CITY OF WOLVERHAMPTON COUNCIL

Adult and Safer Scrutiny Panel

31st January 2017

Report title	**Supporting a Safe and Seamless Transfer From Specialist Care or Hospital Setting.**	
Cabinet member with lead responsibility	Councillor Peter Bilson Economic Regeneration and Prosperity	
Wards affected	All	
Accountable director	Manjeet Garcha, Director of Nursing and Quality	
Originating service	Wolverhampton Clinical Commissioning Group	
Accountable employee(s)	Manjeet Garcha Tel Email	Director of Nursing and Quality 01902 442476 Manjeet.garcha@nhs.net
Report to be/has been considered by		

Recommendation(s) for action or decision:

The Health Scrutiny Panel is requested to:

1. **Receive** and **Discuss** the Report
2. **Note** the current systems and processes in place to assist a safe and seamless transfer out of specialised care
3. **Note** the joint working arrangements in place to facilitate the above
4. **Note** the actions taken to continually improve the commissioning arrangement to meet the needs to vulnerable adults and children to facilitate the above.

1.0 Purpose

The purpose of this report is to give an outline of the systems and processes in place to support a safe, timely and seamless transfer of patients from a specialist care or hospital setting to their usual or new place of abode.

2.0 Background

According the NHS England (NHSE), a 'delayed transfer of care' occurs when an adult inpatient in hospital (children are excluded from this definition) is ready to go home or move to a less acute stage of care but is prevented from doing so. Sometimes referred to in the media as 'bed blocking', delayed transfers of care are a problem for the NHS as they reduce the numbers of beds available to other patients who need them, as well as unnecessary long stays in hospital for patients. Over the last few years there have been many reviews and publications on the statistics and effects of delayed transfers of care. The majority of patients that are admitted to hospital for an acute episode of care or planned surgery will return to their usual place of residence with either very little or no required support. However, there are a growing number of a patients, in the main frail elderly but also patients with complex physical and mental health needs that do require discharge to be planned and executed in a safe and seamless manner for the best adjustment to their condition and surroundings.

This report will cover the steps taken by Wolverhampton Clinical Commissioning Group as the lead commissioner of health care services in Wolverhampton to ensure that there are systems and processes in place to support a safe and timely transfer from an acute episode of care into the community.

3.0 Current Arrangements for planning discharge for adults

3.1 At present we have a wide variety of discharge options from a specialist care or acute hospital setting:

- Home without the need for support
- Home with low level support from 3rd Sector provision
- Home with support from HARP
- Home with support from CICT
- Home with support from a social care package
- Discharge to a resource centre bed
- Discharge to West Park Rehabilitation Hospital
- Step down into a block purchased bed at Probert Court
- Step down into a spot purchased bed in a residential or nursing home
- Discharge back into a residential/nursing home if previously resident there
- Discharge arrangements for young people and adults from secure units of care

3.1.2 Discharge planning has been reviewed extensively in Wolverhampton over the last few years; this has been as result of local need and national recommendation i.e.

Winterbourne View. Locally a number of review and small scale projects as The West Midlands Quality Review Service, Emergency Care Intensive Support Team and most recently The PriceWaterhouse Cooper (PWC) review commissioned jointly by the CCG, City of Wolverhampton Council and The Royal Hospitals NHS Trust have identified the need to improve patient flow through the hospital by improving pro-active discharge planning, having clearly defined discharge pathways, having access to timely and effective support on discharge, moving away from keeping people in hospital whilst they wait for assessments to be completed and for the identified care to be procured.

3.1.3 In Wolverhampton a multi-agency 'Discharge to Assess' programme of work has commenced and it is anticipated this will further improve the discharge arrangements for individuals from acute care settings.

There is also increasing evidence base supporting the move to an integrated Discharge to Assess approach, this was the main recommendation from the PWc Review and the benefits include:

- Improved health outcomes
- Decreased length of stay in hospital
- Reduced length of stay in an acute hospital reduces decompensating; chances of acute physical and mental deterioration, particularly in older people
- It improves patient flow through the system maximising safe discharges, minimising delayed transfers of care and ensuring the availability of beds in the acute care setting for people requiring admission
- Assessments for on-going care are done at the right time and in the right place; maximising peoples' capacity for independent living
- Many people will be able to remain living at home for longer if discharges to assess services adopt a 'home first' approach.
- Reduces duplication of work by ensuring people are discharged to the most appropriate setting and are assessed using a process that is accepted by all agencies
- It makes better use of existing resources by pooling the resource and provision; providing the right care at the right time, prevents wastage
- It builds on existing understanding and enhances working relationships between all staff
- It ensures that people access the right care and support at the right time and in the right place removing the need for any delay associated with the health or social care need debate (seamless for the patient and carer).

3.2 Current arrangements for planning discharge for children and young people across the health economy.

3.2.1 Children and young people from Wolverhampton can be in patients in hospitals both in city and out of city, depending on their medical or mental health needs. When children are in patients at New Cross Hospital, and there is a need for on-going community input following the discharge, it is usually a smooth transition between acute and community services as they are both provided by Royal Wolverhampton Trust.

3.2.2 Birmingham Children's NHS Foundation Trust, where a number of children with Wolverhampton CCG commissioned care patients are admitted over the year have well developed links with local services to ensure a smooth process for children and their families when they return to Wolverhampton, especially if there are actions outstanding which requires links with the individual's school. Occasionally there are times when links are not so robust. A case study has been used below to highlight the complexities that can exist with some cases.

3.2.3 Case Study

There has been a case recently where a young girl who was involved in a road traffic accident. Due to the complexity of the injuries, she still requires significant assistance with activities of daily living i.e. assisted breathing with a tracheostomy and multiple complex handling and lifting aids to move in and out of bed.

This patient had been on an acute unit in a regional specialist hospital for a significant period of time. This was due to the family's property not being adaptable and the time it took for the council to identify an appropriate property which was appropriately adaptable. Whilst this was happening, the adult acute unit where she was an inpatient, started to pursue discharging the young lady from the specialist ward. This was appropriate as an acute ward is not the most appropriate place for someone who is ready for discharge.

It was unclear if the family were going to be able to manage this young lady when she returned home due to her complex medical needs which now included tracheostomy care and frequent suctioning as well as full support with personal care including continence issues. There were many meetings to support the transition of her from the acute unit and whilst there was willingness from the family to care for her at home, their home was not suitable and they did not own their own home to agree the adaptations required.

Several alternative options were considered and multi-agency meetings held with the social, health and family representatives. As an immediate safe, appropriate and interim solution a children's hospice was considered. The hospice could meet her complex needs. Also a full assessment of the family's ability to care for the young person could be undertaken and specialist skills i.e. suctioning could be taught. When she is discharged home, once her home is adapted, there will be carers available who can support her care at home. She was admitted to the hospice in June 2016 and the adaptations have not started yet. There is a complex care team supporting this young person's care at night time and learning the care package so that she will be discharged home with a care package planned and the family will be supported.

The Case Study highlights the complexity of some cases where there is a requirement for multi-agency collaboration.

3.2.4 Discharge planning for Mental Health/CAMHS and Learning Disability support.

For children and young people with mental health conditions that lead to in- patient admissions, the nearest unit is in Birmingham or in Stafford but most of our children and young people have been admitted recently to units much further afield. Currently we have young people in Sheffield and Woking. The CAMHS team who have been involved with the young person tend to keep in touch with the inpatient unit to ensure they are fully aware of the child's condition on a weekly basis and participate as fully as they can and if notice allows, in Care and Treatment Reviews as well as Care Programme Approach meetings. These discharges can be the most problematic as the child is usually located a distance from Wolverhampton which makes it difficult to ensure there is a comprehensive approach to the child's discharge. Furthermore, these placements are commissioned by NHSE and not the CCG. Local processes have been strengthened as a result of recent national inquiries highlighting issues i.e. Winterbourne View. For those young people who are Looked After and have existing placements funded via External Placement Panel, or where there has been a previous Care and Treatment Review undertaken prior to admission, the CCG has employed a Children's Commissioner who is responsible to ensure that commissioning issues do not result in the delay of discharges.

4.0 Financial implications

4.1 Not assessed for this report

5.0 Legal implications

5.1 Not assessed for this report

6.0 Equalities implications

6.1 No equality analysis undertaken.

7.0 Environmental implications

7.1 Not assessed.

8.0 Human resources implications

8.1 Not assessed.

9.0 Corporate landlord implications

9.1 Not assessed.

10.0 Schedule of background papers

10.1 NA