

| Recommendations/ Advice |   | Agencies Involved  | Lead Agency  |
|-------------------------|---|--|--|
| 7.8.a                   | <p>It is recommended that the L&amp;D Hospital takes all necessary steps as follows:</p> <ul style="list-style-type: none"> <li>• to ensure their Pharmacy significantly reduces the time it takes to dispense patients „to take away“ prescriptions, in line with best practice elsewhere, to avoid the unacceptable delays between the time patients are</li> </ul> | <ul style="list-style-type: none"> <li>• L&amp;D Hospital</li> </ul> | <ul style="list-style-type: none"> <li>• L&amp;D Hospital</li> </ul> |

| Recommendations/ Advice |   | Agencies Involved   | Lead Agency  |
|-------------------------|---|---|--|
|                         | <p>informed they are fit for discharge and the actual time they are physically able to leave hospital;</p> <ul style="list-style-type: none"> <li>to ensure clinicians, particularly doctors" co-ordinate their approach to complete electronic discharge letters at the time patients are informed they are fit for discharge, to reduce any delay in prescriptions reaching the pharmacy, which apparently adds to patients waiting time;</li> </ul> <p><b>Action required:</b> L&amp;D Hospital to implement.</p>    |   |  |
| 7.8.b                   | <p>It is recommended that the Integrated Discharge Team take the necessary steps to co-ordinate and oversee discharge planning to ensure appropriate equipment are provided where needed and suitable transport arranged to minimise risks to patients.</p> <p><b>Action required:</b> Integrated Discharge Team to implement.</p>  | <ul style="list-style-type: none"> <li>L&amp;D Hospital</li> <li>CCS</li> <li>LBC ASC</li> <li>SEPT</li> <li>EEAST</li> </ul> | <ul style="list-style-type: none"> <li>L&amp;D Hospital</li> </ul> |
| 7.8.c                   | <p>The L&amp;D Hospital is commended for the introduction of the Patients Experience Call Centre and recommended to continue to use this initiative as an early means of identifying and addressing problems and learning lessons to improve services.</p> <p><b>Action required:</b> L&amp;D Hospital to note and continue with the initiative.</p>  | <ul style="list-style-type: none"> <li>L&amp;D Hospital</li> </ul>  | <ul style="list-style-type: none"> <li>L&amp;D Hospital</li> </ul> |
| 7.8.d                   | <p>The Luton Adult Safeguarding Board is recommended to maintain oversight of safeguarding issues relative to discharge from the L&amp;D Hospital.</p> <p><b>Action required:</b> The Luton Adult Safeguarding Board to note and continue with its oversight.</p>   | Luton Adult Safeguarding Board  | Luton Adult Safeguarding Board                                     |
| 7.8.e                   | <p>Accepting there are risks associated with reliance on patients using their own medicine at home, it is recommended that Luton CCG and the L&amp;D Hospital consider what, if any, changes could be made to the prescribing policy to make the system more flexible to cater for patients already in treatment and whose prescription remained unchanged.</p> <p><b>Action required:</b> Luton CCG and the L&amp;D Hospital to consider if and how current prescribing policy could safely be made more flexible.</p> | <ul style="list-style-type: none"> <li>Luton CCG</li> <li>L&amp;D Hospital</li> </ul>   | <ul style="list-style-type: none"> <li>Luton CCG</li> </ul>        |

## 7.9 Integration of care pathways to support discharge from hospital

- 7.9.1 The review heard 80% of discharges from hospital are described as simple, with patients returning to their own homes with no significant care planning needed. However, with the other 20%, discharge is described as complex requiring a range of nursing and community services. This is the main area services are focusing on.
- 7.9.2 The review accepts there is a very strong commitment to joint working to ensure the ten steps outlined in the Department of Health guidance, „Ready to Go" (see Appendix A) are implemented to improve quality of service and patients" experience.
- 7.9.3 However, the growing number of older people with multiple long term conditions is adding to pressures, including the need for more Continuing Health Care

Assessments (CHCs). This is a concern as resources are limited across all services and CHCs can also add to delay to the discharge process. The review considered the NHS resource issue was a matter beyond its scope and should be referred for scrutiny by the Council's Health and Social Care Review Group.

7.9.4 The Review considered a series of suggestions to help improve integrated care pathways to support discharge from hospital. These are set out in the extract from the report presented to the review on 30<sup>th</sup> May 2013 (see Appendix B). The review supports and endorses them. Given their nature, cross boundary and multi-agency partnership work would be necessary to explore how they could be developed and implemented to improve services. The proposals are summarised as part of the review recommendations below, using the same numbering as in the report.

| Recommendations/ Advice   | Agencies Involved  | Lead Agency  |
|---|--|--|
| <p><b>7.9.a</b></p> <p>It is recommended that NHS Partners and LBC - ASC work together with cross boundary equivalent partners to consider the diverse proposals to develop a strategy for improving the Integration of care pathways to support discharge from hospital as follows:</p> <p>4.1 Explore the possibility of providing a jointly resourced social work service with Central Bedfordshire to cover weekend work;</p> <p><b>(Notes:</b> Dependent on appropriate clinicians being on duty at the L&amp;D Hospital to discharge patients)</p> <p>4.2 All patients eligible for community care to go through Care Track to determine the cost of health and social care services required to keep them safely at home in the community;</p> <p>4.3 The L&amp;D Hospital and CCS should explore developing a feedback loop/ discharge user group to gather factual information on difficulties caused by discharges occurring late in the day;</p> <p>4.4 Explore the benefits of ASC Reablement and CCS Rehabilitation staff working closer together to develop focus and skills;</p> <p>4.5 Commissioners should explore further whether there is a need to increase capacity of Reablement Services accessed from the hospital;</p> <p>4.6. Commissioners (Luton CCG and LBC - ASC) should consider reviewing the number and focus of the block purchased nursing beds.</p> <p>4.7 Luton CCG needs to ensure that sufficient nursing capacity is commissioned to carry out CHC assessments;</p> <p>4.8 LBC- ASC commissioners should consider whether there is evidence to support increasing the capacity/ number of the 3 Step Up/ Step Down flats;</p> <p>4.9 Look at discharge in the context of the following:</p> <ul style="list-style-type: none"> <li>• i. The increases in admissions and reasons why;</li> <li>• ii. The potential for providing additional short term clinical and nursing support to some groups of patients in their</li> </ul> | <p>4.1: LBC ASC/ L&amp;D Hospital/ (Central Beds ASC)</p> <p>4.2: L&amp;D Hospital/ LBC ASC/ Care Track</p> <p>4.3: L&amp;D Hospital/ CCS</p> <p>4.4: LBC ASC/ CCS</p> <p>4.5: LBC ASC</p> <p>4.6: Luton CCG/ LBC ASC</p> <p>4.7 : Luton CCG</p> <p>4.8 : LBC ASC</p> <p>49 : i. Luton CCG ;</p> <p>ii. Luton CCG</p> <p>iii. L&amp;D Hospital</p> <p>iv. Luton CCG (HWBB sub-group)</p> | <p>4.1: LBC ASC</p> <p>4.2: L&amp;D Hospital</p> <p>4.3: L&amp;D Hospital</p> <p>4.4: LBC ASC</p> <p>4.5: LBC ASC</p> <p>4.6: Luton CCG</p> <p>4.7 : Luton CCG</p> <p>4.8 : LBC ASC</p> <p>49 : i. Luton CCG ;</p> <p>ii. Luton CCG</p> <p>iii. L&amp;D Hospital</p> <p>iv. Luton CCG (HWBB sub-group)</p> |

| Recommendations/ Advice |   | Agencies Involved  | Lead Agency   |
|-------------------------|---|--|---|
|                         | <p>own homes, to prevent admission to hospital in the first place;</p> <ul style="list-style-type: none"> <li>iii. Services accepting recent assessments of patients already known to services to cut out duplication in referral process and save time;</li> <li>iv. How IT systems used by different agencies could be integrated to avoid breakdown in communication.</li> </ul> <p><b>Action required:</b> Services identified in the Lead Agency Column to take action to consider the recommendations and decide how to take forward.</p> |  |   |
| 7.9.b                   | <p>To improve the integration of care pathways to support discharge from hospital, it is recommended that relevant NHS Partners and Luton - ASC ensure the ten steps outlined in the Department of Health guidance, „Ready to Go“ (see Appendix A) are implemented to improve quality of service and patients“ experience;</p> <p><b>Action required:</b> L&amp;D Hospital and partners to implement.</p>   | <ul style="list-style-type: none"> <li>• L&amp;D Hospital</li> <li>• CCS</li> <li>• LBC ASC</li> <li>• SEPT</li> <li>• EEAST</li> <li>• Luton CCG</li> </ul> | <ul style="list-style-type: none"> <li>• L&amp;D Hospital</li> </ul>                  |
| 7.9.c                   | <p>It is recommended that NHS funding issues to meet demands for Continuing Health Care Assessments, which is beyond the remit of the current review be referred to the Council's Overview &amp; Scrutiny Board for inclusion on its Health &amp; Social Care Review Group work programme for review in due course.</p> <p><b>Action required:</b> LBC Overview &amp; Scrutiny Board to refer the matter to the Health &amp; Social Care Review Group.</p>  | <ul style="list-style-type: none"> <li>• LBC Overview &amp; Scrutiny Board (For attention of: HSCRG)</li> </ul>  | <ul style="list-style-type: none"> <li>• LBC Overview &amp; Scrutiny Board</li> </ul> |

## 7.10 Quality Assurance and Performance Monitoring Procedures

7.10.1 The review acknowledges services have their own individual quality assurance and performance monitoring processes in place, but is concerned with the lack of an integrated system.

7.10.2 Given the need for greater service integration, the review believes the Integrated Discharge Team provides an ideal opportunity to develop an integrated system, perhaps around the clinical team meetings, which discuss complementary working relationships and problem solving. This would ensure the effects of measures implemented are transparent, so that performance could be clearly monitored and problems detected early and addressed. Shared accountability for the quality of discharges and the appropriateness of care packages and placements would be a constructive way to help avoid a blame culture.

| Recommendations/ Advice |   | Agencies Involved   | Lead Agency  |
|-------------------------|---|---|--|
| 7.10.a                  | <p>It is recommended that all services work in partnership to develop and implement an integrated quality assurance and performance monitoring system that sets agreed standards for the discharge process and quality of care after discharge and provides a procedure that enables performance to be monitored on a daily basis to allow for problems to be</p> | <ul style="list-style-type: none"> <li>• L&amp;D Hospital</li> <li>• LBC - ASC</li> <li>• CCS</li> <li>• SEPT</li> <li>• EEAST</li> </ul> | <ul style="list-style-type: none"> <li>• L&amp;D Hospital</li> </ul> |

| Recommendations/ Advice |  | Agencies Involved   | Lead Agency |
|-------------------------|--|---|-------------|
|                         | <p>identified and addressed as close to real time as possible.</p> <p><b>Action required:</b> L&amp;D Hospital to co-ordinate partners to develop an integrated quality assurance and performance monitoring system.</p> | <ul style="list-style-type: none"> <li>Luton CCG</li> </ul> |             |

## 7.11 Mental Health/ Learning Disability

7.11.1 The review heard evidence and was concerned patients are being discharged from hospital after being treated for their physical conditions, with their psychological needs overlooked, for lack of an integrated and dedicated psychological service.

7.11.2 However, the review is encouraged by SEPT's development of the Liaison Psychiatry Service with the L&D Hospital to meet the psychological needs of patients and support timely discharge, as well as prevent admissions in the first place.

7.11.3 The review also noted, a similar concern relating to vulnerable adults with learning disabilities, but was pleased to hear of SEPT's two specialist nurses attached to the L&D Hospital dedicated to the interest of these service users, to identify and meet their needs. However, the review considered this initiative could only deliver if all services ensured appropriate cases are identified and referred to the specialist nurses to avoid any such users being missed.

| Recommendations/ Advice |  | Agencies Involved  | Lead Agency  |
|-------------------------|--|--|--|
| 7.11.a                  | <p>SEPT is commended for developing the Liaison Psychiatry Service with the L&amp;D Hospital and recommended to ensure the service was appropriately resourced to develop its full potential to meet the often missed psychological needs of patients admitted to hospital with physical illnesses, prevent admissions and support timely discharge.</p> <p><b>Action required:</b> SEPT to note and ensure the Liaison Psychiatry Service is appropriately implemented and resourced to develop its full potential.</p>     | <ul style="list-style-type: none"> <li>SEPT</li> <li>L&amp;D Hospital</li> </ul>                                 | <ul style="list-style-type: none"> <li>SEPT</li> </ul> |
| 7.11.b                  | <p>The review commends SEPT for providing two specialist nurses dedicated to cater for the interest and needs of vulnerable adults with learning disabilities admitted to hospital, and recommends services ensure appropriate cases are identified and brought to their attention to avoid any such users being missed.</p> <p><b>Action required:</b> SEPT to note and services to ensure all vulnerable adults with learning disabilities admitted to hospital are brought to the attention of the specialist nurses.</p> | <ul style="list-style-type: none"> <li>SEPT</li> <li>L&amp;D Hospital</li> <li>LBC - ASC</li> <li>CCS</li> </ul> | <ul style="list-style-type: none"> <li>SEPT</li> </ul> |

## 7.12 Responding to the Discharge from Hospital Review Group Recommendations

7.12.1 In accordance with health scrutiny regulations, the Discharge from Hospital Review Group can request responses from recipients on how they intend to deal with its report and recommendations within 28 days of receipt.

7.12.2 It is also practice for such reviews to request for progress reports from relevant recipients on the recommendations accepted.

7.12.3 As the Task & Finish Group will be dissolved after the review, initial responses and eventual progress reports are requested to be submitted to the Scrutiny: Health & Social Care Review Group.

| Recommendations/ Advice |  | Agencies Involved   | Lead Agency   |
|-------------------------|--|---|---|
| <b>7.12.a</b>           | <p>It is recommended that NHS partners, LBC Adult Social Care and Housing services and the Luton Adult Safeguarding Board respond to the Health &amp; Social Care Review Group, on how they intend to deal with the report and recommendations of the Discharge from Hospital Review Group within 28 days of receipt.</p> <p><b>Action required:</b> Luton CCG to co-ordinate all partners" responses to the report and recommendations.</p>                           | <ul style="list-style-type: none"> <li>• Luton CCG</li> <li>• L&amp;D Hospital</li> <li>• CCS</li> <li>• SEPT</li> <li>• EEAST</li> <li>• LBC – ASC</li> <li>• LBC - Housing</li> </ul> | <ul style="list-style-type: none"> <li>• Luton CCG</li> </ul> |
| <b>7.12.b</b>           | <p>It is recommended that NHS partners, LBC Adult Social Care and Housing services and the Luton Adult Safeguarding Board (as part of its annual update to HSCRG) provide a progress report on those recommendations that are accepted, to a future meeting of the Health &amp; Social Care Review Group at a date to be determined through negotiation.</p> <p><b>Action required:</b> Luton CCG to co-ordinate partners" progress report on the recommendations.</p> | <ul style="list-style-type: none"> <li>• Luton CCG</li> <li>• L&amp;D Hospital</li> <li>• CCS</li> <li>• SEPT</li> <li>• EEAST</li> <li>• LBC - ASC</li> <li>• LBC - Housing</li> </ul> | <ul style="list-style-type: none"> <li>• Luton CCG</li> </ul> |

### The 10 steps outlined in 'Ready to Go' (DH 2010)

1. Start planning for discharge or transfer before or on admission.
2. Identify whether the patient has simple or complex discharge and transfer planning needs, involving the patient and carer in your decision.
3. Develop a clinical management plan for every patient within 24 hours of admission.
4. Co-ordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level.
5. Set an expected date of discharge or transfer within 24–48 hours of admission, and discuss with the patient and carer.
6. Review the clinical management plan with the patient each day, take any necessary action and update progress towards the discharge or transfer date.
7. Involve patients and carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence.
8. Plan discharges and transfers to take place over seven days to deliver continuity of care for the patient.
9. Use a discharge checklist 24–48 hours prior to transfer.
10. Make decisions to discharge and transfer patients each day.

Extract from report, '*Strategy for Improving Integration of Care Pathways to support discharge from hospital*', presented to the Discharge from Hospital Review meeting on 30/5/13

### 4. Recommendations:

- 4.1 Luton ASC should explore the possibility of providing a jointly resourced social work service with Central Bedfordshire to cover weekend work. *(The hospital has identified the need for ASC staff to support in diverting admissions at A&E and progressing discharge of complex cases over the weekend, (however as identified in SWAT weaknesses section, not all services function or take new referrals over the weekend) also patients come from a wider catchment area than Luton, it would therefore be sensible for ASC Luton and Central Bedfordshire to work together to deliver this service.*
- 4.2 Following discharge from hospital all patients who are eligible for community care to go through Care Track to determine and evaluate the cost of health and social care services required to keep them safely at home in the community and enable the cost effectiveness of services to be measured.
- 4.3 The hospital and CCS should explore developing a feedback loop/discharge user group as a pilot where factual information about things such as difficulties caused by discharges that occur late in the day can be fed in and reviewed. This could include simple satisfaction type data collected by district nurses. If this proves effective it could then be extended to include feedback from ASC and others eg Healthwatch.
- 4.4 Explore the benefits from a service user patient perspective of ASC Reablement and CCS Rehabilitation staff working closer together to develop the reablement focus and skills of the Reablement Team (utilising the skills of a wider group of clinical staff).
- 4.5 Commissioners should explore further whether there is a need to increase capacity of (and eligibility criteria for) Reablement Services accessed from the hospital so that reablement can be offered to a wider group of service users (possibly by a wider group of professional staff. *Note: Nurse Navigator already refers*) including many patients whose care is currently restarted when they leave hospital having been in hospital for more than 3 days.
- 4.6. Commissioners (CCG and ASC) should consider reviewing the number and focus of the block purchased nursing beds. This review should also include the fact that currently within Luton the Rehabilitation and CHC assessment beds are located in two different nursing homes. This leads to capacity peaks and troughs, difficulty in moving patients from one "category" to another when necessary, and duplication of rehabilitation provision.

The provision of rehabilitation for patients with a mental health diagnosis and access to step up beds should also form part of this broader review of community bed provision.

- 4.7 Additionally LCCG needs to ensure that sufficient nursing capacity is commissioned to carry out CHC assessments and to aid this should work with other CCGs (Beds Herts, Bucks) to encourage them to purchase CHC assessment beds (following Luton

and other many other areas) to carry out CHC assessments of hospital patients awaiting discharge, in non-acute settings in their own area using their own community nursing staff.

- 4.8 LBC ASC commissioners should consider whether there is evidence to support increasing the capacity/number (to meet current and future needs) of the 3 Step Up/ Step Down flats to reduce the number of service users using short stay private sector residential care beds.
- 4.9 Also it is not helpful to look at discharge in isolation, but also to consider:
- Increases in admissions and reasons for this (which is also a national issue), including whether the average length of stay is increasing for certain client groups, for example because there is an increase in admissions of patients with dementia, or very elderly with other complex problems. *(If patterns can be identified it may be possible to identify alternative services that could be developed to support these patients in the community, thereby preventing admission or speeding up discharge).*
  - What potential there is for providing additional short term clinical and nursing support to some groups of patients in their own homes so that they do not need to be admitted to hospital in the first place (which then involves staff time completing assessments to switch services in the community on again when the patient is discharged home). Currently both Luton and Bedfordshire CCG"s have services in place to support admission avoidance by treating patients in their own homes, providing short term clinical and nursing care, but there is possible potential for these to be expanded with support from local authorities and additional health resources.
  - Time spent referring patients to services they are already known to could perhaps be better spent in accepting assessments already completed within a short time period. A reduction in paperwork or assessments required whilst in hospital to facilitate a discharge may also be of value as it would speed up the discharge process.
  - How IT systems used by different agencies can be integrated. The Integrated Discharge Team and Intermediate Care Teams face many challenges and communication can break down (with negative consequences for patient and their carers) because each organisation has their own recording systems which are needed because they are used by other staff within their organisation. A simple count of the IT programmes available and regularly used by the IDT is a minimum of 5, each with its own specific use. However this increases the time required to document each activity, and means duplication of time and effort is inevitable with consequential risks. (This issue has been recognised and the CCG/Health and Well Being Board do have a sub group looking at this, but finding effective solutions is challenging).