Havering
LONDON BOROUGH

INDIVIDUALS OVERVIEW AND SCRUTINY SUB-COMMITTEE

Subject Heading:	Process of Discharge from Hospital
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Policy context:	The Community Care (Delayed Discharges) Act 2003

SUMMARY

This report outlines the process used by the Joint Assessment and Discharge (JAD) Team at Queen's and King Georges (part of Barking Havering and Redbridge University Trust) Hospitals to facilitate appropriate and timely discharge from hospital. The report also covers services provided in the community and in Accident and Emergency (A&E) designed to avoid unnecessary admissions.

RECOMMENDATIONS

This report is for information only.

REPORT DETAIL

The successful discharge of individuals following an emergency admission to hospital relies on effective joint working between Health, Social Care partners and the independent sector. Achieving timely and safe discharges from hospital is a key concern for both health and social care as a delay represents a delayed opportunity for an individual to return home.

Background

The Trust was placed in special measures by the CQC in December 2013. The current JAD Service was created on 2 June 2014, and in order ensure a whole-system approach between partners and to maximise weekend discharges, the JAD was designed to operated a 7-day service working a minimum core hours of 0900 – 1700. This ensures the availability of social workers, as well as NHS community services and hospital therapists (particularly where they work across the hospital/community interface) matches any increased focus within an acute trust on weekend discharges.

There was a follow up re-inspection undertaken by CQC in 4 March 2015, looking at the work which has taken place to improve care and services for patients. The JAD has played a key role in the BHRUT Improvement Plan - focusing on improving discharges.

Joint Assessment and Discharge Team

The JAD is formed of staff from Havering and Barking and Dagenham Social Care teams, as well as BHRUT and NELFT health staff, working (and managed) together as one team responsible for all LBH and LBBD hospital discharges that require Social Care services. In addition to this the team are also responsible for facilitating discharges in BHRUT for those patients whose case is funded by the NHS and for all self-funding patients requiring placements into residential or nursing homes following discharge. The team are also required to co-ordinate any concerns that may result in delays in hospital such as equipment delays or those awaiting care support from other Boroughs.

The JAD is a multi-disciplinary team of Social Workers, Nurses and administrative staff. The team is spilt into 5 clusters working alongside other teams such as Mental Health Services, Alcohol Liaison Services, and Housing departments etc. Each Cluster works with a group of wards to ensure consistency in professional relationships. This is further supported as a JAD worker is aligned to each ward and is the main contact for that ward.

Discharge Process

The Community Care (Delayed Discharges) Act 2003 places duties upon the NHS and councils in England to communicate about the discharge of inpatients. This applies, by statute, to acute care only, but the approach represents good practice for community hospital inpatients as well.

The NHS is required to notify councils of any patient's, "…likely need for community care services", and of their proposed discharge date. This is done through "Section 2" (pre-discharge notifications) and "Section 5" (discharge notifications) notifications respectively (named after the sections in the Act). A Section 2 requires an NHS body to notify social services of a patient's likely need for community care services after discharge. The information contained in an assessment notification is intended to be minimal, both to reflect patient confidentiality requirements and to minimize bureaucracy, It is a trigger for assessment and care planning. The Act sets out the requirement for social services care management to assess within 3 days. A Section 5 notifies social services of the proposed date of the patient's discharge. Patients and carers should be informed of the discharge date at the same time as, or before, social services. In addition, as good practice, hospital staff may give social services an early indication of when discharge is likely; to help with planning, but a formal discharge notification must be issued to give confirmation of the intended date. Ensure that the legal requirement of Section 2 and Section 5 notifications from acute trusts to social services to share patient information (and the required response standards) are understood and initiated by ward staff. Seek feedback from social care that Section 2 referrals are appropriate to optimise social workers' time. Embedding care managers with wards encourages a proactive and co-operative approach.

In practice, the JAD workers attend a multi-disciplinary Board each day at 0900 hours to go through all patients on the wards and to plan for discharges where Social Care support is required. It is as this point that JAD involvement commences.

The BHRUT ward staff will send an assessment notification to formally notify Social Care that a patient is in hospital and will possibly require social care intervention to enable a safe discharge. The assessment notification will also provide a predicted discharge date.

On receipt of this assessment notification, the patient's case will be allocated to a JAD worker. It is at this stage that the formal assessment process begins.

The JAD worker will work alongside other members of the multi-disciplinary team as a part of the assessment process engaging with the patient and families and representatives as required. When a patient no longer requires treatment or monitoring in an acute hospital setting a discharge notification will then be sent detailing the actual discharge date for a patient.

This assessment process can be completed within 24 hours or can take days, depending on the varied patient circumstances. For more complex cases a discharge planning meeting is held with the patient and their family members or other representatives, and all professionals involved in their care. On completion of the assessment the appropriate services are set up for the patient and start times for services are agreed. The discharge is confirmed once all services have been arranged and all parties are confident that the discharge will be safe.

JAD also has two Social Workers who work exclusively in the Emergency Department at Queen's hospital to support the Community Treatment Team with admission avoidance. These social workers will set up Social Care services for patients/patients who present to A&E, not requiring hospital admission, but needing Social Care support.

This team also provides support in the shape of information and guidance and signposting to other teams and Local Authorities.

JAD Performance

In hospitals such as Queen's, when compared to national comparators, more people are admitted to hospital than is the case elsewhere which creates an additional pressure on achieving improved discharge rates. It is also recognised that there is a particular challenge for Havering in demographic terms – having a high number of frail older people.

The JAD team's overall aim is to ensure the safe discharge of patients back to their homes in the community. Approximately 90% patients who require Social Care support are discharged back home with appropriate support services, the remaining users are discharged from hospital into 24 hour care setting (residential or nursing care services).

There are a number of ways that a delay to discharge can occur: (a) Health may be responsible for the delay (Health only); (b) Health and Social Care may jointly be responsible for a delay (Shared responsibility); or (c) Social Care may be solely responsible a delay.

The most recent analysis of delayed discharges of care has highlighted that of 1302 delay days (April 2014 – February 2015):

a) Health has been responsible for 823 (Health Only) – 63%
b) There has been an agreed Shared responsibility for 351 – 27%; and
c) Social Care responsible for 128 (Social Care Only) – less than 10%.

The primary reason for Social Care delays is patients awaiting a placement into 24 hour care setting (residential or nursing care) - 83 of the 128 days (64.8%); this is a significant decision at a difficult time for the patient and their families and representatives and will on occasion result in a delay in identifying a care home. Delays are also experienced when patients are waiting for equipment to be installed in their homes.

Performance continues to improve and in the last 3 months Social Care has only been responsible for 5 delayed days. Furthermore, in recent times the JAD has been discharging an increased number patients before the discharge notification date. This ensures a better outcome for the patients as they are not remaining in hospital for longer than is necessary.

Going Forward

The JAD team will continue to work closely with BHRUT and the CCG to ensure that delays to discharges are minimised wherever possible. Senior management will also be carrying out a review of the JAD team following its set up in 2014 to ensure that the correct level of staffing and management is maintained in the service. The review is planned to start in June 2015.

The JAD team has also commenced a comprehensive training programme for its staff following on from a detailed training needs analysis and will be ensuring that staff receive identified training to support them in their roles.

IMPLICATIONS AND RISKS

Financial implications and risks:

A joint Section 75 agreement has been set up for the funding of posts and for the delivery of the JAD service, between B&D, LBH and the health service. The funding arrangements and reporting functions have been agreed and the content of this report does not indicate a change in this position.

Legal implications and risks:

There are no apparent legal implications or risks in noting the content of this report**.**

Human Resources implications and risks:

Any HR implications or risks to the Council, or its workforce, or accommodation issues, are contained, and will be managed, using the normal business and HR frameworks for Havering employees working within the JAD Service. The recommendations in this report do not represent a change in this position.

Equalities implications and risks:

This report has no direct equality implications as it is an information report. However, delayed transfers of care can have significant implications on patients, particularly older and vulnerable people. It is therefore vital that the Council continue to facilitate timely and appropriate discharges from hospital. The Joint Assessment and Discharge Team and Management continue to work with BHRUT to support improved performance in this area. This area of work is important in reducing the health inequalities experienced by people with different protected characteristics, such as older people and people with disabilities.

BACKGROUND PAPERS

No background information papers used.