Healthy London Partnership

directors of adass adult social services

Taster session: Interface at Discharge

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Supported by and delivering for:

Public Health England

NHS

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London's NHS organisations include all of London's CCGs, NHS England and Health Education England

Outline of the taster session

Aims and objectives of the session:

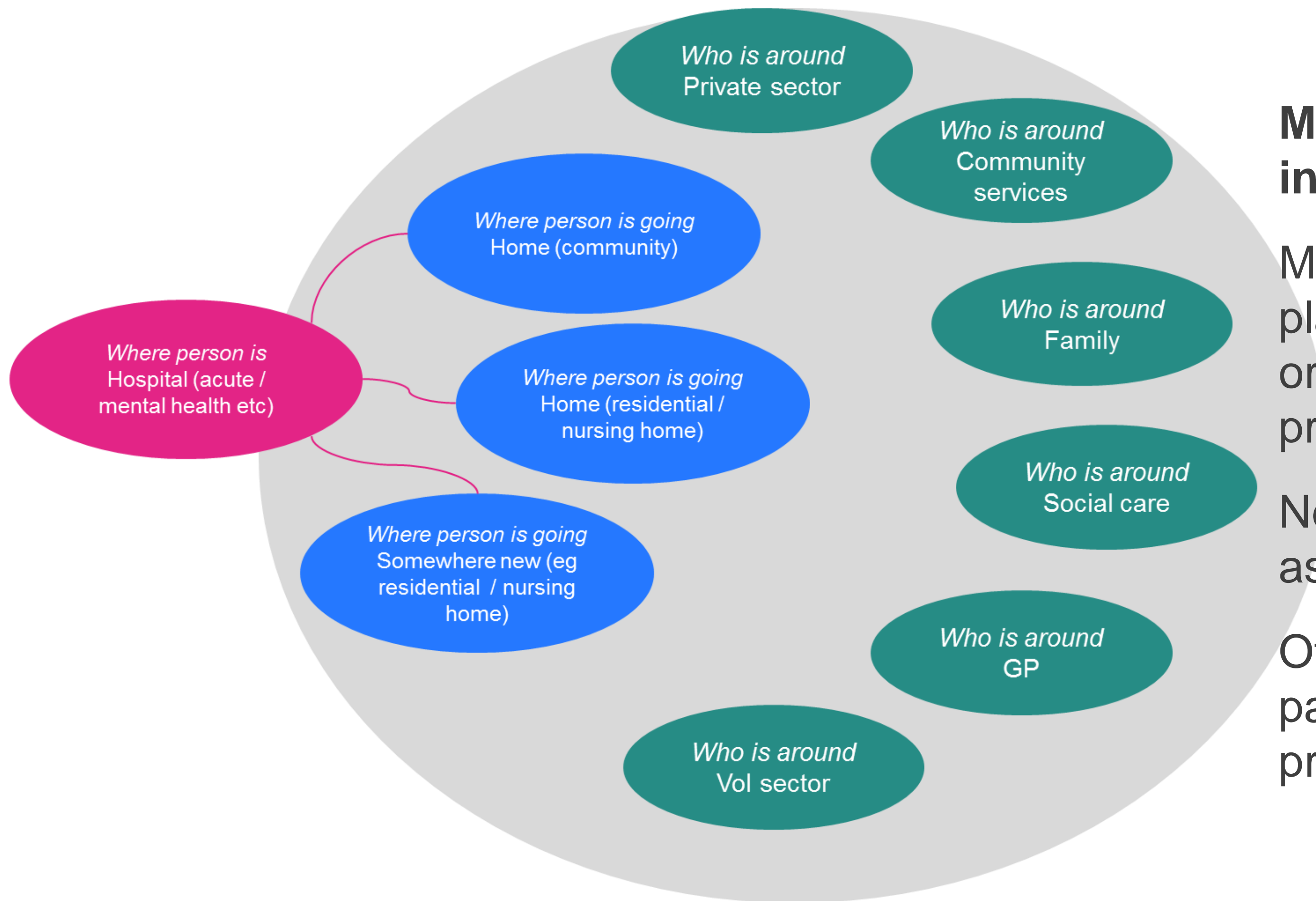
- To further understand what would support discharge from hospital when someone is medically fit to come home – with a focus on reducing delays

We will collectively consider what works well and what doesn't work well across different types of discharge. We will consider opportunities for improving our processes and pace around discharge.

By the end of the session we will have:

- Opportunities to delve into the opportunities and challenges around improving discharge – particularly reducing delays
- Two priority actions and what support is needed locally to take actions forward

Interface at discharge



Multiple people involved

Moving from one fixed place of care to multiple organisations and providers

Need to work together as a system

Often facing fear – from patient, family, pracitioners etc

Group discussion

- What are the positives and negatives about discharge – what words would you use to describe each?

- What works well and what doesn't work well – including mental health discharge?

Why stay in hospital longer than needed?

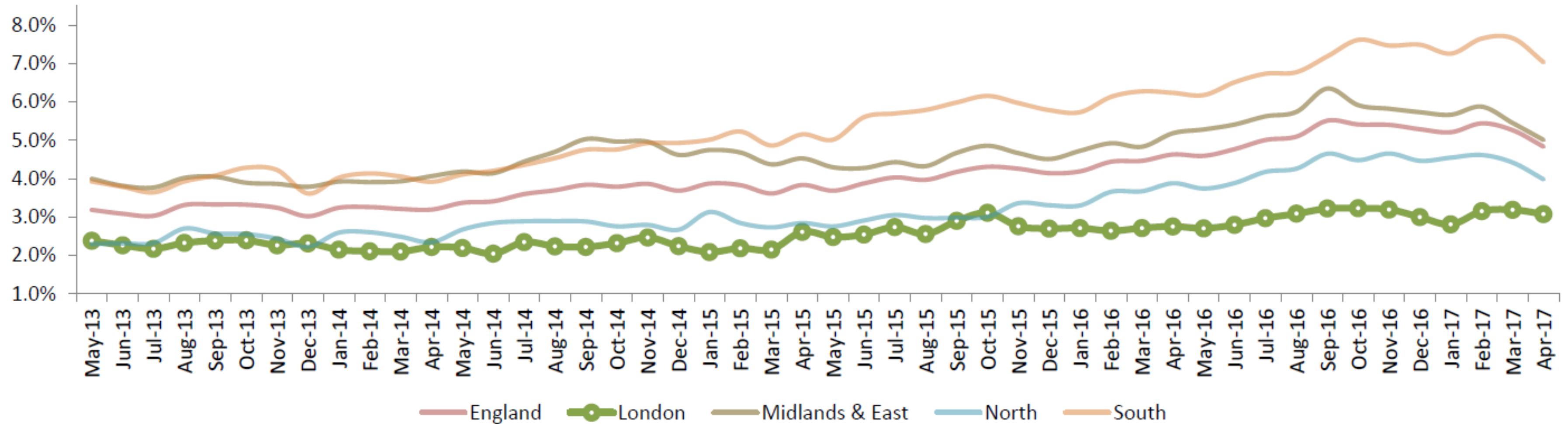
- **People generally don't want to be in hospital –** and their families don't want them there

- **While in hospital capacity and capability decreases**

- We all want to **get people home as soon as appropriate** – but they must be ready

- **Wasted days in hospital are bad for patients, and the system**

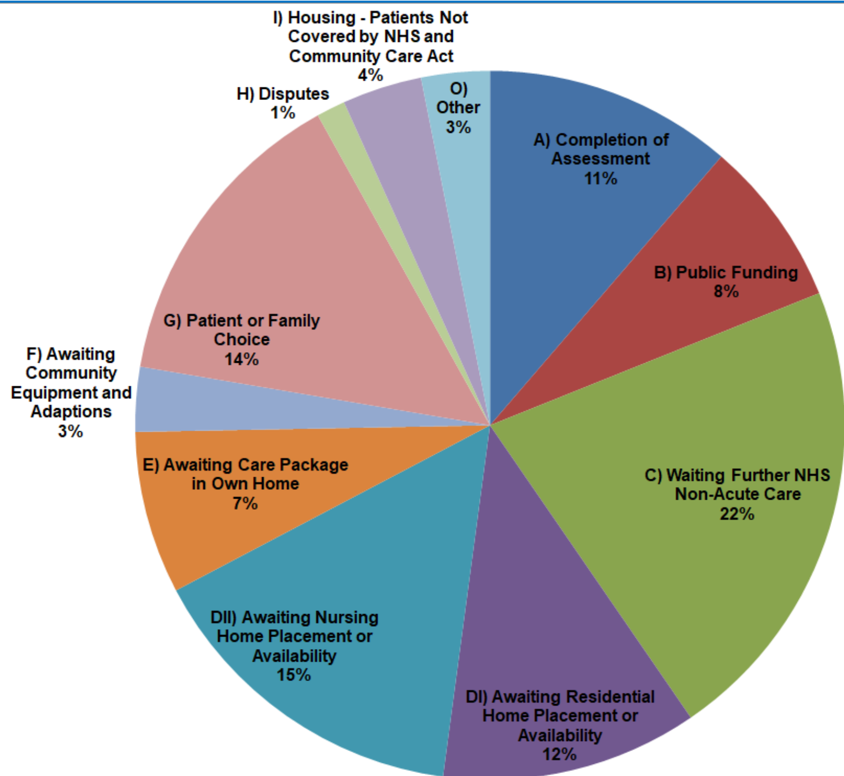
What we know about trends in discharge



London performs better than the rest of the country – but is still experiencing a consistent upward creep in rates of delayed discharge

April 2017 sitrep data

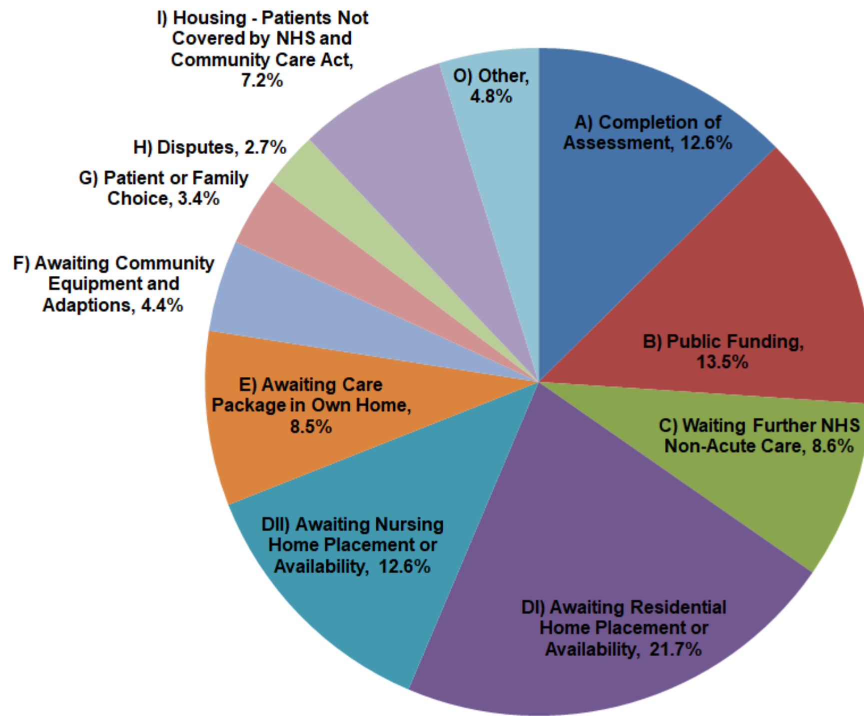
What we know about reasons for acute delays



- 11% of cases are about waiting for assessments – how might we reduce this wait?
- Nearly 50% of reasons relate to waiting for further care (NHS non-acute, residential or nursing home place)
- Patient / family choice much higher than in the mental health, community and specialist beds

April 2017 sitrep data – ie Feb data

What we know about reasons for other delays



- Delays in mental health, community and specialist beds echo those in the Acute sector
- Patient / family choice is much lower than compared to the acute sector

April 2017 sitrep data

Work that is already underway

Change 1

Early discharge planning. In elective care, planning should begin before admission. In emergency/ unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected date of discharge to be set within 48 hours.

Change 2

Systems to monitor patient flow. Robust patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand) and to plan services around the individual.

Change 3

Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector. Coordinated discharge planning based on joint assessment processes and protocols and on shared and agreed responsibilities, promotes effective discharge and positive outcomes for patients.

Change 4

Home first/discharge to access. Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.

Change 5

Seven-day service. Effective joint 24/7 working improves the flow of people through the system and across the interface between health and social care meaning that services are more responsive to people's needs.

Change 6

Trusted assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.

Change 7

Focus on choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options. The voluntary and community sector can be a real help to patients in supporting them to explore their choices and reach decisions about their future care.

Change 8

Enhancing health in care homes. Offering people joined-up, coordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.

Table discussion

Action planning:

- What can we do to improve discharge better?
  - Short term
  - Long term

- Who do you need to work with to address the issues?

- What support do you need to do something about it?

Feedback to the group your number 1 action and support needed

Feedback