Havering
LONDON BOROUGH

INDIVIDUALS OVERVIEW AND SCRUTINY COMMITTEE

Subject Heading:	Hospital Discharges update
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Policy context:	**The Communities Vision:** The needs of our most vulnerable residents are identified and met
Financial summary:	No financial Implications

The subject matter of this report deals with the following Council Objectives

Communities making Havering	[x]
Places making Havering	[]
Opportunities making Havering	[]
Connections making Havering	[]

SUMMARY

This report gives an overview of the current discharge processes into key Adult Social Care services, the changes put in place to support flow during the COVID-19 pandemic, the challenges and the plans for future system development.

RECOMMENDATIONS

That members note the information in this report and respond with any queries.

REPORT DETAIL

Background

The London Borough of Havering (LBH) are currently in a section 75 partnership agreement with the London Borough of Barking and Dagenham and BHRUT for the provision of a Joint Assessment and Discharge (JAD) team. In addition to the social workers and nurses involved in supporting discharges there is also the Discharge Coordination Unit (DCU) which is an admin function to record and coordinate all discharges that require Adult Social Care (ASC) support.

Historically, most patients in hospital requiring an ASC service would receive an assessment prior to discharge and the care would be arranged to start upon their return home. It has been a system intention for many years to move away from assessing people whilst they are in an acute setting and undertake the assessment in the community. The COVID-19 pandemic and need for rapid hospital discharge resulted in this being implemented across BHR earlier than planned with only the very complex cases being assessed by ASC prior to discharge.

Operational Detail

There are a number of discharge pathways into a range of community services across health and social care but the key pathways for ASC are homecare, reablement, residential care and nursing care.

The acute therapists assess people requiring homecare and make recommendations regarding the level of care required. Following discharge the individual is then contacted by a member of the JAD team within 48 hours to do a welfare call and ensure the package is meeting their immediate need. The package is then reviewed by a social worker within 6 weeks of the person returning home.

For placements into residential care homes a basic level of assessment is undertaken by the acute therapists whilst the person is in hospital to identify the need for a residential placement. The individual is discharged into an available residential placement and assessed by a social worker within 6 weeks to determine longer term care needs. If residential care is required longer term there is an option to remain in that placement or the individual / family / carer can choose an alternative placement.

Reablement referrals are referred directly from the acute therapists to the provider. An assessment takes place once the person has been discharged, care is normally delivered for between 4 and 6 weeks. If no further care is required at the end of the reablement period the provider discharges the individual from the service, if further care is required this is communicated to the brokerage team who liaise with ASC to ensure an assessment for longer term need is undertaken within one week and then placement will be made with a homecare agency.

Services available upon discharge

LBH have the following services available to support people following a hospital discharge:
Homecare
Reablement
Home Settle and Support
Residential care
Nursing care
Extra Care / Supported living

To support with the increased demand and to manage the infection risks during the pandemic additional services were commissioned:

- The Lodge designated setting for COVID positive residential placements
- The Fountains designated setting for COVID positive nursing Placements
- Tu Vida homecare for COVID positive homecare placements
- Lodge Group homecare – additional homecare for COVID positive homecare placements or overflow of reablement cases when there are capacity issues
- Additional reablement hours with Essex Cares Limited

Changes implemented to support discharge flow

Over the past 12 months, the brokerage team and the JCU have worked in collaboratively with all system partners to revise discharge pathways ensuring there are no unnecessary delays. The LBH brokerage team in particular reviewed all of their pathways and processes and liaised with providers to ensure they could facilitate same day discharges. The system shifted to a 7 day week for discharges which has been supported by the brokerage team working weekends, this has resulted in an increase in the number of people discharged over the weekend preventing the unmanageable referral numbers on a Monday.

Challenges with discharges

Generally the flow of discharges has improved considerably over the COVID period due to collaborative system working. There are still a few challenges which arise regularly, these include:

- Homeless cases and housing issues resulting in delays to discharge
- Equipment delays, particularly at the weekend
- Difficulties contacting ward staff to confirm discharges
- JAD do not always receive a complete and correct dataset at the point of referral which results in delays whilst they try to contact the ward.

A weekly system wide meeting has been established to discuss and resolve issues with discharge pathways, this is a really positive meeting and has improved relationships between system partners. In addition to this, throughout the pandemic period there has been a daily system call to discuss specific discharge delays.

Future plans

The past year has brought many challenges in terms of discharges but it has also provided an opportunity to drive forward system changes to improve discharge flow. Key system developments include:

Discharge Single Point of Access

The discharge guidance issued in September 2020 stipulated that there must be a single coordinator working across all system partners to secure timely discharges on the appropriate pathway. The BHR system response to this was the Hospital Discharge Unit (HDU) managed by North East London Foundation Trust (NELFT) which worked in partnership with the JAD and the DCU to coordinate all discharges. Prior to the pandemic, the BHR system had already committed to developing a discharge single point of access (SPA) across BHR to coordinate all discharge pathways. The development of the HDU was a step towards this and a project is now underway to review all current arrangements and develop the blueprint for the new SPA with a planned mobilisation date of June 2021.

HomeFirst

The HomeFirst principle is that no one should be assessed for any longer term care whilst in an acute setting. Historically judgements have been made on how an individual will manage when they return home based on the outcome of assessments whilst they are in an alien environment that can confusing for them. In addition to improving outcomes for individuals, a HomeFirst approach can also result in reduced hospital length of stay, reduction in ongoing care packages, equipment costs and referrals to community services.

Following a successful phase 1 pilot in 2019, Havering are currently working with the reablement provider and BHRUT to deliver phase 2. The model has demonstrated more efficient discharge processes and will transition into being the default pathway for access into reablement service from March.

Discharge to Assess

The Discharge to Assess (D2A) principle is the same as HomeFirst but locally we use it to describe the discharge pathway for new nursing placements. Although D2A has been operational for a few years across BHR, Havering are currently running a pilot to determine the benefits of aligning therapy support to 3 block commissioned nursing homes.

Once identified as requiring a nursing placement at the point of discharge the individual is discharged into 1 of the commissioned beds (1 of these is currently for COVID positive patients.) If the individual is able to engage in therapy they will receive daily therapy sessions for the duration of the 6 week stay. A multi-disciplinary team decision is made during the 6 weeks to determine if the individual requires on-going nursing care, can step down to residential care or can even return home with a care package.

The initial 2 months have demonstrated that the D2A pathway streamlines discharge processes for new nursing placements reducing length of stay. In addition there have been extremely positive outcomes for individuals with 2 people having already returned to their usual place of residence following their 6 week assessment period in a D2A bed.

IMPLICATIONS AND RISKS

Financial implications and risks:

There are no direct financial implications as a result of the recommendations made in this report.

Legal implications and risks:

There are no apparent legal implications in noting the content of the Report.

Human Resources implications and risks:

The recommendations made in this report do not give rise to any identifiable HR risks or implications that would affect either the Council or its workforce.

Equalities implications and risks:

The Public Sector Equality Duty (PSED) under section 149 of the Equality Act 2010 requires the Council, when exercising its functions, to have 'due regard' to:

(i) The need to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
(ii) The need to advance equality of opportunity between persons who share protected characteristics and those who do not, and;
(iii) Foster good relations between those who have protected characteristics and those who do not.

Note: 'Protected characteristics' are age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex/gender, and sexual orientation.
The Council is committed to all of the above in the provision, procurement and commissioning of its services, and the employment of its workforce. In addition, the Council is also committed to improving the quality of life and wellbeing for all Havering residents in respect of socio-economics and health determinants.