Response to Portsmouth TECS Scrutiny Panel Questions about Discharge

1. What is the standard process for discharging patients from hospital and who is involved?

Good discharge planning commences from the point a patient is admitted into hospital. This is based on the widely accepted understanding that an acute hospital environment is only the best and most appropriate place of care for an individual during the acute phase of their illness and, beyond that point, seldom is.

In Portsmouth Hospitals Trust, firm internal professional standards have been agreed, that patients should have an Expected Date of Discharge (EDD) set by a consultant within 24 hours of their admission. This should be recorded in the patient notes, and tracked through a daily Clinical Management Plan (CMP) on the visual boards system used by every ward. Performance against these standards is regularly audited.

The Expected Date of Discharge is particularly important for two main reasons. Firstly, it serves as a very useful frame of reference for the patient, their families and friends, allowing them to prepare and make necessary arrangements for discharge. Secondly, in guiding the development of the Clinical Management Plan, it allows the ward team to track delays in the process that may impinge on the ability to transfer the patient on the planned date, and to escalate those delays to senior management for resolution.

Generally speaking, discharges fall into two categories.

The 'routine' discharge process applies to around 70% of patients who leave the QA Hospital. Routine discharges relate to patients whose needs upon transfer out of the hospital do not extend beyond issues such as co-ordination of 'to take out' drugs (TTOs), booking of transport, or a re-start of a relatively low level package of care at home. The Trust uses a Discharge Checklist, which ensures that all necessary tasks have been undertaken.

The process of routine discharge is led entirely from ward level, by the nurses who have established relationships with the patient and their relatives, and who are best placed to co-ordinate the transfer of their care.

The 'complex' discharge process applies to the remaining 30% of patients. The complexity may stem from:

- The sheer volume of arrangements that need to be made for discharge (e.g. referrals for and coordination of health and social care assessments, family liaison, minor adaptations to the living environment, transport requirements), or from
- The clinical complexity of the case (e.g. complex or contested assessments, new residential placements, complicated family dynamics, major adaptations to the living environment, mental health and/or capacity considerations)

While such discharges will still be owned by the ward team who care for and know the patient, extensive support in co-ordinating discharge is provided by the Integrated Discharge Bureau (IDB).

Truly complex discharges can require the input of doctors, nurses, physiotherapists, occupational therapists, social workers, NHS continuing healthcare assessors, mental health professionals, residential home managers, advocates, several family members, and so on. The resultant potential for delay is therefore significant.

The IDB function was therefore introduced in December 2009, and is working to support busy ward staff, and streamline processes across agencies to minimise delays. This virtual team comprises the Senior Nurse for Discharge Services, Hospital Social Care Team managers from Portsmouth and Hampshire, and senior colleagues from NHS therapy and community healthcare teams. Working together, they prioritise their resources to ensure as seamless and timely a process as possible for patients whose discharge is likely to be complex.

On the day of discharge, the Portsmouth Hospitals Discharge Unit is available to take patients from early in the day. It offers a comfortable, modern environment for patients prior to leaving hospital. The transport booking function, and ambulance collection point, are collocated within the Discharge Unit.

2. What obstacles to the smooth running of this process have been identified?

Obstacles to the smooth running of this process can be multiple, but include:

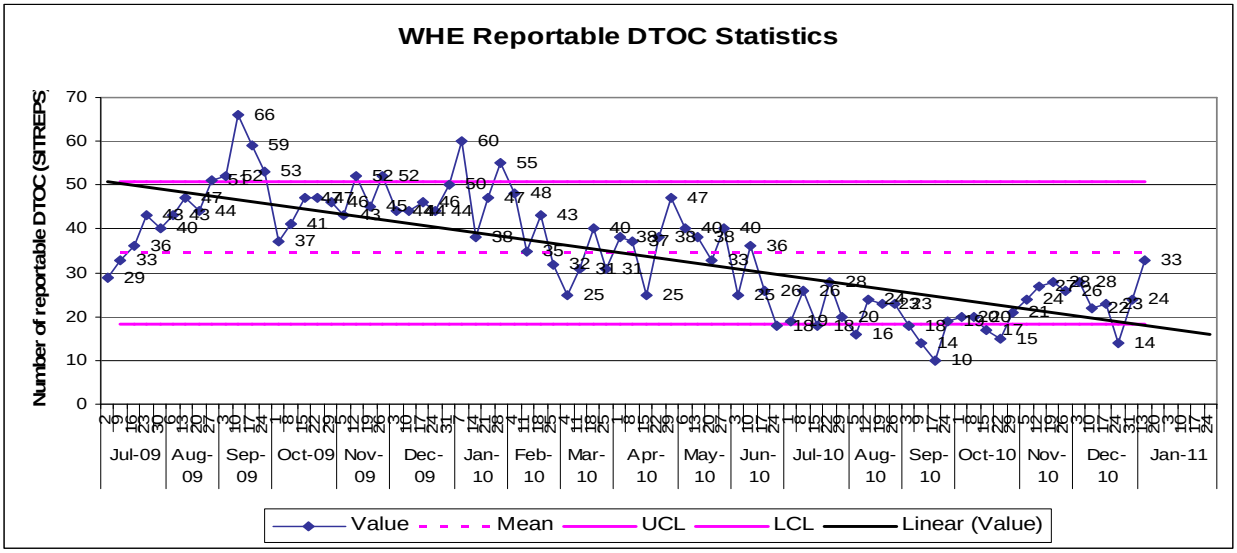
- Multiple and sequential referrals, information gathering and assessment, resulting in blurred lines of communication and occasional duplication / professional disagreements in planning
- Insufficient funded community capacity to routinely perform assessments for long-term packages of care (social care and NHS continuing health care) outside of the acute hospital setting
- Weaknesses in mechanisms to ensure continuous (7-day) pull of appropriate patients from the acute hospital into funded community capacity (e.g. intermediate care teams, GP beds etc.)
- Financial issues related to funding of preferred residential placements, often involving additional liability for costs that would accrue to patients and their families (top-up)
- Extent of influence in timely assessment and acceptance of patients by registered managers of independent residential homes
- Inability to make and sustain contact with, and engagement from, families in the discharge planning process
- ‘Outlying’ of patients within the acute hospital (moving medically stable patients to other wards) when the hospital is under operational pressure, which can disrupt the continuity of discharge planning

3. How many patients are in hospital when they should have been discharged?

The official delayed transfer of care figures are reported monthly to the Department of Health. In these returns, the local health economy reports the number of patients who are officially delayed in their transfer, according to the definitions set down in the Community Care (Delayed Discharges etc) Act 2003. The Act places a very tight set of criteria around the ability to report of a patient as a delay, comprising:

- Agreement from the entire multidisciplinary team (MDT) that the patient is ready for discharge before assessment referrals can be made
- A ‘reasonableness’ allowance of 48 hours for professionals to respond to referrals for discharge assessment

This means that the reportable delayed transfer of care figure is significantly lower than the total number of medically stable patients in the system that would be safe and appropriate for discharge with the right arrangements in place. The chart below shows the number of reportable delayed transfers of care.



Every day, the Integrated Discharge Bureau works with matrons from across the hospital to update the list of all patients who are medically stable to be discharged from hospital. This list invariably comprises around 120 patients (around 10% of bed stock). Of those patients, it is estimated from recent records that:

- Around 25% are new additions to the list, i.e. have been designated medically stable at the last senior medical review (sometimes as recently as that morning)
- Around 25% are awaiting transfer into an NHS rehabilitation or reablement environment (e.g. inpatient rehabilitation or GP beds)
- Around 50% are ongoing delayed transfers, both simple and complex

4. What is the cost of delayed discharges from hospital, to the NHS and to the Local Authority?

Acute Hospital

Portsmouth Hospitals is predominantly paid for the care it provides in line with the National Tariff (Payment by Results). This provides a single amount of income for an inpatient stay, irrespective of the duration, but within a defined upper limit or 'trim point'. As the lengths of stay for the majority of patients are within trim point, bed days that result from delayed transfer of care will incur additional costs with no corresponding income to the Trust.

The average cost of a hospital bed day is £250. With a conservative assumption of 50 patients in the system at any one time that are medically stable for discharge, the total annual cost to the hospital resulting delayed transfers of care would be in the region of £5 million.

Primary Care Trusts

Where a delayed transfer of care results in a length of stay that exceeds trim point, the Primary Care Trust commissioners make an extra payment to the hospital at an 'Excess Bed Day' rate for the component of the inpatient stay that falls beyond the limit.

Social Care

For reportable delayed transfers of care that can be assigned to social care delays, the Hospital Trust is entitled to make a cross charge of £100 per bed day to the local authority. The number of reportable delays that, under the legislation, can be apportioned to social care is now low, and Portsmouth Hospitals has recently ceased the practice of making this cross charge.

Patients

The cost of delayed transfers of care, however, is most significant for the patients that are disadvantaged as a result. There is significant national evidence to show the huge impact of in-hospital 'decompensation', (physical, social and cognitive decline), that results from extended lengths of stay in the inpatient environment. This decompensation is particularly heightened in vulnerable groups, such as frail older people.

The impact of such decompensation is often increased dependence, and higher levels of future admission to hospital.

5. How can the discharge process be improved?

Portsmouth Hospitals has been working closely with partner agencies to improve the discharge process, resulting in a number of improvements (such as the introduction of the Integrated Discharge Bureau), and a forward plan to maintain and accelerate this momentum.

Current plans include:

- Introduction of complexity screen at the point of entry to hospital (Emergency Department / Medical Assessment Unit), allowing patients whose discharge is likely to be complex to be identified and case managed from the very start of their hospital stay
- Agreement of a single, inter-agency Hospital Discharge Policy, aligned closely with outcome measures for quality of care and patient experience
- Design of streamlined processes for inter-professional referrals, with the aim of creating a shorter discharge pathway that appears seamless to the patient
- Introduction of a 'Patient Target List' for long stay patients / delayed transfers, allowing greater visibility and tighter management of extended stays

6. What can the TECS scrutiny panel do to help improve the discharge of patients from QA and St James' Hospitals?

The support and critical oversight of the TECS as the discharge pathway is further developed would be very welcome.