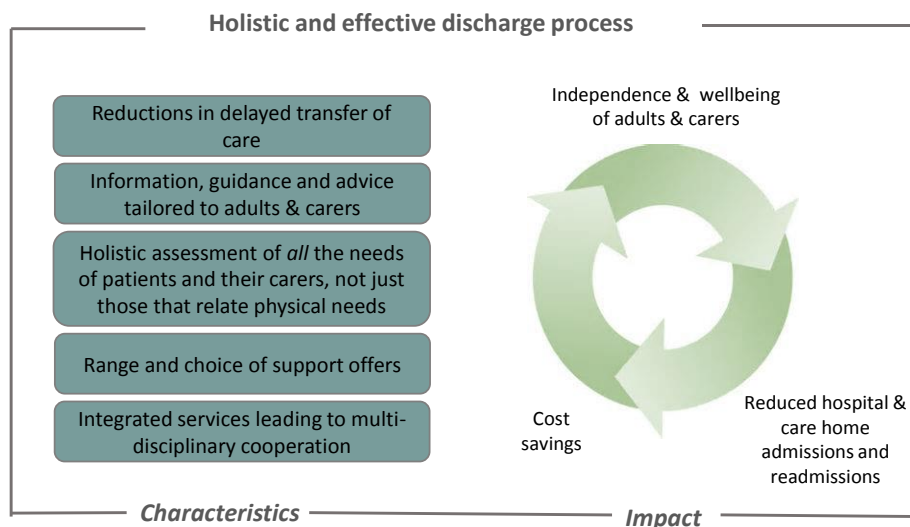


# Hospital discharge: working for everyone

*"I was helped to regain my independence when I thought I would have to go into care"*

## Introduction

Every council and hospital aim to deliver a smooth and timely hospital discharge, but this doesn't always happen. As a result, too many adults with care and support needs are staying in hospitals for longer than they need to and do not get the necessary support at the point of which they are eventually discharged. When and how adults are discharged from hospitals matters. It has a profound impact on the health and quality of life of adults and their carers. If managed well, it is a way in which to reduce the cost of care and address capacity problems in hospitals across the country.



In April 2015, the Care Act will come into effect. It states that local authorities and the NHS must implement a hospital discharge process that features promotion of independence and prevents and reduces further need for care, reduces delays to access the right support, and fulfil the needs for support of carers. What does this mean in practice? This case study provides an overview of how Greenwich has transformed their hospital discharge practices to improve health and wellbeing for adults and carers. Building on the experiences in Greenwich, it draws out valuable lessons for others working to improve discharge processes, deliver better outcomes and meet the requirements of the Care Act.

The Care Act principles and duties provides an opportunity for localities to improve their discharge process – and in effect improve the overall social and health system locally.

## Background

There are five key changes prescribed in the Care Act that affect hospital discharge process:

Change area	Care Act legislation	Implications for hospital discharge
<b>Choice &amp; control</b>	Support is centred around the individual, and they play an active role in determining the best course of action	Develop an integrated health and social care system that works in partnerships with the individual to identify points where action might be taken to prevent more significant needs
<b>Advocacy</b>	Advocacy services are readily available for adults and carers where required	Inform all parties about advocacy support at earliest possible moment, and have supply resource to support this
<b>Support for carers</b>	Carers have access to support equal to that of adults with care needs, and can request an assessment of need	Provide resource to deliver carer assessments, and when perform joint assessments of carers and adults to provide a more holistic picture
<b>Support for self-funders</b>	Sufficient support is provided to help assess, plan and maintain the needs of self-funders	Provide early access to financial information, advocacy and resources for adults with care needs, even if they are self-funding, and alert to potential financial implications
<b>Access to good information</b>	Quality information is provided to adults and carers regarding support services available in the community to enable informed decision-making and enhance prevention	Train discharge team members to effectively signpost adults and carers to relevant information during various steps of the discharge process

## Improving hospital discharge in Greenwich

A local authority located in South East London, Greenwich serves over 250,000 residents with approximately 3,500 adults using social care services. In 2011, Greenwich began developing a more defined, integrated hospital discharge pathway after having to tackle discharge delayed transfers of care (DTCs) and increasing spend of care support. The Greenwich discharge model

provides an example of good practice for others looking to modify their own discharge process that addresses both the Care Act and improved care outcomes for adults with care needs and carers.

### The building blocks

- **Efficiency:** Planning for discharge starts at the point of admission to hospital through response to Section 2 hospital admission notifications which are received from the ward by the integrated discharge team. All assessments and care planning are undertaken within 24 hours of a Section 5 discharge notification – reducing DTOCs and risk of fines to the Local Authority.
- **Integrated assessment & support planning:** All adults are assigned to a single social care and health discharge team. Adults and carers are ‘triaged’ into respective pathways based on their primary need (i.e. physical or mental, short term or on-going). Based on complexity, risk, urgency and other factors the team will assess and provide support planning and packages immediately.
- **Maximising independence:** The hospital integrated discharge team takes an approach founded on maximising independence – providing reablement and rehabilitation that is available to *all* adults and carers who have eligible needs which is free at point of access. This intervention encourages adults and carers to be more self-sufficient, diminishing the need for extensive care and also reducing rehospitalisation rates.
- **Holistic approach:** The assessment incorporates both the needs of the adult and their carer at heart. Approximately 75% of assessments next year will be jointly completed between the carer and adults, providing a more holistic view of needs and appropriate support provision.
- **Information & advice:** Creation of a peer-to-peer marketplace to inform adults and carers of available services, allowing them to craft their own care packages whilst encouraging contact between service providers and adults with care needs / carers.
- **Further supporting carers:** Planned carer pathway (to be implemented in April 2015) will provide emergency services to carers with a sudden change in adult, carer and or family circumstances, and a step down process will allow them to more easily cope with reduction of services over a course of time.

Building on the good practice discharge process in Greenwich, a model of an inclusive pathway that can serve as a starting point is depicted in Appendix A. This model facilitates the addition of carer assessments and needs, the availability of early and often advocacy, and the inclusion of signposting milestones that team members can follow. The pathway can also be used for those that are self-funding, and encourages each adult with care needs and their carers to use available resources in order to take a key role in their own package creation.

### Making it happen

The Greenwich team had a very strong vision for how to improve discharge practices, which aligned with wider goals of integrating health and social care services in Greenwich. Critical enablers include:

1. Recognition for the **need of an initial investment** of time, training and money in order to receive the long-term benefits of integration
2. Successful **cooperation** between health service providers and social care providers, and a high level of communication throughout the process
3. The availability of **quality information** with which the service users and carers can access and help plan their own health packages, and with these resources being readily available to self-funders also
4. The creation of an **overarching team** to facilitate the integration and measure KPIs of the unit as a whole in order to quickly identify and resolve blockages in the process
5. Vision and **strong leadership** support in to catalyse the change, and support effective change management

Which of these enablers can you build on in your local area?

How can you use these principles to catalyse a smooth hospital discharge process that is Care Act compliant?

## GREENWICH SUCCESS

- **85%** adults feel **safe and secure** with their care services
- **90%** older adults still at home 3 months after discharge
- **£900,000** savings in social care budget since 2011
- **35%** reduction in adults going into care since 2011

“The joint working has been brilliant, lots of preventative work, enabling independent living to continue for many, reducing hospital admissions. It is now much easier and quicker to access health professionals.”

## References

### Care Act 2014

<http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>

### LGA value case for Greenwich: “Getting back on your feet”

<http://www.local.gov.uk/documents/10180/12193/Greenwich+-+Getting+back+on+your+feet+-+value+case/9cd224ae-b63d-42f9-872e-18943767a695>

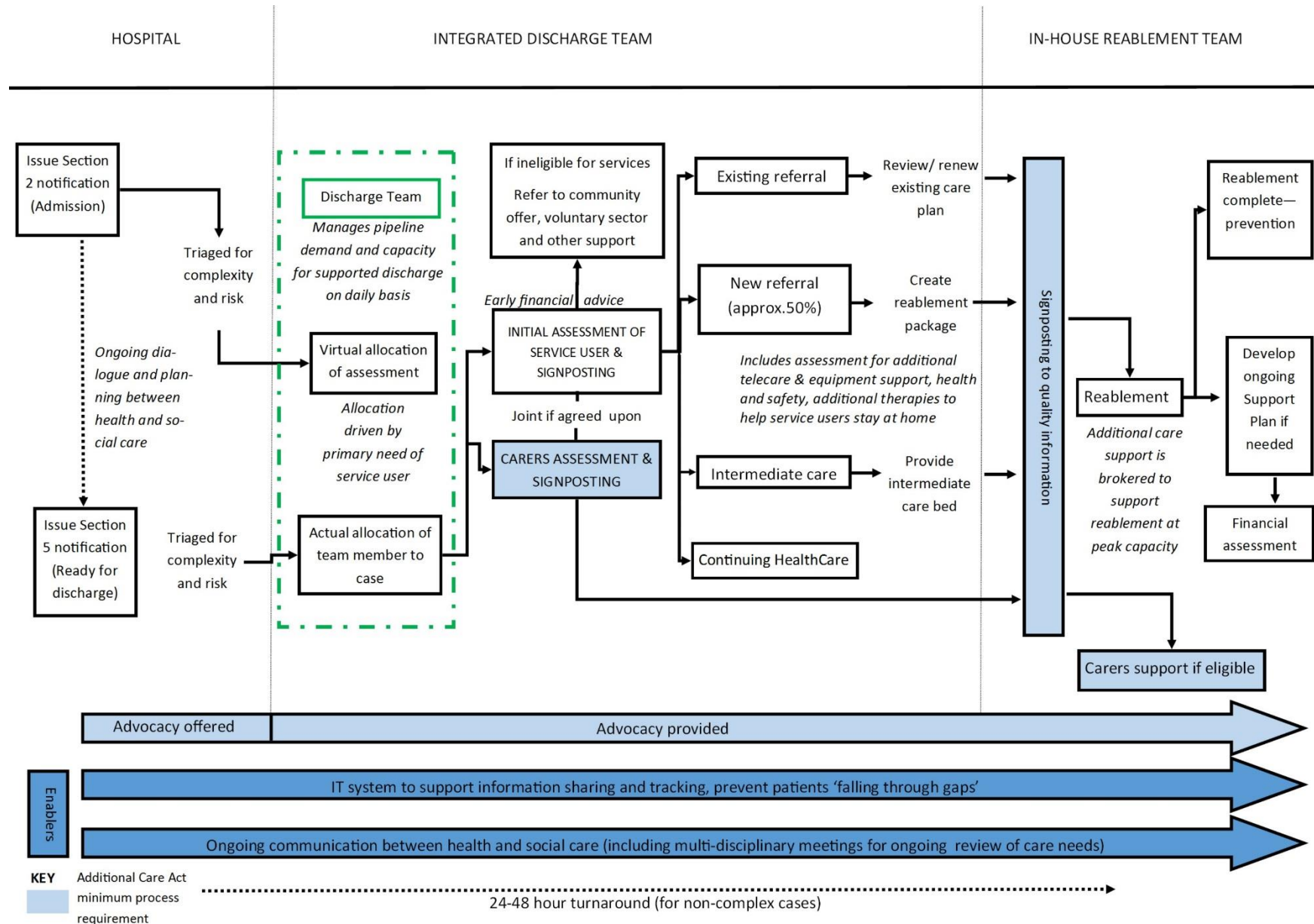
### Think Local, Act Personal (TLAP) Minimum Process Framework

[http://www.thinklocalactpersonal.org.uk/\\_library/Resources/Personalisation/TLAP/Paper4MinimumProcessFramework.pdf](http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/TLAP/Paper4MinimumProcessFramework.pdf)

### Adult Social Care Outcomes Framework (ASCOF)

<http://ascof.hscic.gov.uk/Outcome/703/>

# Appendix A - Suggested hospital discharge process



## Accompanying notes

After an adult is admitted into the hospital, a Section 2 notification is dispatched to the integrated discharge team, and the case is subsequently triaged for complexity and risk. This will trigger a virtual allocation of a team member to the individual's case, based on the unique needs and attributes that the adult may have. During this time, advocacy will be offered to the user and carer, informing them of the resources they have available to them, and providing any assistance that both may require. As the patient is ready to be discharged, a Section 5 notification is sent to the discharge team.

As this is received, the virtually allocated member will then officially begin working on the case, starting with a needs assessment of the adult. At this point, the carer may also request an assessment of his/her needs, and a joint assessment may be performed to consider the case holistically. Early financial advice and signposting to quality information will also be provided to both parties at this point.

Once the needs of both the adult and their carer are assessed, the adult is transferred to the appropriate pathway depending on his/her circumstances and needs. From here, appropriate actions are taken while signposting the carer and adult to information that will allow them to potentially craft a care package that is appropriate for their needs, or to get a better understanding of the services that are available to them. Adults are then discharged from the hospital to reablement, intermediate care (if further time is needed to craft the necessary service package), Continuing HealthCare or directly home. Wherever possible, reablement is offered to the adult in order to improve their independence and to decrease the necessity of complex care packages and carer burden. At this point, both carer and adult needs may be reassessed to determine if a simpler service package will be appropriate.

During this entire process, advocacy that was requested will be available or can be requested at any point. Additionally, IT systems that support information sharing among different members of the discharge team and to other members (such as care brokers) will enable the entire process in addition to tracking case progress and setting checkpoints for review, handovers and reminders to prevent adults from falling through the gaps and preventing DTOCs. It is also key for effective communication to be in place, including regular multi-disciplinary meetings and a collaborative health-social care interface.

## Appendix B - Current hospital discharge process in Greenwich



## Appendix C - Relevant data

### DTOCs in Greenwich 2011-2014

	April	May	June	July	August	September	October	November	December	January	February	March
<b>11/12</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>	<b>11</b>	<b>12</b>	<b>1</b>	<b>2</b>	<b>3</b>
Total Number of delayed discharges	13	16	13	11	16	17	11	6	21	13	13	14
Of which are attributable to social care	4	4	3	5	7	5	3	4	3	2	5	5
ONS MYE 2011	174500	174500	174500	174500	174500	174500	174500	174500	174500	174500	174500	174500
Total Number of delayed discharges per 100,000	7.4	8.3	8.0	7.6	7.9	8.2	7.9	7.4	7.9	7.9	7.8	7.8
Of which are attributable to social care per 100,000	2.3	2.3	2.1	2.3	2.6	2.7	3.0	2.5	2.4	2.3	2.3	2.4
<b>12/13</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>	<b>11</b>	<b>12</b>	<b>1</b>	<b>2</b>	<b>3</b>
Total Number of delayed discharges	10	12	9	8	9	2	3	16	7	10	8	10
Of which are attributable to social care	4	3	2	3	3	0	2	1	1	3	2	3
ONS MYE 2012	174500	174500	174500	174500	174500	174500	174500	174500	174500	174500	174500	194025
Total Number of delayed discharges per 100,000	5.7	6.3	5.9	5.6	5.5	4.8	4.3	4.9	4.8	4.9	4.9	4.5
Of which are attributable to social care per 100,000	2.3	2.0	1.7	1.7	1.7	1.4	1.6	1.3	1.2	1.3	1.3	1.2
<b>13/14</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>	<b>11</b>	<b>12</b>	<b>1</b>	<b>2</b>	<b>3</b>
Total Number of delayed discharges	9	13	15	9	7	15	9	13	12	12	15	17
Of which are attributable to social care	3	4	3	4	3	7	6	5	6	4	2	3
ONS MYE 2013	197550	197550	197550	197550	197550	197550	197550	197550	197550	197550	197550	197550
Total Number of delayed discharges per 100,000	4.6	5.6	6.2	5.8	5.4	5.7	5.6	5.7	5.7	5.8	5.9	6.2
Of which are attributable to social care per 100,000	1.5	1.8	1.7	1.8	1.7	2.0	2.2	2.2	2.3	2.3	2.2	2.1
<b>14/15</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>	<b>11</b>	<b>12</b>	<b>1</b>	<b>2</b>	<b>3</b>
Total Number of delayed discharges	16	19	13	8	10	9						
Of which are attributable to social care	4	2	2	2	1	4						
ONS MYE 2014	197550	197550	197550	197550	197550	197550	197550	197550	197550	197550	197550	197550
Total Number of delayed discharges per 100,000	8.1	8.9	8.1	7.1	6.7	6.3	6.3	6.3	6.3	6.3	6.3	6.3
Of which are attributable to social care per 100,000	2.0	1.5	1.3	1.3	1.1	1.3	1.3	1.3	1.3	1.3	1.3	1.3

### Adult Social Care Outcomes Framework (HSCIC) key statistics

- Greenwich has a higher client satisfaction with care and support than the England average
- Over 75% of carers receiving support received self-directed support
- Over 80% of adults with disabilities received self-directed support
- Over 75% of Carers felt they were involved and consulted during care services development