Joint report from NHS Leeds and Leeds Teaching Hospitals Trust

Leeds Overview and Scrutiny Committee - Health Services

Briefing report into Hospital Discharges - March 2009

1. INTRODUCTION

Discharge from hospital refers to people who no longer need to be cared for in a hospital setting. The person either

1. No longer has any ongoing care needs and can return home.
2. Has an ongoing care need which can be met at home with additional support.
3. Has an ongoing care need which may be more appropriately met in a different setting

The aim of the hospital discharge process is to identify if a person has an ongoing care need which is likely to require additional support on discharge. The objective is then to ensure that the additional support is available when the person is medically fit for discharge and no longer requires inpatient services. Care needs are identified by a process which involves the person concerned and assessment by combination of LTHT (Leeds Teaching Hospitals Trust), NHS Leeds and Leeds Adult Social Care staff. Care needs can vary from arranging frozen meal delivery, provision of a home care package to permanent placement in a care home.

Discharge Facilitators.

The Discharge Facilitators are a team of five nurses two employed by NHS Leeds and three employed by LTHT. The team works within LTHT to primarily provide advice, guidance, education and support to hospital staff and patient carers with regards to the discharge process. The team also acts as a point of liaison with staff from NHS Leeds and with Adult Social Care. The discharge facilitators also monitor record and disseminate the reasons for delayed discharges within LTHT and through the Multi Agency Operational Discharge Group (MAODG) resolve and learn from concerns raised regarding discharge of patients.

Multi Agency Operational Discharge Group (MAODG)

This is an operational group with representation from LTHT, NHS Leeds and Adult Social Care. This group meets weekly to discuss delayed discharges from hospital and also the difficulties that exist with individual discharges. The group also provides a forum to discuss and address issues arising with the discharge process, and to problem solve any reasons for delay in discharge and also to improve the quality of the patient experience. The group is able to monitor and review the process and work in partnership with colleagues to facilitate safe and effective discharges. (Terms of Reference of MAODG at Appendix 1)

2. SUMMARY OF THE DISCHARGE PROCESS FORM ADMISSION TO HOSPITAL AND SUBSEQUENT DISCHARGE FROM HOSPITAL

From 1st April 2008 until 31st Dec 2008 there were 162,489 adult inpatients discharged from LTHT.

In the 12 month period January to December 2008, there were 10,798 referrals received by NHS Leeds discharge referral point (DRP) requesting an assessment from Local Authority Adult Social Care or NHS Leeds to facilitate a supported discharge. Not all of these referrals originate from LTHT some originate from neighbouring NHS Trusts. These referrals are called Section 2 (S2) and comply with the Community Care (Delayed Discharge Act) 2003 requiring hospitals to notify the community when an assessment is required to facilitate a supported discharge.

The process for discharging patients from hospital follows the LTHT discharge policy first published in November 2006 The LTHT discharge policy and Joint Protocol were developed collaboratively by LTHT, Local Authority Adult Social Care and NHS Leeds, and are currently under review.

Discharge from hospital is not an isolated process and is specific to the individual concerned. The trigger for instigating additional assessment can come from a variety of sources (patient, family, friends, health professionals, local authority staff and voluntary agencies). The need for ongoing support can be identified at any time during the person's hospital admission pathway.

Discharge Pathway for a person following an acute hospital admission (see appendix 2)

- On admission to a hospital ward, a nurse will complete a Contact Easy Care document. The aim of this document is provide a picture of the patient on admission. The document clarifies biographical details this also identifies existing care provision and gives the patient / carer opportunity to identify any difficulties they may have been experiencing prior to admission.
- The hospital nurse will complete a nursing specialist assessment identifying the patients existing care needs.
- If appropriate referrals will be made to Allied Health Professionals such as Occupational Therapy, Physiotherapy and Speech and Language Therapy to assist with the patient's rehabilitation and also to identify any ongoing care needs.
- If the patient and /or the Multi Disciplinary Team identify care needs that will be ongoing once the patient no longer needs to remain in Hospital. A referral will be made to the Adult Social Care Team or NHS Leeds requesting an assessment of the patients care needs (S2).
- The documentation for a referral to Adult Social Care Team or NHS Leeds comprises of a Contact Easy Care document, nursing specialist assessment and a Continuing Health Care Checklist.

- On receipt of the referral a social worker or joint care manager is allocated and will work with the patient, carer and MDT to identify specific ongoing care needs.

- Once the patient no longer needs to remain in hospital and there is no more therapy or investigations required as an inpatient, the social worker or joint care manager will be informed. This is done by sending a Section 5 (S5) notification. This is a requirement within the Community Care (Delayed Discharge Act) 2003 whereby the hospital has to inform the local authority of a potential discharge date.

- Once provision to meet the patients ongoing care needs are in place and it is safe for them to be discharged a discharge date will be planned.

3. ASSESSMENT AND CARE MANAGEMENT

Adults with eligible social care needs can receive assessment and on going care management from a number of services depending on their presenting needs.

In summary these services are

Initial Response Teams (community-based)
Initial Response Teams (hospital-based)
Area Care Management Teams
Joint Care Management - Learning Disability Teams
Joint Care Management - Older People Teams
Disability Service Teams
Mental Health Teams

Each team has defined “entry” criteria which describes the circumstances in which they work with an individual (see appendix 3), and also “exit” criteria.

4. COMPLAINTS RECEIVED IN RELATION TO PATIENT DISCHARGES

Leeds Teaching Hospital Trust

From 1st April 2008 until 31st Dec 2008 LTHT received a total of 1,001 complaints which were recorded by patient relations. Of these complaints 51 refer in some way to discharge. These can be further broken down as:

Discharge Planning	14
Communication / Information	13
Transport	7
Early Discharge	5
Aftercare	5
Medication on Discharge	4
Discharge Delayed	2
Time of Discharge	1

NHS Leeds

NHS Leeds Investigated	1
LTHT investigated	3
NHS Leeds/LTHT Joint Investigation	2

Re-admissions of patients discharge to Intermediate Care /CIC beds

May 2008	10
June 2008	7
July 2008	12
August 2008	11
September 208	10
October 2008	9
November 2008	12
December 2008	11

The number of complaints identified above may reflect patient perceptions of expected support and also breakdown in care provided by specific agencies.

5. LEEDS UNPLANNED CARE - DISCHARGE REVIEW

Significant progress has been mad on reducing delayed transfers of care and improving the overall quality of the discharge process and patient/carer experience.

However it is acknowledged that more work on ensuring quality discharge for patients and streamlining the process would provide further improvements.

A Discharge Review has been proposed with the major deliverables.

- Agreement to work collaboratively across the health and social care interface
- Production of a discharge action plan - including process mapping/full system
- Satisfying the requirements of the CSCI report

It is proposed that recommendation from the review will be implemented by September 2009.

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January 2009

Appendix 1

THE LEEDS TEACHING HOSPITALS NHS TRUST

Multi Agency Operational Discharge Group

TERMS OF REFERENCE

PURPOSE

The Multi Agency Operational Discharge Group (MAODG) will provide a forum for multi agency members to meet, identify and resolve operational issues regarding patient discharge.

Membership

Membership will be from the following agencies

- Leeds Teaching Hospitals Trust (LTHT)
- Leeds Adult Social Care
- Leeds PCT

Membership is not limited and other departments can, or may be invited to, attend as required

Chair

Directorate Manager - LTHT

Deputy Chair

Service Manager - Leeds PCT
Service Delivery Manager - Leeds Adult Social care

SECRETARIAT

The Chair will coordinate & circulate papers including note taking and transcribing

REPORTING & ACCOUNTABILITY

The Multi Agency Discharge Operational Group is an operational group to identify and resolve issues. Any items requiring corporate /strategic decision making will be taken by the appropriate group member and / or the Chair of the group to the relevant senior manager of the appropriate agency.

FREQUENCY & COMMUNICATIONS

- The MAODG will meet weekly
- Minutes will be circulated to group members for action/information
- Members of the MAODG have responsibility for communicating discussions, actions and decisions to their relevant staff group or forum as per individual Agency communication structures

KEY OBJECTIVES

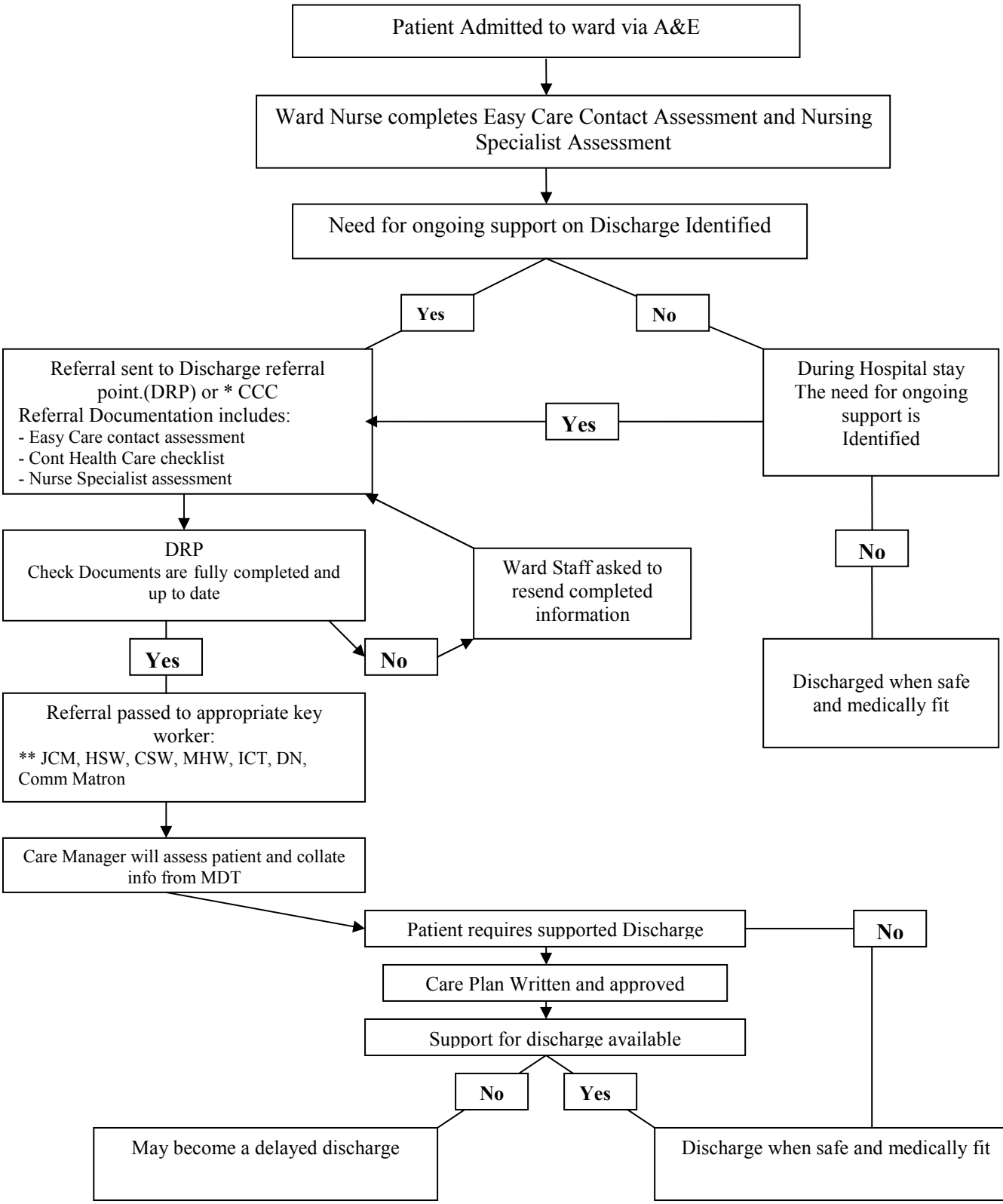
To address cross cutting issues and initiatives to ensure consistency of approach and maximize capacity through shared working.

RESPONSIBILITIES

- To advise group members on potential or actual patient discharge operational issues.
- To reduce the numbers and length of stay of delayed transfers of care in the Leeds healthcare system.
- To consider the Escalation process for specific patients as appropriate.
- Record, monitor and interrogate statistical information regarding delayed transfers of care.
- To ensure there are robust communications of operational cross cutting issues and decisions between agencies regarding delayed discharge.
- To identify and discuss issues impacting on the operational delivery of services agreeing solutions, appropriate escalation and review of effectiveness.
- To receive updates on initiatives/projects relevant to the MAODG
- To provide a forum to discuss and influence the development of future relevant policies, procedures and processes
- To ensure operational systems and processes are developed to support efficient and effective service delivery

Appendix 2

Discharge Pathway for Leeds residents



** Key Worker: JCM - Joint Care Manager HSW Hospital Social - Worker CSW - Community Social Worker
MHW - Mental Health Worker DN - District Nurse ICT - Intermediate Care Team
Comm Matron - Community Matron

* Care Communication Centre if Leeds Resident is being discharge from out of Leeds Hospital. eg: Harrogate

Appendix 3 Extracted from document agreed 11/2006
(Updated 14/01/20090

LEEDS SOCIAL SERVICES DEPARTMENT
ADULT ASSESSMENT AND CARE MANAGEMENT SERVICE

ENTRY CRITERIA

1. Initial Response Teams (community-based)

- Introduction
  Initial Response Teams (community-based) provide a screening and assessment service, sign posting to and/or commissioning services as appropriate.

- Entry criteria

  The Initial Response Teams (community-based) provide services to people:

  1. Aged 18 and over.

  2. For whom the Local Authority has a duty to provide an assessment as they appear to be in need of Community Care services.

  3. Whose current case episode is not active to another worker in the city, i.e. they are new to the Department or passive.

  1. The 'within 3 month review' identifies that the service user no longer requires support from the Department or is no longer eligible. The case will be closed and involvement with the Initial Response Team will cease (see point 1 above).

  2. The person referred does not appear to be in need of community care services. No formal assessment of need will be undertaken, information or advice, including signposting to others services may be offered. Exceptions to this include the provision of statutory responses under the National Assistance Act (Section 50 Burials, Section 48 Protection of Property, etc).

2. Initial Response Teams (hospital-based)

- Introduction
  Initial Response Teams (hospital-based) provide a screening and assessment service, sign posting to and/or commissioning services as appropriate.

  Hospital Social Workers will:-

  1. Work jointly with workers from other services to assess and provide for people's needs e.g. JCM Learning Disability or Head Injury Teams.
  2. Liaise with workers from other Local Authorities concerning patients in hospital from Authorities outside Leeds.
  3. Review (reassess) needs on those people already living in residential care.

Leeds Teaching Hospital Trust directly funds some Social Workers to provide a service to specific 'specialist' units in LTHT e.g. Liver Unit, Renal Unit, Haematology Unit. Social workers will provide 'specialist' assessments as required by the Units for people from Leeds and other Local Authority areas addressing psychosocial issues and decision making regarding treatment/transplantation. They will also signpost, offer advice, carry out any level of assessment, commission services, and review their needs under the FACS criteria where appropriate. Social Workers will provide assessment and care management until the overall package is stable and active care management is no longer required or where there are no further tasks for the service to undertake. Access to these services is via the relevant Consultants.

- Entry Criteria for people not receiving a service from specialist units in LTHT

  The Initial Response Team (hospital-based) provides services to people:

  1. Aged 18 and over.

  2. For whom the Local Authority has a duty to provide an assessment as they appear to be in need of Community Care services.

  3. Whose current case episode is not active to another worker in the city, i.e. they are new to the Department or passive.

  4. Who are patients of the LTHT on the following sites: - Leeds General Infirmary, St James' Hospital, Chapel Allerton Hospital and Cookridge.

  For people who are aged 65 years and over, in addition to the above, they must also have needs that can be met through a less-intensive package of care or transfer from one type of care home to another.

3. Area Care Management Teams

- Introduction
  Area Care Management Teams provide on-going monitoring and reviewing of Care Plans for people in receipt of services from the Department who do not require a specialist team to provide this. They will undertake assessment where the need for longer-term care management has been identified through the IRT screening processes.

- Entry criteria

  The Area Care Management Teams provide services to people:

  1. Aged 18 and over.

  2. Where an Initial Response Team has determined the service user is eligible for services.

  3. Where a care plan is in place and the active input of a care manager to support its implementation is required.

4. Joint Care Management - Learning Disabilities Teams

- Introduction

  The Joint Care Management – Learning Disabilities Teams are specialist teams who provide assessment and care management services. Service users who meet the entry criteria will be considered for either allocation or joint working.

  The Teams can provide support to an adult worker holding the case where this is appropriate, rather than taking the case. Team members will be available to offer advice to workers involved with service users with any level of need associated with a learning disability through the 'specialist learning disability advice line' which operates on 0113 **247 8880**. Lines are open:

Monday -Thursday	9.00am to 12.00 and 2.00pm to 5.00pm
Friday	9.00am to 12.00 and 2.00pm – 4.30pm

  Involvement in an advisory capacity to workers in Children's Teams supporting young people in transition will be offered where appropriate.

  NB A learning disability is:

  "A significantly reduced ability to understand new or complex information or to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood, with a lasting effect on development" (from the National Framework for NHS Continuing Healthcare, 2006). This may have its onset before birth or during infancy and is associated with an IQ of 70 or below.

- Entry criteria

  The Joint Care Management - Learning Disabilities Teams provide services to people **who meet all of the following criteria**:

  1. Aged 18 and over.

  2. Where an Initial Response Team has determined the service user is eligible for services.

  3. Whose primary presenting need is associated with their Learning Disability?

  4. With complex needs which require a Specialist Multi–Disciplinary Team Assessment* or Comprehensive Assessment (as defined under SAP).

     *A Specialist Multi-Disciplinary Team in the learning disability (LD) context is one that includes more than one LD professional.

5. Joint Care Management (Older People Teams and Continuing Health Care) (OP and CHC)

- Introduction

  Joint Care Management – Older People Teams are specialist teams who provide assessment and care management services and work primarily with older people who have intermediate care or continuing health care needs.

- Entry Criteria

The Joint Care Management – (OP and CHC) provides services to people:

1. Aged 65 and over.
   Adults aged 18-65 years who are eligible/likely to be eligible for CHC funding.

2. Resident within Leeds City Council boundaries.

3. Registered with a Leeds General Practitioner but living outside the Leeds City Council boundaries where the person is eligible/likely to be eligible for CHC funding.

And where one or more of the following are met:-

1. Health needs which meet the 'critical' level of FACS eligibility and/or are of such complexity they are likely to meet Continuing Health Care criteria.

2. A community based healthcare professional identifies a patient who is at immediate risk of admission to hospital.

3. A patient requiring discharge from hospital where a specialist assessment is required and either interagency coordination of an intensive care package or an admission to a care home for the first time or chronic disease management is required.

4. There is a requirement to co-ordinate an on-going multi-disciplinary/inter-agency assessment to either facilitate an early discharge from hospital or avoid a long-term placement by ensuring all avenues have been explored.

5. Have an identified need for a Community Intermediate Care bed.

6. Disability Service Teams

- Introduction

  The Disability Service Teams are specialist teams who provide assessment and care management services, signposting to and/or commissioning services as appropriate for disabled people.

  Disability Service Teams have a range of specialist staff within them and do not operate as a multi-disciplinary team in relation to service users they work with. Therefore entry and exit criteria are related to each area of the service in order to best reflect the specific services available to people with differing needs and circumstances.

- Entry criteria

  The Disability Service Teams provide services to people:

1. Aged 18 years and over.

2. Where an Initial Response Team has determined the service user is eligible for services.

And where one or more of the following are met:-

<u>For Specialist Social Work – Physical Impairment</u>

1. The service user is newly diagnosed with a neurological long-term condition.

2. The service user is at a transitional life stage and requires specialist and detailed planning.

3. The service user is experiencing a stepped change in their level of impairment.

   Note: Specialist Social Workers can provide support to adult workers holding the case, where this is appropriate, rather than taking the case.

   For Rehabilitation Officers Visual Impairment

1. The service user requires mobility/orientation assessment and training e.g. long cane.

2. The service user needs to learn adapted communication skills, including Braille, Moon or ICT.

3. The service user requires to develop and/or maintain personal and/or domestic skills related to sight loss.

4. The service user has experienced sudden sight loss.

5. The service user also has a significant hearing loss.

6. The SSD has received a CVI/BD8 for the service user.

For Occupational Therapy

1. The service user is experiencing environmental barriers which cannot/no longer be overcome by simple equipment and/or minor adaptations.

2. Risk assessment has identified moving and handling issues that cannot be resolved by the locality manager/unit manager/service provider.

3. The service user needs Occupational Therapy assessment and intervention to develop/maintain independent living skills.

4. The carer requires Occupational Therapy intervention to prevent breakdown of the care package.

5. A SSD building used by disabled person/people has barriers which prevents inclusion.

6. A new building/service for disabled people is being planned by or in partnership with SSD.

7. Mental Health Teams

- Introduction
  The Mental Health Unit is the section of Social Services Department that covers social work staff working in a variety of adult mental health settings. Many of these services are provided and managed by LMHT (see 'secondary services' below).

Primary mental health services

- Approved Social Work service

  Access to this service is via a request from a professional for an assessment under the Mental Health Act and subsequent screening undertaken by the Mental Health Unit who can be contacted on 0113 **295 4440**, lines are open:

Monday – Thursday	8.30am to 5.00pm
Friday	8.30am to 4.30pm

Secondary mental health services

If a secondary mental health service may be useful to a service user, this should be discussed with their GP in the first instance who can access these services directly. All of the following are secondary mental health services provided by LMHT. Each service has specific entry and exit criteria, which are taken into account during the screening process for the service.

- Acute General Mental Health Services for people aged over 65 (CMHT)

- Acute General Mental Health Services for people aged 18 – 65 (CMHT)

  CMHT Acute services are accessed via referral through from the person's GP and are made to the CMHT in that geographic area.

- Specialist Mental Health Services including

  - Community Rehab – Long-term support for people with serious and enduring mental health problems.*
  - Assertive Outreach Team – Intensive support to 'hard to reach' people.*
  - Continuing Treatment and Recovery Service – In-patient rehabilitation service for people with severe and enduring mental health problems.*
  - Early Onset Dementia – Psychiatric assessment consultancy & treatment service
  - Forensic Service – Citywide service for people needing secure care or referred via the Courts.
  - Special Care Services – Short-term intensive care for people too disturbed for normal wards.
  - Liaison Psychiatry – Psychiatric assessment and follow-up service for people at LGI or St James's
  - Self-harm Service – Psychiatric assessment and follow-up service for people who self-harm and present at A & E at LGI & St James's.

- These services only accept referrals for people already known to secondary mental health services.