Delayed Transfers of Care and the discharge process
A rapid review of good practice examples
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Overview

Delays in transfer of care are preventable and all too often the delays experienced are as a result of the barriers that prevent organisations working effectively as one system. Some groups are more affected than others by delayed transfer of care and discharge, namely older people, mental health patients and the homeless.

This rapid review was requested from North Central London to look at good practice examples across the UK of initiatives that have reduced delayed transfer of care and good examples of successful discharge schemes.

The review begins by providing literature on the specific groups affected more by delayed transfers of care, improving discharge for older patients, patient flow within hospitals, and early supported discharge. It also summarises how patients and care users say they are currently being let down by the system, followed by what they want when they are discharged.

It then outlines 10 good practice examples of initiatives that aim to reduce delayed transfers of care, some of which focus specifically on the most affected groups.

One of the most common themes across the initiatives is the importance of integration and collaboration between health and social care. This is a vital aspect of the good practice examples listed below. Engaging commissioners from the start and ‘setting the ground rules from the outset’ were also highlighted as good practice.

It is important to note that as this is a rapid review, it is not systematic nor does it cover all existing initiatives and data on the subject. Rather it pulls out some key examples to share learning and provide good practice guides.

Methodology
This review used quantitative approaches to capture a broad range of examples. The first stage used desktop research via academic resources such as the King’s Fund, Nuffield Trust, British Medical Journal and Google Scholar. The research team also examined a range of sources such as project reports, stakeholder websites and press releases and then contacted project leads and practices directly to identify the quantifiable impact of the studies and fill in any missing information.

# Key studies

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Literature Reviews
The review identified that some groups are more affected than others by delayed transfer of care and discharge. These are as follows:

**Older People**

The health and social care system’s management of discharging older patients from hospital does not represent value for money, according to the National Audit Office. The spending watchdog estimates that the gross annual cost to the NHS of treating older patients in hospital who no longer need to receive acute clinical care is in the region of £820 million. Caring for older people, who no longer need to be in hospital, in more appropriate settings at home or in their community instead could result in additional annual costs of around £180 million for other parts of the health and social care system. This would reduce the potential savings of £820 million arising from discharging patients earlier from hospitals.

**Mental Health Patients**

The problems social workers and other professionals have securing beds for mental health patients is mainly driven by discharge delays and cuts to community services, not bed closures.

**The Homeless**

Homeless people and hospitals are often blighted by inappropriate admission and discharge practice, which creates a “revolving door” situation, where homeless people’s multiple health and other needs are never fully addressed. This can lead to regular readmissions, lengthy hospital stays, and loss of housing or failure to find appropriate accommodation. Often this problem is due to a lack of communication between services and lack of the appropriate procedures, and can happen in both general and mental health facilities. Staff working in both health and homelessness services can find admission, discharge and joint working challenging. They need more support and information to ensure safe and appropriate discharge for homeless people. Nurses are often the key professionals who can take this work forward. This article provides information about guidance on improving care for homeless people, including national government guidance and recent case studies.

References:

https://www.kingsfund.org.uk/blog/2016/05/older-people-leave-hospital
http://media.wix.com/ugd/0e662e_a93c62b2baa4449f48695ed36b3cb24ab.pdf
https://www.nursingtimes.net/clinical-archive/public-health/ensuring-safe-and-appropriate-discharge-for-people-who-are-homeless-or-in-housing-need/5007225.article
In October 2015 the King’s Fund published a report on improving hospital discharge for older people. It said:

“Acute hospitals in England are under unbelievable pressure right now and winter is on its way. Even though we have a rapidly ageing population and an increasing number of people living with complex long-term conditions, frailty or dementia, we have lost hospital beds at pace over the past three decades.”

- Against this backdrop, hospitals are experiencing record levels of emergency activity and delayed transfers of care. The recent high-profile Care Quality Commission report on Addenbrooke’s Hospital highlighted a high number of acute beds occupied by patients medically fit to leave. A recent audit by NHS Benchmarking showed that while only 5 per cent of people aged over 65 who are admitted to hospital stay for more than 21 days, that 5 per cent accounts for more than 40% of all bed days.

- There’s pressure on hospitals from emergency readmissions too – emergency readmissions within 28 days of leaving hospital run at around 15% for people over 65 and overall numbers are rising. Improving support for older people at home – either to prevent hospital admission (or readmission) or to facilitate discharge when they are ready to leave hospital – is key to patient flow and ultimately to delivering the four-hour A&E waiting times target.

- It’s a stressful environment for clinicians and operational managers, who are under constant pressure to prevent hospital admissions, discharge patients sooner and get them home when capacity and responsiveness in primary and community health services is lacking. Social care has also suffered, with an estimated 40 per cent cut in revenue since 2010, and with many people receiving no statutory care despite their needs being classed as ‘substantial’. In addition, few carers for older people get formal support.

- It can be too easy for acute hospitals to place all the ‘blame’ on those services and not do enough to put their own house in order and work more collaboratively across organisational boundaries. It’s also too easy for those services to throw blame back onto hospitals when people cannot be discharged because of a lack of support within the hospital to facilitate it. We need to move away from these behaviours.

- Hospital inpatients are increasingly old. Many are living with frailty and most have a degree of functional impairment – either in mobility or other activities of daily living. Many such patients leave hospital less mobile and independent than when they were admitted – making rehabilitation after acute illness and injury a core business, not just for hospitals, but also for their partners in ‘step-down’ intermediate care services. These services also have the potential to provide ‘step-up’ (admission prevention) care, for early supported discharge from the hospital front door or wards.

The Nuffield Trust: Understanding Patient Flow in Hospitals

Understanding Patient Flow:

In October 2016 the Nuffield Trust published a report on understanding patient flow in hospitals. It said:

“The aim that 95% of patients attending A&E should be admitted, discharged or transferred within four hours is one of the highest profile NHS targets, yet it is being consistently missed across England. Previous Nuffield Trust work has argued that although the target can be over-emphasised, struggles in meeting it are associated with deeper problems in the capacity to move patients into hospital wards. This briefing draws on theories about congestion to look at why this has become more difficult, and what can be done about it. It aims to be useful to the hospital managers and people involved in Sustainability and Transformation Plans who tackle these problems on the front line, as well as to the policymakers who oversee them.”

- The document lays out how greater speed through a system often requires more space. Looking at trusts that meet the four hour target and those furthest from meeting it, it estimates that at least 5.5% of beds need to be free for the standard to be met. Yet many hospitals are unable to provide this much of the time, making target breaches inevitable.
- It looks at ongoing changes driving this squeeze on bed space, including mortality, the squeeze on bed space during years of austerity, rising numbers of patients with multiple conditions, and delayed discharges.
- An analysis examines how bed use and patient flow change through the course of the day, drawing on Hospital Episode Statistics which track admissions and discharges. It shows that bed occupancy does not peak at midnight, when the official census of patients is carried out, but in mid morning. Meanwhile, the highest need for patients to be moved through hospital peaks at an entirely different time of day, in the evening.
- With the NHS facing an unprecedented financial squeeze, the briefing looks at solutions available short of actually building enough beds to restore free space. It suggests managers should focus in particular on the minority of long-staying patients who account for a majority of bed use. Given the variation during the day, and with an increasing number of patients leaving in a matter of hours, it urges the NHS to invest in IT and management systems that can track and deal with the need for beds and patient movement in real time.
- These different sections will be of interest to different people – those managing beds, those looking at local health services as a whole, and those thinking about the resources needed by the NHS nationally. The document has a hyperlinked contents page allowing readers to jump straight into different sections.

References: http://www.nuffieldtrust.org.uk/publications/understanding-patient-flow-hospitals
Early Supported Discharge

In 2012, 66% of hospitals had an early supported discharge team.

Early supported discharge teams, can provide better (and potentially more cost-effective) outcomes than exclusively hospital-based rehabilitation for stroke patients with moderate disabilities. Modelling from the 2010 National Audit Office report suggests that “increasing the availability of early supported discharge from its current level – equating to around 20% of patients – to a more optimal level of 43% of patients, with all stroke units providing early supported discharge, would be cost-effective over a ten-year timeframe”.

NICE Guidance on Stroke Rehabilitation also covers early supported discharge:

Transfer of care from hospital to community
1.1.8 Offer early supported discharge to people with stroke who are able to transfer from bed to chair independently or with assistance, as long as a safe and secure environment can be provided.
1.1.9 Early supported discharge should be part of a skilled stroke rehabilitation service and should consist of the same intensity of therapy and range of multidisciplinary skills available in hospital. It should not result in a delay in delivery of care.

Case Study: Stroke Early Supported Discharge Team in Richmond

Richmond Rehabilitation Unit has a Stroke Early Supported Discharge Team which provides an early, intensive rehabilitation service for stroke patients.

- The team helps patients to leave hospital more quickly and return to their own homes so that patients can maximise independence as quickly as possible after their stroke.
- Patients are referred directly from stroke units or rehab units and are assessed within one working day (Monday to Friday).
- Treatment is intensive in the home for the first two weeks. After this time treatment will gradually reduce in intensity over the next four weeks.
- Patients may also be supported by a care package or district nurse if needed and must be organised prior to discharge. Any equipment must also be organised prior to discharge.


References:
https://www.nice.org.uk/guidance/cg162/chapter/1-recommendations
Feedback from Patients and Carers
Waltham Forest patients and carers feed into Healthwatch England national report on hospital discharge

Background:
The report identifies a number of common basic failings including hospitals not routinely asking patients if they have a home or safe place to be discharged to, details of new medications not being passed on to GPs and carers, and families not being notified when loved ones are discharged. Many of the problems stem from organisations failing to think beyond their own direct responsibilities, with discharge plans often not considering patients’ other clinical needs or home environment, including whether or not patients themselves have carer responsibilities. Over the past two years Healthwatch Waltham Forest has been collecting patient experiences relating to discharge from the local hospital, Whipps Cross.

Key Findings:
Focusing on those most affected by poorly managed discharge processes – those with mental health conditions, older people and homeless people – the Healthwatch England report reveals five ways patients and care users say they are currently being let down by the system:

1. People are experiencing unsafe, delayed or untimely discharge due to lack of coordination between health, social care and community services.
2. There is a lack of support available for people after discharge, often leading to readmission.
3. Many people feel discriminated against or stigmatised during their care, often feeling ‘rushed out the door’.
4. People do not feel involved in decisions about their ongoing care post discharge.
5. Individuals’ full range of needs are not considered when being discharged from hospital or a mental health setting – including their housing situation, carer responsibilities etc.

This varies from what people in the report said they want when they are discharged:
1. To be treated with dignity, compassion and respect.
2. For their needs and circumstances to be considered as a whole – not just their presenting symptoms.
3. To be involved in decisions about their treatment and discharged.
4. To move smoothly from hospital to onward support available in the community.
5. To be properly informed about where to go for help after discharge.

Key Local Schemes:
In Waltham Forest the Better Care Together Board oversees the integration of Health and Social Care services for local people.

One of the newer projects it oversees involves the development of an ‘Integrated Discharge Team’ made up of both health and social care workers, functioning together to ensure patients experience an appropriate and safe discharge, and have timely support and services in place for them once they arrive back at home. This new service encourages joined up and cross organisational working for the benefit of patients and their families.

Care Navigators in Waltham Forest support discharge from specialist mental health services for 12-18 months, supporting people to attend appointments with GPs and practice nurses, and providing additional contact if people enter a period of crisis. In addition, numerous local voluntary and community organisations support people in the community with particular health and care needs, supporting them to remain out of hospital.

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Case Studies
Case Study 1: New Oxford Hospitals

Background:
In 2015 Oxfordshire had the highest rate of delayed transfers in the country, with over 9,000 delayed days per 100,000 population during the year. The health economy also has had the worst rate of delays for at least five years.

December 2015 saw a joint initiative by Oxfordshire Clinical Commissioning Group (CCG), Oxford University Hospitals (OUH), Oxford Health and Oxfordshire County Council, all working to move people out of hospital more quickly when they have been appropriately treated and no longer need to be there.

The £2m initiative includes funding extra temporary care home beds where people can stay until they are ready to return to their own home or move to a permanent care home and the recruitment of more home care staff to support people in their own homes.

Impact:
In six months the initiatives saw positive impact of:
• A reduction in delayed transfers of care by over 50%
• In contrast, nationally Delayed Transfers of Care (DTOC) cases rose by 25% cent between May 2015 and May 2016.
• The release of 75 acute beds

Month | Jan | Feb | March | April | May | June
--- | --- | --- | --- | --- | --- | ---
Delayed patients (one-day snapshot) | 123 | 91 | 93 | 69 | 76 | 57

"These encouraging figures demonstrate that targeted spending and excellent cooperation between the NHS and our social care partners has made a real difference to many older, frail patients. Fewer people are now getting delayed in hospital beds. We have made it possible for them to move to more appropriate settings where they can make a quicker recovery after treatment."
- David Smith, Chief Executive of Oxfordshire CCG

The Solution:
• OUH hired around 60 care support workers in May, who provide social care in people’s homes after discharge from hospital.

• The majority of the new social care recruits came from outside the health and care sector, and had been employed on more attractive terms and with better prospects for career development than are typically offered by social care providers.

• The initiative includes a multi-disciplinary hub, led by a senior nurse but involving a range of professionals.

• As well as directly employing social care staff, a set of measures has been adopted which includes commissioning extra intermediate beds in care homes, and OUH staff working much more closely with other clinicians, such as GPs and care home nurses, to increase capacity and capability outside the acute hospital.

• The trust is expected to be the lead provider to care for frail and older people.

References:
Case Study 2: Doncaster integrated working – health and social care in partnership

Background and Case for Change:
Doncaster Metropolitan Borough Council, Rotherham, Doncaster and South Humber NHS Foundation Trust and Doncaster and Bassetlaw NHS Foundation Trust worked together to improve discharge processes, prevent hospital readmissions and reduce direct admissions into permanent care from hospital. Previously, social care assessments were completed in an acute bed, resulting in delays in the system, duplications of assessment and patients remaining in bed for longer than may have been clinically appropriate. A high proportion of patients were also admitted to long term nursing care post discharge.

The Solution:
Using Department of Health reablement and readmissions funding, two main changes were implemented: redesign of discharge pathways and introduction of a multidisciplinary ‘rapid assessment programme team’ within the Emergency Department and Medical Assessment Unit, focused on admission avoidance. The system changes implemented included:

- Every patient admitted into hospital is put into a computerised ‘i-tracker’ system, with an expected date of discharge set within 24 hours
- Healthcare professionals, including GPs have access to ‘i-tracker’ system to follow pathway of care, and identify reasons for and act on any delays to their discharge
- Patients who are able to be discharged home with support are referred into a single point of contact; a joint health and social care assessment takes place in the patient’s own home within two hours of discharge, with support packages in place on the same day. More complex patients are referred into the Integrated Hospital Discharge Team, which works across boundaries over five days with seven day working on the agenda to start in the new year
- Co-located with this team are discharge nurse specialist case managers who manage complex patients and are managed within a single management structure. The nurses work three long days (08.00-18.00hrs), ensuring continuity of handover with the Integrated Discharge Team
- Three assessment units for complex social care needs, two specifically for dementia needs, provide more appropriate assessment of patients within a home setting. This has reduced the number of patients going directly into long term care
- At the hospital front door, the multidisciplinary rapid assessment programme team offers a seven day admission avoidance service, with acute physician consultant support across all days of the week.

Impact

Patients
- There is now more of a patient focus on rehabilitation and reablement, with earlier assessment and intervention and personalised support packages put in place. As a result, patient experience and outcomes have improved
- Prevention of hospital readmissions – since introducing this service, 76% of patients within the Emergency Department or Medical Assessment Unit have had an admission avoided, following an assessment and an alternative community based package of care put in place
- Reduction in direct admissions into permanent care from hospital

Staff
- Integrated health and social care teams have enabled a better understanding amongst professionals of each other’s roles and understanding of what can be done.

Overall system
- Changes in the discharge pathways have reduced delays across the whole system
- No elective cancellations due to reduced delays
- Reduced administrative burden associated with delays in discharges; no section 2s or 5s used
- Reduction in length of stay and occupied bed days.
- Over a nine month period, 4,176 bed days were saved

Contact: Debra Everton, Strategic Lead for the Integrated Discharge Pathway, Doncaster Council | Email: Debra.everton@doncaster.gov.uk
Impact

• There has been clear evidence that the scheme benefits the efficiency of hospital discharge, reduces burden on hospital and social services staff. The availability of the service, staff understanding of housing issues, and the ability to action solutions and mitigations assists in expediting the discharge process

• The current annualised cost to MDC of running the scheme is £340,000 pa. The savings realised to the NHS system as a whole as consequence of reduced ‘bed days’ amounts to £1,371,060 pa – a 400% return on investment

• Average bed days saved per admission – 4.5 days

• Average cost saving per admission - £936

Moving forward MDC is looking at another arm of the scheme by providing ‘social triages’ within GP surgeries to prevent people accessing health and social care services to address a social need.

Reference: [https://www.nice.org.uk/sharedlearning/better-together-assist-hospital-discharge-scheme-ahds](https://www.nice.org.uk/sharedlearning/better-together-assist-hospital-discharge-scheme-ahds) Contact: Michelle Turton, mтурton@mansfield.gov.uk
Background and Case for Change:
The CCGs identified a widely established need to move care closer to home and reduce prolonged acute hospital stays. They also identified best practice evidence that decisions about long term needs are best made after a period of recovery and assessment outside of hospital. They established three discharge to assess pathways running at scale across the patch that linked to Better Care Bristol objectives and funding e.g. additional reablement capacity and funding for homecare services.
The principle pillars of these are: Right care, right place, right time; ‘Releasing time to care’; No long term care decisions made from acute hospital; and putting patients first and working well together.

Pathway 1: home with support
Support may be social care (e.g. support with ADLs) or health (e.g. complex medications, complex wound care, rehab by therapies at home) - Patient is discharged home once physically/cognitively safe to be alone between support visits.

Pathway 2: rehab step down bed
Patient is identified as having additional Rehabilitation, Reablement or Recovery needs that are best met in a step down facility to then enable discharge to their usual place of residence following their maximum 4-6 week pathway 2 stay. Care is delivered to promote independence and increase a patient’s ability to self care.

Pathway 3: care home
Patient has likely longer term care needs and requires additional assessment in a supportive environment to identify the most appropriate setting to meet these needs

There can be movement between the 3 pathways if clinically appropriate e.g. patient needs/abilities have changed (improvement/deterioration)

Aims
- Longer periods of assessment in out of hospital settings which provide a more accurate picture of patient’s needs
- Minimise hospital stay and maximise independence, with care at home which is safe and reliable as the default for care delivery
- Decreased requirement for long term, high cost packages of care following successful period of reablement at home, where this is possible
- Joint decision making and an integrated health and social care response
- No decision about long term care needs in an acute setting (including full CHC assessments)
- A functioning urgent care system all year round
- Fewer patient ward moves
- Reductions in length of stay and discharge delays
- Single, patient-focussed assessments
- Reduction in permanent placements in care homes

Impact:
- There have been reductions in Length of stay for both the acute phase of treatment and the “Green to Go” phase
- The total average stay is now 3.4 days shorter than the same period last year
- Number of green to go patients has reduced due to the reduced LOS

Reference: Information provided by project lead - lucy.parsons@bristolccg.nhs.uk
Case Study 5: Bristol Community Health's 'in-reach' service

Background and Case for Change:
In Bristol, and beyond, the NHS is contending with changes in the demographics and disease profiles of its patients. When frail older people with complex conditions are admitted to hospital they can experience longer stays due to difficulties in putting in place support for them in the community. The local acute trusts in Bristol have experienced a large reduction in acute hospital beds in recent years, putting extensive pressure on these resources. Bristol Community Health has previously established a REACT (Rapid Assessment Emergency Care Team), based in the emergency departments of the Bristol Royal Infirmary and Southmead Hospitals. This team acts to prevent admissions wherever possible. Acute hospital stays are expensive and it is widely agreed that patients should be treated in the community wherever this is clinically appropriate. As a result, the service has been extended to ensure that those who are admitted can be discharged into the community as soon as possible.

The Solution:
- Bristol Community Health established a new in-reach service, as an addition to the existing REACT service. This allows REACT team members to actively ‘pull’ patients from short stay wards and into existing community services. The team identifies older patients who are suitable for early supported discharge within five days of admission. They may come from the Older Persons Assessment Unit (OPAU), Medical Admissions Unit (MAU) or Surgical/Trauma Assessment Unit (STAU). These units make up a total of 85 beds.
- The team often follow up patients who have already been involved with the rapid response teams in the community prior to their admission, or following a REACT assessment in the emergency department. They aim to assess and refer them back to community teams where appropriate, to prevent prolonged admissions. These patients are given a comprehensive geriatric assessment, ensuring all their problems are identified, prioritised and addressed.
- The service relies on multidisciplinary team working, with effective communication and proactive clinical risk taking. Staff also need a working knowledge of the community service capacity available, particularly in the rapid response teams, as well as the ability to work collaboratively across the traditional boundaries of acute and community care.
- Staff attend daily morning board rounds to identify suitable patients, complete timely assessments and communicate with the ward coordinator to update them on potential discharges. If necessary, they are able to refer patients to step down beds at South Bristol Community Hospital for short term intensive rehabilitation of up to seven days, prior to discharge home with rapid response teams.
- The in-reach team are led by advanced practitioners, supported by nurses, physiotherapists and occupational therapists from the rapid response team, working on a rotational basis. This ensures staff have expert knowledge of the ability and skill mix within the rapid response team to manage clinically complex patients, allowing them to plan safe and effective treatment alternatives in the community.

Impact:
- From the beginning of April 2015 to the end of June 2015 the in-reach team have facilitated 110 discharges; with 82 patients supported by RRT and 10 patients discharged to a step down bed at South Bristol Community Hospital. A further 18 patients were discharged to other services.
- Estimated average saving in bed days per patient - 3
- Cost of bed day (approx.) - £400
- Bed cost savings made in total (based on 110 discharges) per quarter - £132,000

Reference: http://nhsconfed.org/resources/2015/11/bch-case-study Contact: Eleanor Pearce Willis | Eleanor.Pearce-Willis@nhsconfed.org | 020 7799 8630
Case Study 6: Sheffield Teaching Hospitals NHS Foundation Trust

Background:
Five years ago (2011) Sheffield Teaching Hospitals, like many hospitals, had a problem. Older people, admitted as an emergency, were spending a considerable length of time waiting to be discharged once they were medically fit to leave hospital.

After spending time listening to people and examining the traditional ways of working, the Sheffield team, which comprised a multidisciplinary group of clinicians and non-clinicians, realised they could make a significant change to the length of stay for older people while also improving their experience and care.

The teams caring for older people were challenged by the traditional method of assessing medically fit patients for discharge home, which could often lead to longer lengths of stay in hospital than necessary and also a predicted higher level of home support than was actually required.

Impact:
Readmission rates have not been affected and the number of patient falls has reduced in the group of patients who were assessed at home, because patients are less likely to fall in their own home. Shorter stays mean they are also less likely to get hospital-acquired infection.

Patient satisfaction has been high and, in the past year in Sheffield, more than 7,000 older patients have been discharged home in an average of 1.1 days compared with 5.5 days three years ago – a saving of over 30,000 bed days and a higher quality of patient experience.

The Solution:

- The Sheffield team, with involvement from service users, decided to turn things on their head and instead of determining fitness to return home by assessing patients in the artificial surrounds of the hospital environment, they trialled assessing patients in the more familiar surroundings of their own home.

- The aim is to assess the patient at home within a day of the decision that they are medically fit to discharge.

- As the starting point for change, a single medically fit patient was taken home and assessed in their own home by a physiotherapist.

- The patient’s bed was kept available in case their care needs could not be met at home in real time.

- The patient in fact proved to be very confident in their own home and the visit ended up with the patient making the physiotherapist a cup of tea.

- This patient and many more showed that assessment in familiar surroundings proved a useful way of judging how they would cope on discharge.

- In general, it showed people needed a lower level of support at home than staff would have expected from seeing them in hospital. The process was iteratively refined and expanded, and discharge to assess (D2A) has now been rolled out further in the trust.

Contact: Tom Downes, Consultant and Clinical Lead for Quality Improvement, Tom.downes@sth.nhs.uk

Reference: http://www.nhsconfed.org/resources/2016/01/urgent-care-for-older-people-sheffield
Case Study 7: Epsom and St Helier University Hospitals NHS Trust and Surrey County Council
Adult Social Care

Background:
Social care presence on the acute medical unit, seven days a week, improves discharges from hospital. Building on the success of co-locating Social Care on the acute medical unit seven days a week at Epsom Hospital, the model has now been spread across Surrey County. Epsom Hospital has a 56 bedded acute medical unit (AMU) across two wards with 16 assessment beds and 40 short stay beds designed for patient hospital stays of up to 72 hours. The social care team has been co-located within the assessment unit and take a lead role in daily meetings to facilitate discharge.

Impact:
• Since October 2012, the number of days where patients have been delayed in hospital waiting for Social Care support has fallen by 50%.
• Between October 2012 and August 2013, 17% of Surrey Social Care supported discharges have taken place during an evening or weekend, and this figure continues to grow.
• Between October 2012 to March 2013 360 avoidable admissions were prevented at the weekend or weekday evening, 43% of the total number.
• Since April 2013, complaints in relation to support hospital discharges have fallen, an 80% reduction when compared with figures for the same period last year.

The Solution:
• The unit is supported by a team of four acute physicians who work directly on the unit providing senior consultant reviews to all patients every day. The AMU receives all admissions to the hospital, apart from people needing treatment for Stroke. After patients are admitted, they are assessed in the AMU to determine their treatment plan. If a patient needs to stay in the hospital for a long time, they are transferred to a speciality ward. However, if the patient only needs to be in hospital for a short period (up to 72 hours), they will be moved to one of the short stay beds on the AMU and discharged home when fit.
• With the social care team located on the AMU, a new multidisciplinary team approach was developed to manage the discharge process from the point of admission to hospital.
• Senior members of the team meet every day at noon to discuss new admissions and the progress of patients already on the ward.
• The multidisciplinary meetings produce actions with accountable individuals and timeframes. Everyone is clear about who is doing what and when, which helps to ensure that things really get done. It has also created a team environment where all disciplines can collaboratively work together.

Spread of this model was achieved by:
• Engagement events during 2011, which revealed a demand for more accessible hospital services across the whole County during evenings and weekends.
• Surrey County Council’s ‘one team’ approach with partners to improve services, which recognised that expanded Social Care services would help reduce pressure on hospital beds.
• Establishment of a project group to implement the new service across all five acute hospital sites.
• Taking a co-design approach to engage staff and enhance staff trust, sharing success stories, and giving staff opportunity to voice their views and concerns, (including involving Trade Unions representatives).
• Inviting all of the teams to visit Epsom to show how it can be done.
• Developing a ‘bank’ of staff for each acute hospital team to help cover shifts when necessary - these staff are Social Care staff who usually work in community teams.
• Including hospital team cover within the senior management on call rota to support staff working shift hours.

Top tips:
• Remove barriers and blame culture between health and social care.
• Open and honest relationships and leadership are vital.
• Set the ground rules from the outset.
• ‘White board meetings’ must happen on a daily basis.
• Mutual trust and respect are key – one team approach.

Reference:
Case Study 8: Northumberland, Tyne and Wear NHS Foundation Trust

**Background and Case for Change:**

In 2011/12, Northumberland, Tyne and Wear Trust became alerted to a number of serious incidents and complaints that related to a lack of consistency and common approach to discharge and transfer arrangements for patients. The Trust is made up of a large number of inpatient and community teams and other provider organisations, all geographically dispersed, presenting logistical difficulties when patients under the care of community teams happened to be admitted to hospital outside their own locality. Due to the increasing number of incident reports and complaints received, the executive medical director championed the review of discharge processes and an improvement project was launched under his direct support, with guidance from clinical governance, under the remit of the Trust safety programme.

**The Solution:**

In 2014 the Trust undertook a programme of work aimed at facilitating a safe and smooth transition between inpatients and community for adults of working age, suffering with acute mental health concerns. The team introduced a standardised discharge decision making process across all services based on individual patient need, an initiative that also helped to improve patient experience of care. Elements of the service include:

- A standardised transition of care process.
- Introduction of the role of Community Liaison nurse.
- Integrated ward based discharge planning meetings.
- Improved joint decision making.
- Improved patient experience of care.
- New process algorithms and transitions checklist.
- Collaborative working between hospital and community care teams.

New processes were designed based on good practice already in place in one hospital site and local community teams. Updated guidance including role descriptors, process algorithms and a transitions checklist were developed to support implementation of the new way of working across all acute MH wards in the Trust.

A joint working group introduced the role of Community Liaison Nurses (CLN), and standardised the scheduling of ward based 72 hour meetings with consistent community involvement, where a planned approach to discharge enables community based plans to agreed, and services or support is put in place in preparation for the patient leaving hospital.

**Impact:**

The new process and guidance is now established practice across the Trust, and the CLN is now considered to be an essential role, supported by the trust corporate decision team, resulting in the following:

**Patients**

- Multi professional clinical decision making provides greater clarity around discharge planning for patients, carers and families.
- Patients and carers have greater involvement in the decision making process.
- Safer transition of care for patients from inpatient to community based care setting.

**Whole system**

- Community staff assurance that input to decision making is meaningful and relevant.
- A reduction in transition arrangements being identified as an issue in serious incident investigations.
- Consistent attendance at 72 hour and discharge planning meetings, evidenced through audit.
- Timely discharge, reducing the number of extended lengths of stay or delays.
- Case note audit December 2014 revealed 100% of patients discharged in the previous 3 months had a discharge planning meeting prior to discharge with joint review of care plan and risk assessment, improving the quality, relevance and accuracy of documentation and discharge certainty of arrangements.
- The dedicated function of Community Liaison nurses has been identified by all involved as positive and supportive to the patient journey.

Case Study 9: Birmingham Children’s Hospital NHS Trust hospital @ home - early discharge and improved patient experience

**Background:**
- Hospital @ Home (H@Home) was established as a virtual ward of Birmingham Children’s Hospital with the aim of delivering high quality care in the home, facilitating discharge, and reducing the length of admission.
- Care is delivered by a team of five nurses who visit a child up to 3 times a day and is overseen by a senior nurse and consultant.
- Children are identified as suitable for H@Home by acute service teams and a daily ward round is undertaken with a consultant to ensure robust ongoing care.
- The service has been operational for 5 years and has evolved significantly to develop nursing skills and enhance retention, respond to bed pressures, and cater for children with a variety of medical needs.

**Impact:**
- Over 12 months, 477 patients were admitted to H@Home resulting in 1450 bed days being released.
- 72% (347/477) patients were from general paediatrics. Other sources were medical and surgical specialties.
- The majority of admissions (66%) were for intravenous antibiotic administration but the service accommodates other patients, for instance ACTH in infantile spasms.
- Re-attendance rates are low (49/447), the majority being for intravenous access.
- Patient feedback has been very positive and recent data has demonstrated that 92% would be likely or extremely likely to recommend the service to friends and family. No patients would choose to remain in hospital rather than being admitted to H@Home after using the service. They valued the benefits to the child, to siblings, and an earlier return to work.
- Areas for ongoing improvement include cannulation at home, training ward nurses to facilitate expansion during winter pressures, and microbiology ward rounds to identify suitable patients.
- @Home has become an important part of delivery of paediatric care in the children’s hospital. The care delivered is highly rated by families, effectively facilitating early discharge and improving patient experience.
- Over 5 years, the service has expanded and continues to develop, playing a vital role in increasing bed capacity.

Reference: [http://adc.bmj.com/content/101/Suppl_1/A181_1?hwoasp=authn%3A1480688848%3A5531210%3A1365882340%3A0%3A0%3A2vU45GbwwOq3iggYHjp%3D%3D](http://adc.bmj.com/content/101/Suppl_1/A181_1?hwoasp=authn%3A1480688848%3A5531210%3A1365882340%3A0%3A0%3A2vU45GbwwOq3iggYHjp%3D%3D)
Case Study 10: Homeless Patient Pathway

Background:
The Homeless Patient Pathway (HPP) was launched in November 2014. Trident Reach spearheaded the HPP in partnership with Sandwell and West Birmingham Hospitals Trust, Heart of England Foundation Trust, Midland Heart, University Hospital Birmingham Foundation Trust and Birmingham and Solihull Mental Health NHS Foundation Trust. The clinical team led by an experienced GP works alongside housing specialists to provide health and housing support and advice. The team worked alongside hospital trusts and other health partners to develop a clear pathway for all patients who access acute hospitals who are at risk of being homeless.

The Solution:
• Homeless Patient Pathway identifies those at risk of rough sleeping prior to discharge. Its team of staff includes a GP, two nurses and a ‘Hospital Navigator’ who leads on all referrals. They work together to assess patients, establish their needs and deliver a package of housing, health care and support which continues into the community after the person has left hospital.
• This includes nurses carrying out regular support home visits in the community after discharge, as well as making sure people are registered with a GP and dentist and accessing the health and other services they need.
• The project involves working with specialist hospital consultants, housing providers and agencies such as social services, the alcohol advice service Aquarius and specialist mental health service RAID (Rapid Assessment, Interface and Discharge).

Case for Change:
• National studies into homelessness have described the problem as a ‘silent killer’, with homeless people dying at an average age of 47 compared to 77 for the general population.
• Estimates indicate that homeless people attend A&E departments up to six times more often than people with a home and stay in hospital three times as long. Currently, 70% are discharged back onto the street without their housing or care needs being properly addressed.
• The Department of Health estimates homeless people use four times as many acute health services and eight times as many inpatient health services as the general population, costing the public purse around £85.6 million a year.

Impact
The multi-disciplinary scheme is the only one of its kind in the West Midlands, unique in combining clinical services with housing support.
• Reducing length of stay in hospital: In the first six months of the pathway over 180 patients experiencing homelessness were safely discharged to suitable accommodation, as well as being supported to better manage their health once out in the community. This has reduced the average length of stay in hospital by 3.2 days per person. It ensures patients ready to be discharged have somewhere to live and a full package of health and social care support after they leave hospital.
• Best use of resources and generating savings: A recent ‘social value’ report into the project concludes that it has saved the public purse 541,483 – a ‘social value’ return of £8.80 per £1 invested through reduced pressure on health services, the justice system and welfare benefits, plus the increased contribution to the local community through homeless people finding employment and voluntary work.
• Avoiding readmissions: 80% of people helped have not been readmitted to hospital, 10% have since gained employment and 10% are doing voluntary work. It says individuals helped by the project were keen to improve their skills to enable them to find work.
• The pathway’s ground-breaking work has recently been acknowledged when they won a GP Enterprise Award in the Caring for Vulnerable Groups Category in 2014.