HEALTH & WELL-BEING SCRUTINY COMMITTEE

REHABILITATION AND EARLY SUPPORTED DISCHARGE

DRAFT FINAL REPORT

Foreword

Together with my colleagues from the Health & Well-Being Scrutiny Committee we have spent the last few months investigating how health and social care services are working together to support timely and smooth discharges from hospital and support independence in the community.

One of the primary aims for the council and its health partners is to help the residents of Sunderland to have long, healthy, fulfilling lives for as long as possible. Many people may need a stay in hospital at some stage of their lives, and we know that health and social care staff do their utmost to support each individual to rehabilitate. We have heard examples of a lot of good practice around smooth transitions of care and it is clear that all partners aim for a genuinely shared vision of the model that will actively promote smooth transitions. Unfortunately this is not always achieved. All too often the patients with complex post-hospital needs are delayed in hospital after they are clinically fit to leave and then once discharged, many find themselves having to be re-admitted.

We know that there are many reasons for this. The Scrutiny Committee I chair cannot hope to solve all of these complex problems with a review. Many experts have been trying to solve the problems for many years. But what we can do through this review is to make recommendations for improvement and to highlight policy gaps where efforts can be better focused. I hope this will go some way towards helping to improve services.

Our aim with this review has been to review the policies and strategies and to take evidence on the practical application of the policies to determine if they are fit for purpose. The users' experience defines the effectiveness of the policies and our evidence has focused heavily on service user experience.

I am confident the findings and recommendations in our report will go some way to achieve the aims of supporting better services.

Mention needs to be made of the contribution of the health and social care workforce to achieving these objectives. This large group of dedicated staff work exceptionally hard for the people that they care for, often under difficult circumstances.

We would like to thank all of the witnesses who provided evidence to the review. Members would particularly like to thank the co-opted members of the Committee representing Sunderland Link, Age UK, and the Carers Centre and the staff at Sunderland Link who gathered patient evidence to allow their views and experiences to be reported.

Councillor Peter Walker
Chair, Health & Well-Being Scrutiny Committee

1. Introduction

1.1 On 8th June 2011 the Scrutiny Committee agreed to pursue a review of Rehabilitation and Early Supported Discharge. This report sets out the evidence gathering, findings and conclusions from that review.

2. Aim of the Review

To establish how effectively health and social care services are working in partnership to support timely discharges from hospital and promote independence in community settings.

3. Terms of Reference

3.1 The Committee agreed the following terms of reference:

1. To identify the factors which cause delays in discharging people from hospital.

2. To assess the community-based health, social care and support available after hospitalisation including intermediate care, reablement and other rehabilitation pathways and the expectations put on families and carer support.

3. To make recommendations to appropriate commissioners to consider how any gaps or perceived gaps in service provision can be addressed.

4. Membership of the Scrutiny Committee

4.1 Members of the Committee during 2011/12 :

Councillors Peter Walker (Chair), Christine Shattock (Vice-Chair), Jill Fletcher, Bob Francis, Anne Hall, Paul Maddison, Fiona Miller, Neville Padgett, Dianne Snowdon, Debra Waller, Norma Wright and co-opted members John Dean, Ralph Price, Victoria Brown and Eihblin Inglesby.

5. Methods of Investigation

5.1 The Committee engaged partners, stakeholders and service users as participants, observers and witnesses. This included Health, Housing and Adult Services Directorate, NHS Trusts, independent sector, voluntary sector providers, service users and their carers.

5.2 Evidence was included in scheduled Scrutiny Committee meetings held on 6th September and 19th October. Evidence gathering took place at two intensive sessions held on 23rd November 2011 and 12th January 2012. A stakeholder event was held on 29th February 2012 with 90 invited representatives from commissioners, providers and service users.

5.3 The Committee co-opted representatives onto the Health & Well-Being Scrutiny Committee for this time-limited project. Organisations represented were Links, Carers Centre, and Age UK.

5.4 The Scrutiny Committee has also considered information contained in national guidance, research and best practice.

6. Setting the Scene

6.1 At a meeting on 6th September 2011 the Committee received detailed service information to set the scene for its investigation of services in support of the rehabilitation and early supported discharge from hospital. The Committee was informed that City Hospitals Sunderland and Northumberland, Tyne and Wear NHS Foundation Trusts, working with multi-agency partners have developed 'Hospital transfer and discharge' policies. Key principles for discharge planning set out in policies include:

- Discharge planning will commence prior to or on admission following a holistic assessment of needs and an individualised discharge care plan will be formulated.
- For acute hospital admissions, every patient will have a clear documented clinical management plan within 24 hours of admission which will be reviewed daily.
- For mental health admissions, a full MDT meeting will take place within 7 days (or earlier if appropriate) and care plan developed.
- For acute admissions, ongoing discharge needs will be clearly identified as either simple or complex for acute patients and the appropriate action taken.
- For mental health admissions, the service user's needs for immediate discharge and also successful reintegration into the community are considered and the care plan will make reference to support in the first week and subsequent 3 months.
- For acute admissions, an expected date of discharge will be identified within 24 hours of admission for simple discharges and 48 hours for complex discharges and reviewed on a daily basis.
- For mental health admissions, planning for discharge will take place at every review.
- Ward staff will have ownership for individual patient transfer and discharge arrangements.
- All patients and carers will be at the centre of the discharge process and will receive a copy of the discharge checklist or discharge care plan as appropriate.
- For acute admissions, primary and community care professionals will be invited to attend a case conference prior to discharge for those patients who have complex needs.
- For mental health admissions, there will be a care coordination review prior to discharge and primary, community and other relevant external agencies will be invited to attend, to review the service user's needs including assessment of risk and formulate a discharge plan.
- Identified equipment will be provided prior to discharge.

6.2 Services to support discharge were described to the Committee including intermediate care, reablement, rehabilitation, personalisation, use of personal budgets, and support for carers.

6.3 The definition and recording of delayed discharges was described and members were informed that much work has been undertaken both regionally

and nationally to understand the features of delays and consider the improvements required in discharge planning processes.

6.4 The SHA have also identified a number of factors that they believe may provide optimism towards joint working to address the challenges behind delays in discharge, which are:

- The significant productivity challenges that both the NHS and local authorities face throughout the current comprehensive spending review period and beyond which are creating a burning platform for working differently.
- The direction of health and social care reforms including the transfer of public health responsibilities from PCTs to local authorities and the introduction of health and well being boards, which are giving a far greater role for local authorities in health and healthcare.
- The impact of reablement and other social care funding which is flowing through the NHS to local authorities in a significant way from 2011/12 onwards.
- The very strong emphasis on integration that has come through in PCT cluster integrated plans and emerging clinical commissioning group pathfinder plans.

7. Findings of the Health & Well-Being Scrutiny Committee

Discharge and Transfer of Care Policies

7.1 Discharge and transfer of care policies are in place to manage the discharge and post-discharge process and to establish consistency and good practice. The aims of this review included reviewing these policies and taking evidence on the practical application of them in determining if they are fit for purpose. The users' experience defines the effectiveness of the policies and our evidence focuses heavily on service user experience. The best test of such complex services is whether they work well together from the point of view of the person receiving them, and whether they provide care and support in the most effective and efficient means possible.

7.2 The discharge policies aim for a whole system approach intended to put the patient or service user at the centre of the service provision. Delayed transfers of care can be a symptom of problems in the way the whole system of health and social care operates. The system incorporates a mixture of organisations, people, professions, and services which have patients and service users as their unifying concern and deliver a range of services in a variety of settings to provide the right care, in the right place, at the right time. This is also the nature of the complexity around transfers of care.

7.3 At the outset of the review it was clear that all partners aimed for a genuinely shared vision of the model of services that can actively promote the smooth transition of care. Although there is 'sign-up' to integration, separate commissioning budgets for health, social care, housing and other services tends to entrench a fragmentation of services. Responsibilities lie across several different organisations, from Primary Care Trusts, to local authorities and, through personalisation, with individual service users.

7.4 It was evident to the Committee that positive work has been undertaken across the health and social care sectors to identify and resolve delays across the health and social care system; both at an operational and strategic

level. However success relies on teams of people, not on strategies. All individuals within the system need to be given the chance to be self-critical to evaluate and improve their own role in the whole system. We heard that communication can be poor both between professionals and with patients, families and carers. The volume of cases in the system leads to pressures on one team to move the 'problem' on to the next service and patients and service users complain they are dealing with too many different people.

7.5 All partners are aware that there are areas of improvement still to be implemented to avoid delayed discharges and unnecessary re-admissions particularly when this affects the most vulnerable and frail people who get caught up in the complex issues involved. Improvement works were underway as we conducted this review and our proposals are intended to be complementary to the planned improvements.

7.6 A fully integrated system of care, support, health, housing and other services is essential, not just to provide high quality support for individuals, carers and families, but also to provide good value.

7.7 The aim of establishing such an integrated system has long been an objective through successive government policies. Fragmentation in the system is both difficult to use and expensive to provide, and funding (which comes from a multiplicity of sources, including local and national government spending programmes as well as private sources) is coming under increasing pressure from the numbers of people using the services. The quality of services delivered and the outcomes achieved are highly variable.

Case Study - Torbay Integrated Care Project

An integrated care project for older people looking at delivering services closer to home. The outcomes have successfully avoided the need for many hospital admissions through health and social care services working closely together. The results include:

- The average length of stay in hospital is low, they have few delayed discharges and there is rapid access to equipment and services that keep people out of hospital.
- A reduction in the average number of daily occupied hospital beds used from 750 in 1998/90 to 528 in 2008/09.
- For people aged 85 and over, Torbay uses only 47% of bed days for people experiencing two or more emergency hospital admissions compared with similar areas.
- Torbay is one of the best performing areas in England in the use of hospital beds and day surgery according to independent analysis conducted by the NHS Institute for Innovation and Improvement.

The importance of these results is that they provide hard evidence of the benefits of integrated care. This has been achieved in an area in which there is a much higher proportion of people aged 65 and over than in England as a whole. By bringing health and social care together, pooling budgets, and setting up integrated teams of front line staff, it has been possible to reduce the use of hospital beds and provide more services to people in their own homes.

The experiences of Torbay suggest that the cause of integrating services around the individual can be best served by integrated funding streams and integrating commissioning.

7.8 The Committee has concentrated on reviewing the policy framework rather than the precise institutional framework and we would be wary of recommending a single structural solution. A more ambitious approach is required than we are able to propose through this review. We have tried to avoid over-prescription, with an emphasis instead on developing performance

and outcome frameworks that create incentives to a more integrated approach.

Avoiding Admissions

7.9 There has been a longstanding ambition across the health sector to manage demand and reduce unplanned as well as planned hospital admissions. NHS trusts are doing all they can to reduce the pressures on A&E resources, including ensuring that patients use existing alternatives to A&E.

7.10 It is clear that tackling delayed transfers needs to begin with bringing about a reduction in the demand for admissions to hospital. Once a patient accesses A&E there is a likelihood they will be admitted as an inpatient. There are many reasons why people access A&E rather than alternative services. These may include:

- Limited awareness of alternative services;
- Limited availability of services out of hours and at weekends;
- Attitudes of families and carers who see hospital as the safest option;
- Poor self-management of conditions;
- Weak case management in mental health.

7.11 Most A&E referrals are self-referrals, but others are by GPs. Generally, experienced GPs make fewer referrals than inexperienced GPs and there are higher numbers of GP admissions to hospital from deputising services. There are occasions when the GP has not seen the patient and may be making a 'social admission' rather than a clinical one. Also, if someone can't get a GP appointment when they want they will go to A&E.

7.12 The capacity to provide care on a 24/7 basis is an important factor in extending the possibility of independent living, reducing hospital admissions, and further reducing admissions to care homes when people are frail or ill. For example, the Urgent Care Team comprising a team of nurses works over 24 hours 7 days a week as a community based resource to prevent unnecessary admissions. The team picks up the most vulnerable cases and this is a good resource for keeping people out of hospital but the Committee noted there seemed to be fairly low awareness of the service.

7.13 Out-of-hours services in Sunderland which provide people with an increased and more varied range of support options to people have been reviewed by the Scrutiny Committee over a number of years and aspects of the range of provision such as Telecare have been highly commended. It is also hoped that the roll out of the 111 service as the 'Single Point of Access' which will be live by September 2012 for NHS South of Tyne and Wear will make an impact on the use of emergency services.

7.14 One of the main causes for admission of patients aged 70 or over includes the treating of preventable injuries like falls which can have a considerable impact on the lives of older people, some of whom may never regain independence again. Too many people are being admitted to hospital from entirely preventable causes. The NHS spends £600 million on treating injuries from falls and other preventable accidents at home. The prevention and management of falls is part of the government's public health strategy and one of its targets is to reduce the rate of accidents among older people that require medical attention by at least a fifth. Multidisciplinary collaboration

can reduce the number of falls considerably. During evidence gathering Members asked questions about how services work together to keep people safe, reduce the risk of harm and avoid hospital admission. In the Committee's view the risks of preventable injury for older people further emphasises the need to create a support system, which balances the expenditure on services for older people across the whole NHS, social care, housing and welfare.

7.15 Where a patient is readmitted to hospital following a recent discharge the re-admittance will take place for very good clinical reasons. However, reducing readmission rates to the lowest possible level ensures patients are getting the right treatment, both in and outside hospital after their initial discharge. In Sunderland readmissions during 2010/11 reduced to 6.1%, significantly lower than the hospitals peer group, which reported 7.0%.

7.16 The Health and Social Care Bill places the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy at the heart of joint working between health and social care, alongside the new duties to promote joint working. The Government has stated that through these joint strategic initiatives it will 'identify and remove barriers to collaboration and to pooling or alignment of budgets across health and social care'. Priorities in the Sunderland needs assessment include preventing hospital admissions and care closer to home. The aim is to better target advice, information and practical support and interventions at specific individuals, including at a more preventative stage which should gradually tend to reduce the major causes of admission to hospital.

7.17 Locally, it is the intention that the soon to be established Health & Wellbeing Board and the concentration on public health responsibilities will help to bring about faster improvements in public health which should in time contribute to reducing the need for admissions to hospital. The Health Board would seem to represent an obvious starting point for a radically strengthened commitment to integrated health and social care commissioning.

7.18 The development of the Sunderland Clinical Commissioning Group will have an important role in identifying and standardising best practice and promoting the engagement of GPs to assist in keeping people in their own homes. In the Committee's view real progress towards integrated care must begin with a clear commitment to create a fully integrated approach to commissioning and this integration could take place around the clinical commissioning group.

7.19 Analysis of research evidence has identified that some interventions being used in the NHS, although designed to avoid admissions, do not work. At ths same time, there is evidence to support greater use of such interventions as self-management of some conditions, senior clinician review in A&E, hospital at home, assertive case management in mental health, and structured discharge planning. Evidence should be used to assess programmes having little or no effect as preventative measures with the de-commissioning of those programmes where there is evidence of little impact.

7.20 In order to successfully reduce avoidable emergency admissions, there needs to be clarity around which types of admissions are potentially avoidable and which interventions are likely to be effective for particular populations.

Planning for Discharge

7.21 Department of Health Best Practice Guidance is clear that discharge planning should be initiated as soon as – or even before – the patient is admitted. Discharge or transfer planning needs to start early to anticipate problems, put appropriate support in place and agree an expected discharge date. Ideally an expected date for discharge should be set within 24-48 hours of admission, and discussed with the patient and carer.

7.22 In Sunderland, approximately 20% of discharges are categorised as complex and require planning and coordination by a multi-disciplinary team. This team often spans not only a range of professionals but also a number of different organisations, which adds an additional layer of complexity to the process.

7.23 The Committee heard evidence that there had previously been a scatter gun approach to referrals in relation to preparation for patient discharge. Patients had not been central to discharge planning and appropriate exit routes were not clearly identified. This fragmentation led to health and social care staff spending unnecessary time gathering, clarifying and processing information and awaiting responses. This contributed to delayed discharges and a poor experience for some patients.

7.24 'Ward Pow Wows' were introduced with the aim of ensuring that the patient is at the centre of a more streamlined, proactive approach to discharge planning. Basically, this takes the form of a daily, structured meeting of health and social care professionals. They have initially been concentrated on the busiest wards including dementia and stroke wards. Measures of success are: reductions in inappropriate referrals; reductions in length of stay, and fewer delayed discharges.

7.25 It seemed clear that with the introduction of Pow Wows the discharge process had been improved and it was anticipated that this communication mechanism could be built on. However, evidence was reported to Committee that referrals can be made with staff under pressure to release beds and moving the patient on to keep the flow of bed management rather than patient-centred care. Also, there was still not a consistency of approach with variable standards reported from service users.

7.26 Pow Wows had been running for about a year and the Committee proposes that this may be an opportune time to review the ward-based discussion groups, particularly with the establishment of the Single Point of Access, this will promote multi-disciplinary consultation and more appropriate use of step-down care in a way that supports the individual patient.

7.27 Patients admitted to hospital and requiring a formal assessment will be allocated to the hospital-based social care team. The team receives 3,500 referrals a year which amounts to 40% of all adult social care assessments. Capacity in the team means that no social worker has more than 20 cases. However, the team often has a very short window to plan a care package and if the patient's condition changes the process will need to start again.

7.28 The Committee heard there is often a very limited time to carry out a patient assessment, and that this may reduce the adequacy of the assessment. Evidence was provided that the time available for assessments may limit successful outcomes which avoid re-admission. Witnesses reported that

assessment was based on the presenting health problem, and excluded any underlying health issues. Planning for hospital discharge is part of an ongoing process that should start prior to admission for planned admissions, and as soon as possible for all other admissions. This involves building on, or adding to, any assessments undertaken prior to admission. Implementation of the assessment process needs to take account of this critical issue.

7.29 The assessment for, and delivery of, continuing health and social care should allow patients to understand the continuum of health and social care services, and enable them to make informed decisions about their future care. The Committee was informed that, in the view of service users, the criteria is not fit for purpose and favours cases at the extreme end of care which are, in a sense, easier to define and plan for. Evidence was provided from a carer who reported that a patient with multiple health problems did not meet the criteria despite having repeated admissions to hospital.

7.30 The Committee is aware that support for independent living has delivered choice and control for many, when compared with receiving care in a residential home or long-stay hospital. However, when re-organising support to further restrict the number of care home admissions, adequate alternatives need to be provided otherwise there is a risk of people's health and wellbeing deteriorating if they do not qualify for support.

Alfred's story

Alfred is hospitalised on a regular basis with a number of health problems including chest, water and other infections. He experiences short stays but can be admitted several times in short periods.

Alfred was admitted to hospital with a urine infection on a Friday. After treatment he was discharged on a Sunday night. As he was due to be admitted at 8.30 am the next morning for a planned procedure. Alfred's wife asked if he could not be kept in overnight to avoid the upheaval of getting him home and settled only to have to get him up early the next day.

On another occasion Alfred was being discharged but his wife thought he was not well enough to come home. One of his medical conditions is Diabetes and the carer thought that he was displaying signs of a diabetic episode. She challenged the doctor who was discharging him, but he insisted that Alfred was well enough to go home. He has difficulty walking and uses an electric wheelchair. As they were coming along the corridor she noticed that Alfred was swerving and he eventually collided into the wall. Concerned that he was going to go into a diabetic coma she took him to the nearest ward and explained to the staff there what had happened where she was told to take him straight back to the ward he had come from where Alfred was readmitted. It took a couple of days to bring his sugar levels down to normal.

7.31 There are challenges for social care teams in implementing care packages, particularly at holiday times and also at weekends. For example there is a huge demand for care packages just before Christmas. Patients can find themselves having to wait until the care provider can re-start the package. With the emergence of self-directed support patients admitted to hospital with a pre-existing care package may find them more difficult to have them re-started in future. The Committee also heard evidence that there can be communication gaps between the medical social worker and community social work team.

7.32 Views were expressed by families and carers that in their view patients are sometimes discharged too soon. The pressure to discharge/transfer patients and release beds, and a trend to shorter lengths of stay means that assessment and discharge planning, by necessity, is concentrated into a shorter time scale. Effective and efficient discharge practices are necessary to ensure that premature discharge is avoided and an increase in re-admissions prevented. Evidence was received that often the patient themselves believes they can go home, and feels they are safe but the support levels can be extensive for the family. In these cases re-admission can be caused by carer breakdown. Additionally, it was evident that funding a care package too early before full recovery is known will push more patients into having less choice on how their services are provided and they may face a higher risk of premature admission to care homes.

7.33 Premature discharge typically leaves the patient with some unmet needs and poorly prepared for living at home. Carers have reported that inappropriate assumptions are made about their ability to cope. Preparation to ensure medicines compliance, chronic disease management and the provision of, and ability to use, equipment are some aspects of helping the individual prepare for life outside of hospital that require sufficient time and attention.

7.34 As part of on-going improvement work discharge training has started for all disciplines within the hospital starting with nursing staff. A discharge 'issues' form highlights issues and complaints from patients and patterns emerge which can be identified and learned from, for example, balancing the needs of the patient and the carer can be complex.

7.35 Rather than making the decision on future care needs while someone is in hospital, more step-down assessment outside of the hospital would ideally give more time for recovery so that appropriate decisions can be taken. In many complex cases enhanced assessment will be needed. Where there is doubt about the patient's ability to cope after discharge, the ideal would be to transfer the patient to another setting which enables enhanced assessment to take place. This advanced care planning would allow patients to be involved in planning their own future.

Delayed Discharge

7.36 A delayed transfer of care is experienced by a hospital inpatient when they are ready to transfer to the next stage of care, but this is prevented by one or more reasons. It is frustrating when patients cannot leave hospital because they are waiting for something such as the completion of an assessment, a care package, or community equipment.

7.37 The numbers of delayed discharges locally are set out in the tables below:

City Hospitals Sunderland NHS Foundation Trust		
2010/11	All Discharges	
	57735	
Northumberland, Tyne & Wear NHS Foundation Trust		
2010/11	All Discharges	Sunderland TPCT Discharge
	644	540
Approximately 80% of discharges per annum are for adult mental health		

7.38 The Department of Health requires NHS Trusts and Councils to record and report reasons for delayed discharges under ten headings.

Delayed Discharges – August 2010 – September 2011	Sunderland		NE Region	
	NHS Related	LA Related	NHS Related	LA Related
Completion of assessment	32%	25%	6%	13%
Awaiting housing	26%		6%	
Patient or family choice	13%	4%	13%	11%
Further non acute NHS care (including intermediate care, rehabilitation etc	9%		56%	
Community equipment / adaptations	7%	9%	2%	2%
Disputes	5%	1%	2%	3%
Awaiting residential care home placement	4%	12%	4%	29%
Care package in own home	3%	25%	2%	19%
Awaiting nursing home placement	1%	9%	6%	10%
Public Funding		15%	3%	13%

7.39 The highest categories contributing to delays include awaiting an assessment, care package in own home and awaiting suitable housing.

7.40 Delayed transfers of care can be a symptom of problems in the way the whole system of health and social care operates. There is a need for partner organisations to develop genuinely shared visions of the model of services that can actively prevent delays including a focus on key parts of the whole system, particularly services that might prevent admission to hospital.

Whole System Approach

7.41 It is increasingly evident that effective hospital discharges can only be achieved when there is good joint working between the NHS, local authorities, housing organisations, primary care and the independent and voluntary sectors in the commissioning and delivery of services including a clear understanding of respective services. Without this the diverse needs of local communities and individuals cannot be met.

7.42 For example, the Committee heard that the voluntary sector provides a valuable contribution in managing capacity within a whole system and often 'fill the gaps' both at the point of discharge and when they have returned home. Low level interventions can be provided by the voluntary sector to contribute to greater independence for vulnerable older people. Such examples include the provision of new slippers to prevent falls, loans of care equipment and proactive support for carers.

7.43 Age UK Sunderland provides a Hospital Discharge Service for patients without a care package or family support. Patients receive assessments from the Age UK team in the discharge lounge and receive referrals from staff on the wards as well as linking with the hospital reablement team. The Age UK service is gaining an increasing number of referrals on a daily basis. Positive relationships have been built up with hospital ward staff. Coordinators and staff are at full capacity on most days. The service could expand but to do so would require more staff hours to meet the extra demand.

7.44 There is certainly scope for promoting additional services and support networks to patients, including services from the voluntary sector. There are still gaps that people without an assessment fall through. For example, we heard that there are gaps in staff on the wards identifying patients who could benefit from referral. Patients in the discharge lounge are 'in the system' but others slip through who may be discharged directly from the ward.

7.45 Other patients who will benefit from interventions from other sectors include people living in temporary or insecure accommodation who may have difficulty accessing primary care, which means that they do not seek treatment until their problem is at an advanced stage. Once admitted, they can present a complex medical and social picture. Patients at risk of homelessness, and in particular rough sleepers or those with a chaotic lifestyle – have poorer health than the rest of the community.

7.46 Older people are the principal 'customers' of Housing Associations with something like half of all housing association tenancies held by people who are 60 or over. The NHS, social care and social housing are most frequently used by older people, and these older people often have several needs at the same time; a need for NHS care from their GP and a specialist for a long-term condition like diabetes, a need for help with washing, dressing or getting around that is often provided by the council, and a need for housing. The Committee heard that in Sunderland 60% of patients with heart conditions live in Gentoo properties. The evidence is therefore clear that many older people, people with disabilities and people with long-term conditions need to access different health, social care, housing and other services, often simultaneously and this requires partners *working together differently*. Unfortunately the evidence is also clear that these services can be fragmented, and those who need to rely on them often find that they are hard to access and that there are inadequate links between them.

7.47 It is clear that the independent sector can bring specific skills to partnerships with the NHS, enabling innovation, investment and transformation in integrated care services. Building capacity and partnership in care requires a strategic, inclusive and consistent approach to capacity planning. The Committee heard views that there was scope for the independent and voluntary sectors to be further involved in constructive co-operation with health and social care in providing care and support for adults.

Case Study - Havebury Housing Partnership,

Havebury has come to an arrangement with a local hospital about discharge. They provide a flat, at a cost of £150 a week, which stops someone potentially having to stay in hospital while the discharge programme is properly set in place, at a cost of £2,800 a week. There is research evidence of the value of having a warm and secure home, in terms of reducing demand on the health service and about the impact of supporting people through this type of partnership agreement, for example: £1.6 billion generating £3.4 billion of savings and many of those savings are in health.

7.48 Evidence shows that discharge policies benefit from joint working agreements, with the voluntary sector (and for example those working with the homeless, people in prison and asylum seekers). Successful joint working often benefits from jointly owned protocols, including with the voluntary

sector, for assessment, referral, monitoring and review of services in all sectors. Joint working can be improved by :

- Making available information about who does what in the organisation, whom to contact for different purposes etc co-locating staff;
- Sharing training strategies and programmes;
- Staff spending time "shadowing" partners in other sectors or short-term secondments;
- Using the independent sector in formal monitoring mechanisms;
- Sharing records.

7.49 To make best use of the resources of all providers, tailored to the needs of particular communities, locality specific information gathering will be required to jointly commission what is needed in those localities. This will allow the right services to be commissioned in each area of the city.

Information on discharge

7.50 It is the responsibility of the referrer to ensure any previous assessment and care planning information accompanies the individual, or is transferred as soon as possible.

7.51 Transitions between care settings and services are significant points at which patients are particularly vulnerable to loss of continuity. A recent report from the Health Foundation concludes that 'poor communication, particularly during handover from one team to another, and during discharge from hospital, is the commonest cause of poor quality care'.

7.52 Patients are aware of the importance of information in continuity of care and expect GPs to know about their hospital treatment, and to have the results of investigations. They dislike having to repeat their story to different clinicians. When the processes between professionals are working smoothly they are generally invisible to the patient however it becomes apparent when co-ordination breaks down and impacts negatively on the patient's experience of care.

7.53 GPs themselves are frustrated by poor communication. A nationwide survey of GP practices carried out by the NHS Alliance in 2010 found that more than half of practices surveyed (124 practices) have seen patient safety put at risk because of poor discharge information; 7 out of 10 doctors say they have experienced instances where the clinical care of patients has been compromised because discharge information was late, incomplete or both, and when asked about the past three years 9 out of 10 say clinical care has been compromised.

7.54 In Sunderland it is generally agreed that there have been improvements in sharing information in the last few years following the introduction of new standards introduced by the Department of Health in 2008 which required hospitals to provide discharge information to GPs within 48 hours of the patient's discharge. Evidence was provided of good practice in this area including nursing staff going through information with patients before discharge but there are occasions when some patients report they had been discharged with no information. GPs report that communication is better but still patchy. Some specialities were highlighted as good practice for example intensive care send out information the same day.

7.55 We can see that preventing admission and re-admission requires active management of transitions, including timely and accurate information, good communication between hospital and primary care physicians, and a single point of co-ordination. The Committee recommends an audit the timely supply and completeness of in-patient discharge information as a useful start in setting standards and quality monitoring of information continuity.

Discharge to Community

7.56 The North East has historically had the highest levels of hospitalisation and care home admission in the country; however, in Sunderland there has been a strategy to reverse this trend and provide care closer to home.

7.57 Re-abling people within their own homes through the provision of intensive therapy and care while focusing on skills for daily living is a key policy priority for health and social care in Sunderland. The Council's aim is to eliminate the need for admissions to residential and nursing care, and for all people to be enabled to live independently in their own home, in the community.

7.58 Members heard that the impact of reablement and other social care funding which has been flowing through to the local authority in a significant way from 2011/12 provides optimism towards addressing some of the challenges behind delays in discharges. Funding from the Department of Health is allocated to the PCT for post-discharge support. The focus of schemes in the South of Tyne & Wear has been on increasing and enhancing established services.

7.59 An evaluation of the reablement scheme in Sunderland was carried out in May 2011 by a consultancy commissioned on behalf of SOTW.

7.60 The Committee was informed that for all schemes assessed patient and staff feedback has been very positive and timeliness and quality of services has been enhanced with the investment. However, not all schemes are operating to full capacity and for some measures it was too early to assess the impact although there was a significant decrease in excess bed days compared with the same period in 2009/10 and 2008/09.

7.61 While the provision of enhanced services it to be welcomed, it was very clear from evidence received that both the service users and many professionals had limited knowledge or understanding of the services available and the distinction between the different types of support was confused. There is potential for this to be exacerbated when services start accepting direct GP or patient referrals.

7.62 Unlike the services provided by the NHS, which are largely provided free at the point of need, social care services are subject to a means test and many people will be expected to pay for some or all of their care and support. This may come as a shock to many. It also serves to sustain the artificial distinction between health and social care services, making joined-up, integrated care more difficult to achieve.

7.63 Personal budgets (one element of the personalisation agenda) allow individuals to have direct control over how their care needs are met. Following an assessment, an individual can be allocated an indicative budget that could

be made available to them to meet those needs. Individuals are given the choice of an account held and managed by a local authority, a direct cash payment in lieu of services or a mixture of both.

7.64 Personalisation raises issues of how to dove-tail reablement and self-directed support. For example, in some cases an individual's reablement will be followed by a home-care package from an independent provider. In these cases home care contracts should promote continued reablement to avoid a dependency culture existing within the independent sector. Providers are likely to require training to support this culture. In other cases, people will want a Direct Payment, or to employ a Personal Assistant. This raises the issue of how to ensure effective hand-overs which maintain independent living. The disparate nature of service provision will potentially make efficient patient pathway navigation more difficult.

7.65 It is known that significant savings can be achieved by investing in expansion of reablement services. User satisfaction rates are consistently high and clear benefits for users have been identified. To gain the full benefit of the services, there needs to be greater access and awareness of reablement, its impact and how it can complement Intermediate Care. This could include exploring how reablement could be re-positioned to reach all those who could benefit, by becoming an integral part of the 30-day post discharge process and how it could be expanded to an admission avoidance service.

7.66 Living independently at home requires the availability of services in the community. Repeated emergency admissions can suggest a lack of effective community support. The Committee heard that sometimes unrealistic expectations can be given to patients in hospital about the level of support that will be available when the patient returns home. There may be no mention of having to wait for equipment or adaptions particularly when staff are under pressure to keep the system moving. This may support the flow of early discharge but there is evidence that support and equipment is not always available in a timely way. It is important to be honest and open with patients about the realities of going home so that things don't go wrong out of hours when patient realises nothing is available.

7.67 Evidence was received from South of Tyne & Wear Community Health Services which South Tyneside NHS Foundation Trust manages as a new model of care and partnership working across South of Tyne & Wear. Services include amongst other things district nursing, health visiting, and specialist nursing care supporting patients with diabetes, community matrons, and palliative care. The service works with partners to identify people who need help and support within the community.

7.68 The services had originally been just step-down (from the Ambulance Service). Latterly, GPs have been more involved in signposting to the team. The service supports 17,000 patients per month. Community services encourage self-referral however it is not known how many more people could benefit if the services were better known.

7.69 The Committee heard evidence of concerns following this centralisation of services, some of which have apparently worsened in exactly those areas which cause service users the most frustration, for example, ensuring that care is provided by as few professionals as possible, and being able to

demonstrate good communication between professionals and with the service user and their informal care networks (cross-boundary and team continuity).

7.70 In 2010/11 District Nursing teams delivered care to 312,012 patients. Some of these patients were hospital discharges and some required care either at home or in a care setting. District Nurses work with a range of teams including 366 GPs in Sunderland over 74 bases. The current provision of district nursing services had caused concerns particularly in relation to the single point of referral and also around certain aspects of the specification e.g. link nurses and named nurses. It is not clear of the extent to which this is affecting services to patients as the review did not carry out research around this specifically but it is certainly causing frustration for clinicians.

7.71 Prior to the centralisation of the service in 2011 GP practices had a team of district nurses attached to their practice and were able to form relationships with individuals. GP practices have reported they are finding the district nursing service more difficult to access since centralisation and the current arrangement is more formal through multi-disciplinary team meetings. To attempt to address these issues a revised service specification will be implemented using localities so the patient has the same nurse most of the time. The Committee would like to see the role of the district nurses aligned to the whole-system approach as described throughout this review and involved, as necessary, at each stage of a transfer of care.

7.72 The Sunderland Clinical Commissioning Group has started work on patient consultation and is linking in to local authority improvement work. One of the objectives is around avoiding asking patients to explain the same information to different agencies. This should help to identify and standardise best practice. Currently, GPs may not even know which social workers operate in their patch. It is hoped that through the CCG it will be able to improve knowledge and services in the five localities.

7.73 We heard evidence that more support is needed in managing medication as this could lead to re-admission if not taken properly. Various prompting devices can be used as medication reminders. They can be used when the user forgets to take medication, gets confused about which medication to take or has a complex medication regime. We would propose the investigation of a city-wide medication support solution for vulnerable people living at home.

7.74 The Committee heard evidence that while there is a range of services in the community to support people to live at home that there is too little understanding about what services are available and how to access them. For example, there seems to be limited knowledge about the ability to self-refer for many community services. Over-servicing in some areas and a confusion of when and how to use services leads to duplication and waste.

Discharge to Intermediate Care

7.75 Sunderland has a good record of intermediate services. The Council working in partnership with Sunderland TPCT, City Hospitals Sunderland and NTW established a joint intermediate care service 10 years ago, which is regarded as one of the best in the country. The Committee visited the focal point for intermediary care at Farmborough Court, a revamped nursing home, currently with access to 38 single rooms (14 nurse supported beds are currently provided by the Hospital), which concentrates on getting patients back to

independent living. It was the first in country to offer intermediate care to dementia patients. The service has access to community therapy and reablement, nurse practitioners, community psychiatric nurses and GP input during the day. Training to NVQ level is available to all staff.

7.76 It was evident that a lot of work had been done in Sunderland to provide intermediate care and keep people out of hospital. Between 2008/10 significant re-design and development of intermediate care, reablement and rehabilitation pathways led to a number of new services filling critical gaps.

7.77 A variety of additional resources are available including Extra Care Reablement Flats at Cherry Tree and Bramble Hollow which will be available soon for those people who would benefit from living in a supported environment. 'Time to Think' services are also provided for people who have had a recent episode of ill health but require further time to recover while undergoing some support. The Committee visited the new Primary Care Centre at Houghton where the original specification had been limited to rehabilitation and reablement. The centre which will open fully in 2012 now includes step-up care (just short of hospital care). A GP will be attached to the PCC 7 days a week.

7.78 The supply of services needs to provide people with genuine choice over their future care with appropriate capacity in a wide range of services that promote independence. There is still an over-reliance on institutional settings rather than community or home-based solutions. There is a tendency for vulnerable older people to default to a hospital bed at a time of crisis and subsequently become institutionalised, when an earlier intervention might well have been more effective in maintaining their independence.

7.79 The Committee has seen evidence of intermediate care services supporting timely discharge from hospital and increasing the numbers of successful transfers to independent living, however, there was concern expressed to the Committee that new facilities are not used for the 'whole-system' approach with too much emphasis on early supported hospital discharge and insufficient emphasis on prevention. It is hoped that an increased range of provision will help to prevent some hospital admissions, and reduce the number of individuals admitted prematurely to a care home.

7.80 The Committee welcomes developments towards greater joint working between health and social care to develop a more integrated model for intermediate care, reablement and rehabilitation for individuals with long term conditions and complex care needs. The quality and range of provision is to be welcomed in providing alternatives to hospital, when recuperation and rehabilitation is required.

7.81 The Committee heard that, while there is a range of provision available, there was a view that provision was not always used to best effect. It is important that the range of provision is not fragmented and that each facility can function as part of a coherent network of services to prevent unnecessary admissions and facilitate swift discharge from hospital. It was reported to Committee that there had been limited communication with some parts of the health and social care sectors, even though those individuals were referring into services, about the purpose and referral criteria for some of the new provision. There was also some confusion and concern about failure to

make best use of the range of services, for example, what is available, in what circumstances to access services.

7.82 The previous system of referrals to services had been fragmented and a new improvement during the period of this review is the development of a Single Point of Access Model (SPA) for the hospital, GPs and Local Authority for routes into intermediate care and reablement.

7.83 The SPA Team commenced service on 5th December 2011, initially based in Farmborough Court but as soon as possible will re-locate to the acute hospital site with access to hospital and City Council IT systems. Referrals to the SPA can be made by any professional following the provision of basic information on a single referral form. Referrals will be accepted for both step up and step down services for people who are medically stable following an episode of acute hospital care and requiring further rehabilitation / reablement either within their home or a bed based service.

7.84 We welcome this development and it is hoped this will overcome some of the issues raised in relation to lack of clarity about when and how to use services and will further support the transformation of the services into a single integrated service. The Committee will be interested in monitoring the success of the SPA model as it is embedded.

Discharge to care placements

7.85 Whilst it is important to ensure that discharges are timely, it is also fundamentally important to ensure that the outcome of the discharge is appropriate to individual needs. Department for Health guidance states that there is evidence that too many older people inappropriately enter long-term residential care direct from an acute hospital. Guidance recommends that such decisions should not be made in an acute hospital other than in very ffexceptional circumstances and rehabilitation and enablement should always be considered as the first options.

7.86 Currently, it is thought that the numbers of people admitted to residential care directly from hospital in Sunderland is too high. The number of hospital admissions from care homes to hospitals is also under scrutiny with a number of trials taking place in other areas looking at admission avoidance by working with GPs and concentrating on care homes that send older people into hospital inappropriately such as reaching end of life when there is nothing that can be done to alleviate the inevitable.

Bernard's story

Bernard was in independent 90 year old living alone and active when he started to experience stomach problems and having a few falls. Following a fall last autumn, he was taken to A&E and admitted as an in-patient with a head injury. Following an operation for the head injury his family were given the options of discharge to Farmborough Court for rehabilitation or to a care home.

Bernard did not want to go to a care home so he was discharged to Farmborough Court for rehabilitation. At this time the cause of Bernard's stomach pain was not diagnosed and he was being treated primarily for the head injury with painkillers and laxatives for the stomach pain. After a short time in Farnborough Court he needed to be re-admitted to hospital because of severe stomach pain. From there he was discharged to a care home despite not wanting this and this caused some distress. Bernard's family had asked for him to remain in hospital for further investigation of the stomach pain before discharge. When Bernard was discharged to the care home in early January he was in his pyjamas. It was a cold day and he was agitated. He remained in considerable pain and was not eating. A few weeks after being transferred to the care home Bernard died.

7.87 Solutions could include providing care staff with the training and confidence to be able to care for patients with long term conditions and those with dementia. The Committee felt it would be helpful to explore what is expected of care homes in order to avoid hospital admissions and to ensure that all care homes provide a good standard of practice that, where evidence shows a disproportionate rate of admissions, that future contracts include arrangements for employers to be required to release staff for training.

7.88 A CQC inspection of Sunderland Adult Services in 2010 noted "Hospital discharge arrangements …. needed to ensure care homes were not asked to admit people prior to pre-admission assessments that ensured their needs could be met."

7.89 The discharge process is now through a panel to oversee decision making with regard to long term care placements. The panel was set up for quality assurance. The practical operation of the panel has typically agreed around 7 cases a week into placements. The number of individuals seeking panel assessment is higher than this, resulting in a bottleneck while cases wait to be considered. Individuals 'who are waiting to go to panel' may wait in a variety of places however evidence was provided that the panel is causing some patients to stay in a hospital bed for long periods as some patients can wait 6-7 weeks for a panel discussion. It was reported that in one case a patient had been waiting since 27 September 2011 in a hospital bed for a decision which ultimately could be overturned anyway.

7.90 The current operation of the panel reinforces the Committee's view that there should be greater focus on multi-disciplinary consultation and full utilisation of the range of step-down options. The Committee proposed that in relation to the existing discharge panel, there is a need to review and reconfigure the model for decisions on long term care.

Patients' Views

7.91 The main focus of this report is the needs of those individuals often, but not only elderly people, who suffer from long term and chronic conditions and who need coordinated packages of care to allow them to lead fulfilling lives. People with long-term conditions are major users of the NHS. Greater life expectancy means patients can typically have several long-term conditions. One of the most challenging of these is dementia. 70% of acute hospital beds are occupied by older people, 20% of acute beds are occupied by people with dementia and 75% of residents of care homes have dementia. These individuals who constitute the 'typical' users of services - account for 29% of the population, but 50% of all GP appointments and 70% of all inpatient bed days.

7.92 The views of some of these 'typical' services users were collected through structured interviews in several wards at Sunderland Royal Hospital and the discharge lounge.

7.93 Patients and their families reported a mixed experience when discharged from hospital. Most had a very good experience while others had or some issues which had caused some concerns. A common reason for dissatisfaction was the lack of communication between clinical staff and the patients and their families. The feeling amongst some relatives and friends

was that where patients were unable to understand, hear properly or speak up for themselves this sometimes compromised care as the carer was not always fully involved.

Patient Pathway – Mental Health and disability services

7.94 Issues for this service are the complexity of the cases, length of stay can be significantly longer than in the acute sector, multi-disciplinary care packages can be required and effective discharge must involve the family and carers, and in some cases advocacy services.

7.95 In order to reduce hospital admissions for this group of patients prompt assessment and treatment is required together with needs led support. The discharge policy requires that a multi-disciplinary team meeting will take place within 7 days (or earlier if appropriate) and care plan developed. To reduce the length of stay in hospital requires appropriate rehabilitation services, relevant accommodation and engaged community support. As of 1 January 2012 there were 19 people from Sunderland defined as delayed discharge in this service.

7.96 The structure and facilities linked to this service has altered significantly through the plans developed to provide new in-patient accommodation in Sunderland and South Tyneside. Known as the PRIDE Project; meaning Providing Improved mental health and learning Disability Environments. In September 2011 work got underway with the demolition of the former Ryhope General Hospital. Pride also includes work on the Dementia Care Centre at Monkwearmouth Hospital, which the members of the Committee visited and a new Memory Protection services to start in April 2012. The Committee had been consulted on the closure of two campus wards at Monkwearmouth where people with very complex needs had been moved into the community. One of the outcomes of all of these developments is that there are many less in-patient beds and alternatives have to be found with appropriate accommodation, engaged community support and localised provision.

7.97 The Committee is aware of the stigma of mental health in the community and the type of community the person lives in is therefore very important. NTW are working with the police on tackling disability hate crime and there is a good relationship with housing partners although there can often be long delays in finding suitable accommodation. If the housing or the community is wrong the individual will end up back in hospital.

7.98 For a mental health service user who requires an in-patient admission, the original mental health social worker or health professional retains responsibility for care co-ordination throughout the hospital stay. The care coordinator needs to be in close liaison with the ward staff.

Hawthorn Ward - Outreach service

Assertive outreach teams provide long term and intensive support to people who are suffering from a mental health problem and are judged to be the most vulnerable. The outreach service has been running for 8 years and is successful at preventing re-admission to hospital. A member of staff follows the patient journey which includes early prevention. The approach proves the case for supported discharge. They support people who have historically avoided contact with mental health services. The team strives to establish a relationship with the service user and understand his or her specific needs, hopes and aspirations. This improves the way people cope with mental health problems and helps them to live as full a life as possible, with the aim of boosting their quality of life.

7.99 Currently there are no mental health nurses in A&E or mental health social workers based in the hospital. There is however a liaison service and a crisis assessment and home treatment team which routinely works with A&E. The Committee heard that once a patient with mental health problems is admitted to hospital, there are often complex issues which make smooth discharge more challenging. Patients can be supported by this team at home as an alternative to an in-patient admission if that is appropriate for the individual.

7.100 Greater community level support may avoid the need for many individuals to present to A&E. While it is beneficial that there are community based workers offering specialist assessment, treatment and care to adults with mental health problems in their own homes, the Committee felt this could be extended further to provide support and advice to primary care services including providing advice and training which could provide useful skills, including to help 'skill-up' voluntary sector workers. This could also extend to meeting with other providers to discuss management of patients, and undertaking shared clinical governance at community level.

7.101 The Committee believes that information received through this review provides evidence that an increased focus on mental health support within the community, through a model of clinical governance in the community would reduce the level of A&E access and subsequent in-patient care.

Carers' Views

7.102 It became evident throughout all aspects of the services we reviewed that supporting carers in their role needs to be a key element of ensuring that the reablement and intermediate care services are as successful as possible.

7.103 Sunderland has more carers than the national average and more provide care for over 50 hours a week. According to the last Census, Sunderland had a population of 280,807, of which, around 32,000 people reported themselves to be a carer. Carers in Sunderland save the economy £706.9 million per year - this is what it would cost the city if the care they provide had to be replaced. Many people do not consider themselves to be a carer therefore the true figures are likely to be higher.

7.104 As many people do not readily identify themselves as a carer, it becomes about making sure that people recognise that they can get the support that they are entitled to from being a carer. That is a major problem: to get people to identify themselves, let alone other professionals to help identify them.

7.105 The Government has taken a number of actions on identification of carers. The Quality and Outcomes Framework (QOF) is a voluntary incentive scheme that rewards GP practices for, amongst other things, identifying carers on a carers register and referring them to the local authority for assessment. The Princess Royal Trust for Carers has stated that take up for this QOF indicator has been quite high (though this does not mean that all carers have been identified). Carers UK, the Princess Royal Trust for Carers and the Royal College of General Practitioners have also been awarded funding from the Department of Health to look at using carer and GP ambassadors to support early identification of carers on GP lists.

7.106 City Hospitals Sunderland and Northumberland, Tyne and Wear NHS Foundation Trust include in their discharge policies that all patients and

carers will be at the centre of the discharge process. We were aware of much good practice, however, there were also examples reported in evidence gathering of a gap between the understanding of good practice which is shown in training sessions, and what actually happens on some wards. For example, discharge discussions do not always include the carer. Sunderland Carers' Centre has the potential to support carers at discharge meetings and throughout the follow-up. Involvement of the carer would support discharge planning including the practicalities of a patient discharge. People have been discharged in their pyjamas as the family were not told it was happening so had not brought clothes.

7.107 The Committee sought the views of carers through a forum meeting and through a written survey. Due to the breadth of services that link to the hospital discharge and wider community health and social care services, there a broad range of experiences related. However, concerns post-discharge for carers can be summarised as:

- Feeling that they were not 'fully' involved in decisions about discharge
- Not being able to deal with the same support staff and having to repeat the medical history to different workers
- Poor communication with families
- Families not listened to when concerns are raised
- Roles of and access to district nurses
- Not being talked to or supported in their role as a carer
- Not being given information to help in a caring role

7.108 One carer described the discharge process as 'erratic' although in the main carers did have a contact to go to if concerned about anything post-discharge. Reference was made to the discharging of patients who may still be unwell who have to be re-admitted a few days later. The Committee had already heard that some patients do overstate their ability to cope at home in order to be discharged and carers need to be honest about what they can manage which reinforces the need for greater dialogue with the carer.

7.109 Once discharged, carers commented that Community Matrons were a valuable support and much appreciated as was the support from the Carers Centre. There are 16 Community Matrons in Sunderland working across the city and linked with GP practices. They coordinate services for people with complex needs, which may reduce admissions to hospital by providing support at home. They have clinical assessment skills, extended and supplementary prescribing skills, and supportive skills across the patient pathway.

7.110 Whilst intermediate care and reablement services have been developed locally for service users and patients the Committee felt that the potential for providing services to carers needs to be fully explored. There was also a lack of understanding about the different support services.

7.111 The Committee was informed that the Council is in the process of developing a Carers Resource Allocation System (RAS) which will deliver personal budgets for carers, to enable them to access support and respite as flexibly as possible. This system will build on existing experience from the Carers Breaks and Opportunities pilot. Although this is contingent on success in the testing of the model, it is anticipated that this will be fully operational by the

spring 2012 and should afford carers a better level of choice and control over the support they need to maintain their caring responsibilities and look after their own health and well-being.

7.112 The cross-Government Carers Strategy identifies four key priorities:

- supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages;
- enabling those with caring responsibilities to fulfil their educational and employment potential;
- personalised support both for carers and those they support, enabling them to have a family and community life; and
- supporting carers to remain mentally and physically well.

7.113 Despite these commitments, the NHS Information Centre Carers Survey found that only 6% of identified carers were offered a carer's assessment in 2010-11. Some 67% of carers who had been assessed said they had received a service of some kind as a result of the assessment. The most common services were equipment such as mobility aids (26%), services for the person they care for (22%) an assessment of the person they care for (21%) and information about benefits (20%).

7.114 The Committee welcomes the Government's recognition of the importance of support for informal carers and carers' assessments. The Committee is however concerned that the effectiveness of the policy is too often undermined by the failure of GPs, social workers and others to identify carers. The Committee believes there needs to be new and more effective ways to identify carers in order to ensure that their needs are properly assessed and met. The Committee heard that discharge information passed to GPs may usefully include discharge 'coding' to identify when someone is a carer which may build additional support into the system.

7.115 As a safeguard to ensure appropriate checks are in place for carer support, and to ensure what is appropriate for the individual and the locality they live in, the Committee recommends drawing up a check list of information needed by carers which could be used as a template for discharges. This is a fitting support mechanism within a multi-disciplinary approach.

8. Conclusion

8.1 We have spoken with people who use and work in the services and heard evidence that integration can prevent hospital admissions and support independence in the community.

8.2 This report highlights several significant issues that the Committee has identified from the substantial body of evidence received during our review. Our aim is to paint a picture of how a fully integrated system could be achieved with more efficient use of what is already available and the improved outcomes that it could deliver.

8.3 The Committee heard that there is a whole system approach to discharge and aftercare but every link has to work otherwise the patient doesn't get what they need. Full integration and team work is not yet fully in place and

successful delivery will rely on team work, rather than on any strategy or structure.

8.4 In the future, the joint strategic approach has the potential to provide a platform whereby self-assessment, resource allocation, and the individualisation of a range of health and social care / welfare / education / training can be articulated in a structured manner. Such a platform will undoubtedly generate better outcomes and savings in social care including the potential to deliver a range of other benefits including reduced hospital admissions and supporting personalisation.

8.5 The work currently being co-ordinated through new partnership structures will also address public health factors which should in time contribute to reducing the need for admissions to hospital. This needs to include health education with people being made more aware of how to manage their health in the long term.

9. Recommendations

9.1 The Committees key recommendations to the Cabinet are as outlined below:

1. Policies and strategies should have an overarching emphasis on developing performance and outcome frameworks that create incentives towards a more integrated approach.

2. In order to successfully reduce avoidable emergency admissions, further clarity is needed around which types of admissions are potentially avoidable and which interventions are likely to be effective for particular populations.

3. A review of the ward-based discussion groups should be carried out based on an assessment of their success against the measures and in the context of the establishment of a Single Point of Access.

4. An audit of the timely supply and completeness of in-patient discharge information is required to set standards and quality monitoring of information continuity.

5. How to achieve greater access and awareness of reablement, its impact and how it can complement Intermediate Care should be explored. This should include how reablement could be re-positioned to reach all those who could benefit by becoming an integral part of the 30-day post discharge process and how it could be expanded to an admission avoidance service.

6. The Committee would like to see the role of the district nurses aligned to the whole-system approach as described throughout this review and involved, as necessary, at each stage of a transfer of care.

7. A working group should investigate possible solutions for a city-wide medication support model for vulnerable people living at home.

8. Where evidence shows a disproportionate rate of hospital admissions from care homes, future contracts should include arrangements for employers to be required to release staff for training.

9. In relation to the existing discharge panel, there is a need to review and reconfigure the model for decisions on long term care.

10. An increased focus on mental health support within the community, through a model of clinical governance in the community would reduce the level of A&E access and subsequent in-patient care.

11. There should be a check list of information needed by carers which could be used as a template for discharges.

10. Acknowledgements

The Scrutiny Committee is grateful to all those who have presented evidence during the course of the review. We would like to place on record our appreciation in particular of the willingness and cooperation we have received from those named below:

Witness	Subject Area	Date
Jean Carter, Deputy Executive Director, HHAS Ailsa Nokes, Strategic Lead for Long Term Conditions, NHS South of Tyne and Wear	Setting the Scene	6 September 2011
Bev Atkinson, Managing Director of Community Health Services for NHS South of Tyne and Wear	Community Health Services	19 October 2011
Olwen Pollinger (Service Development Officer), Parkinson's UK (North East Regional Team)	Parkinson's Patient Pathway	23 November 2011
Louise Hedley and Brenda Walker The Stroke Association (North East Region)	Stroke Patient Pathway	23 November 2011
Victoria Brown Age UK Sunderland	Hospital Discharge Team	23 November 2011
Eibhlin Inglesby, Sunderland Carers Centre	Carers Focus Group	23 November 2011
Houghton Primary Care Centre	Site visit of facilities	6 December 2012
Dr Ian Pattison, Chairman, Sunderland Clinical Commissioning Group	How GPs work with and are supported by other services	12 January 2012
Norman Wilson, Social Work (Team Manager), Health, Housing & Adult Services Susan Martin (RLN) City Hospitals Sunderland Divisional Discharge Co-ordinator Carol Harries, Director of Corporate Affairs	Hospital Transfer & Discharge Policy and Social Care Support Services	12 January 2012
Caroline Wild, Head of Partnerships Gail Kay, Directorate Manager, Northumberland, Tyne & Wear NHS Foundation Trust	Discharge from mental health and disability services	12 January 2012
Anne de Cruz, Manager Karen Wright, Rehabilitation Service Manager Sharon Marshall, Deputy Centre Manager Farmborough Court	Visit by Members to Farmborough Court and meeting with residents	16 February 2012
Neil Revely, Executive Director Jean Carter, Deputy Director, Health, Housing & Adult Services Ailsa Nokes, Strategic Lead for Long Term Conditions	Presentations to the Stakeholder Event	29 February 2012
Mike Lowthian, Christine Swain, Janet Butler Sunderland Link	Patient Evidence gathered at Sunderland Royal Hospital	February / March 2012

11. Background Papers

The Community Care (Delayed Discharges) Act 2003
CQC Inspection Report of Sunderland City Council's Adult Social Care 2010
DH The Operating Framework for the NHS in England 2011/12
DH National Stroke Strategy 2007

12. Key Terms

Assessment	A process whereby the needs of an individual are identified and their impact on daily living and quality of life evaluated.
Avoidable admission	Admission to an acute hospital, which would be unnecessary if alternative services were available
Care management	A process whereby an individual's needs are assessed and evaluated, eligibility for services is determined, care plans drafted and implemented, and needs are monitored and reassessed.
Care package	A combination of services designed to meet a person's assessed needs
Care pathway	Care pathways are described variously as integrated care pathways, clinical pathways, critical pathways, care maps, or anticipated recovery pathways. A care pathway is an agreed and explicit route an individual takes through health and social services.
Delayed transfer of care	A delayed transfer of care is experienced by a hospital inpatient who is ready to move on to the next stage of care but is prevented from doing so for one or more reasons.
Intermediate care	A range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living. This can be delivered in an individual's own home, housing schemes, day centres and hospitals, as well as in more traditional care and rehabilitation settings such as community hospitals and care homes.
Multidisciplinary team (MDT)	A group of health care workers and social care professionals who are experts in different areas with different professional backgrounds, united as a team for the purpose of planning and implementing treatment programmes for complex medical conditions. They work in a coordinated manner depending upon the patient's needs and the condition or disease being treated. MDT is used interchangeably with another term, interdisciplinary team.
Reablement	Reablement complements the work of intermediate care services. Reablement seeks to support a different phase on the continuum of care providing services for people with

	poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living. In reality, the intermediate care and homecare reablement phases for specific individuals may overlap.
Rehabilitation	A programme of therapy and reablement designed to restore independence and reduce disability.
Sheltered housing	Specially designed accommodation, available for rent or purchase, mainly for older people. Some sheltered schemes are called 'extra care'.
Transitional care	Care provided to a person who is not able to be placed in their home or the permanent setting. It can be used, for example, while someone is awaiting major adaptations to their own home.

13. Appendices

Appendix 1 Parkinson's Patient Pathway
Appendix 2 Stroke Patient Pathway
Appendix 3 Patient Consultation – *to be completed*
Appendix 4 Improvement Work

Appendix 1

Parkinson's Patient Pathway

Parkinson's Disease (PD) is a complex and incurable condition, but its effects can be mitigated through effective management and timely intervention. This can only be achieved through liaison between patients, doctors and other health professionals. There is a rounded pathway for Parkinson's patients and it was reported to Committee that the hospital discharge process had improved for PD patients.

There are over 700 people with Parkinson's on the City Hospitals Sunderland neurology database and several hundred more with additional complex conditions under care of the elderly, including referrals from South Tyneside and Durham.

A Parkinson's Patient Group is located within Sunderland hospital. This has been meeting for 5 years working on continuously improving the patient experience. At any one time there may be 20 PD patients in the hospital. It was felt that although the pathway was much better for this group of patients there were still patients getting 'lost' in the system. The Committee heard that once a Parkinson's patient was in hospital they may remain in hospital longer than other patients because of medication issues.

The main issues for this group of patients in relation to hospital admission, discharge and support in community settings, related to medication and a need for specialist knowledge about PD by those delivering care and support, including once they have left hospital. The options for PD patients on being discharged may be affected by knowledge of the condition and the expertise in the community.

A lack of specialist support in the community may be contributing to higher hospital admissions for this group. It was reported to Committee that outreach specialist nursing care including working to care homes would assist people to live with the condition away from hospital. Additional improvements could be achieved with access to respite day care to provide carer relief, palliative day care and greater levels of training for all health and social care staff in Parkinson's, its conditions and medication.

Patients believe that support from specialist nurses is particularly important because generalist community health professionals may have little knowledge or awareness of the complexities of managing a long-term neurological condition. It can also be difficult to access services quickly and out-of-hours services may be variable in capacity and quality.

Those advocating for PD patients believe that Farmborough Court was underused due to a lack of awareness and misunderstanding that the service doesn't take PD patients. The service was cited as an example of good care and support for PD patients and for the help with enablement prior to the patient returning to their own home. However it was felt there was cautiousness about pursuing a nursing level of care for this group of patients.

City Hospitals Sunderland has reviewed the reasons for readmission of Parkinson's patients and this has led to a formally agreed set of criteria for earlier involvement of palliative care. This was shared with local GPs to enable patients to be added to the Community Palliative Care Register earlier in the course of their disease.

Appendix 2

Stroke Patient Pathway

Starting with the National Stroke Strategy in 2007, there has been a national, regional and local drive to improve services and outcomes for patients suffering a stroke. Good progress has been made in Sunderland in treating and preventing stroke. The Committee heard from the Stroke Association which is a great advocate for further work to improve post stroke rehabilitation and help in the long term.

The Committee heard that effective discharge is vital for the good care of this group of patients. A holistic care plan needs to include physical, psychological and rehabilitation needs. Ideally, there will also be a care plan for the carer, including training on moving and handling and how to engage with professionals.

Although the hyper-acute stage of the stroke pathway can be classified as emergency care, patient experience is still important. It is important to ensure that patients receive the most appropriate care, at the most appropriate time and in the most appropriate environment. Good practice models indicate that direct admissions to a stroke ward help to achieve these standards.

Previously most stroke patients who arrive at hospital by ambulance have been admitted to a stroke ward after spending time in A&E or on a general ward. This could result in delays in patients receiving the specialist assessment and treatment that they urgently need and leads to longer stays in hospital.

City Hospitals Sunderland has been developing stroke services in line with the National Stroke Strategy. The Acute Stroke Unit (ASU) has moved to a 40 bed facility in the new ward block on the Sunderland Hospital site. The unit has dedicated and trained stroke nurses and therapy staff, who provide care and therapy within the ward area. This move will enable the Trust to achieve its objective of treating the majority of stroke patients on a dedicated acute stroke unit for most of their stay.

On 13th June 2011 South of Tyne & Wear launched a new model for hyper-acute stroke services across three NHS Foundation Trusts – the Queen Elizabeth, the Sunderland Royal and South Tyneside Hospitals. Patients are seen at their local hospital and managed through a rota system of specialist consultants using telemedicine to review and treat patients. The new referral process will mean that the North East Ambulance Service will take patients to their nearest local hospital from pick up via A&E. This will enable all patients suspected of having a stroke to be reviewed by a stroke physician 24 hours a day, seven days a week.

After discharge stroke patients have to adjust to the impact of a stroke and changes to their life at home. They require community-based rehabilitation to ease their move from hospital back into the community. Early access to rehabilitation can restore movement, improve recovery and reduced delayed discharge.

Stroke rehabilitation requires a range of community services including physiotherapy, speech and language therapy and occupational therapy. Inadequacies in community provision would be detrimental to recovery. The Community Stroke Rehabilitation Team (CSRT) was launched in September 2009 offering home- based rehabilitation and health promotion for stroke patients. The team has close links with hospital and community social services and patients are seen within 2 days of hospital discharge. The service works within Sunderland Royal Hospital to introduce patients to the service receives and receives referrals from health and social care

professionals and self-referrals. The service is funded this year by both the PCT, and the Local Authority through their grant scheme. There are significant demands on the service and capacity is an issue. There is also uncertainty about how future personalised services will impact on continuation of the service.

The Committee heard evidence that access to various services can be patchy. There is an issue of demand outreaching capacity and improvements would require additional resources. However, better information sharing and better co□ordination of all support services would make better use of existing services.

The main issues for this group of patients on discharge are not enough information on discharge and occasional poor communication along the stroke patient pathway, the need for more joined up care and efficient transfer back into the community. Joint discharge care planning with other relevant agencies and services would support a more integrated approach. Aspects that were valued were review after leaving hospital and long term into the community and having someone to talk to about how they were coping.

It was evident that there are good support groups available in the community but this is not always made known to individuals at discharge. The Stroke Association makes available a variety of information and are proactive in making contact with patients but there are still patients falling through the gaps.

Health and social care could help with this by ensuring that the patient's details are transferred with their consent from hospital to adult services so that an appointment is initiated in the community. Community support groups can help by advertising the existence of their groups, sharing information at their groups.

Appendix 3

To be completed

Appendix 4

Improvement Work

At the time of this review a strategy group had been established with the aim of developing a Joint Intermediate Care and Reablement Strategy. The Council and PCT were also developing a new set of measures covering a number of different perspectives on performance.

The improvements will aim to achieve the best distribution, redesign or development of capacity that minimises the number of patients whose discharge is delayed and maximises outcomes and value for money. This model should critically take into account the increasing proportion of older people in the population. It should also focus on key areas affecting delayed discharge such as chronic disease management, admission avoidance schemes, reducing assessment times, attitude to risk management and specialist housing/care home provision.

Multi-agency Hospital Discharge – Rapid Process Improvement Workshop (RPIW)

In March 2010 SoTW led a multi-agency RPIW focusing on hospital discharge processes with the intention of the reduction of overall lead time the hospital discharge process on three care of the elderly wards at the Royal Hospital Sunderland within existing resources.

Improvement measures identified were encapsulated into four themes.

1. Referral process to social care (inappropriate or incomplete)

There was a scatter gun approach to referrals in relation to patient discharge leading to unnecessary time spent gathering, clarifying and processing information. This contributed to delays and poor discharge experience for the patients. Key issues were referrals being made to inappropriate teams and discharge planning was driven by bed pressures rather than patient focus. The solution was the implementation of a system known as PowWow bringing together multi-professionals to make timely decisions about referrals.

2. Full multi-disciplinary team work (no social work)

A problem was identified with lack of hospital social work into routine multi-disciplinary meetings which created delays in the patient pathway and also frequent readmissions for certain patients. A protocol pathway was developed to include all relevant people. It is also necessary to look at re-admission trends and prevent unnecessary admissions by mistake proofing.

3. Patient experience (fragmented)

It was identified that patients, families and carers felt that there was poor communication between themselves and professionals leading to confusion on discharge. A key issue was availability of information in each area with no standard practices for providing patient information. The solution has been to simplify and standardise information about the patient with a single patient file used by everyone.

4. Assessment and discharge (significant readmission)

It was identified that discharge policy did not seem to inform discharge practice. A 'visual control' was developed which depicts the discharge pathway including roles and responsibilities.

City Hospitals Sunderland Project

During 2010/11 the hospital undertook significant improvement work to improve processes within the hospital. In spring 2011 a project took place to improve patient flow and eliminate 'bed batching'. The intention is to implement a 'pull' system for admissions onto the base wards by declaring beds to the bed managers as soon as the bed becomes vacant and then re-utilising the bed within 1 hour. Work is ongoing to implement a full system. In addition, the Trust increased the use of the discharge lounge by introducing obligatory use as part of the patient's discharge.

Multi-Agency Delayed Discharge Project

In February 2011, HHAS and SOTW established a 'delayed discharge project' to review current discharge pathways. Key areas were identified which it was felt were the greatest cause of delays:

- Lack of streamlined pathways to reablement
- Limited access to transitional 'step-down' accommodation

Actions proposed included:

- Development of a joint strategy for intermediate care and reablement
- Development of a shared gateway to intermediate care and reablement with standard criteria for referral and assessment
- Development of a Compact for working collaboratively
- Agree a standard set of performance and outcome metrics for all providers of intermediate care and reablement
- Review access to services out of core hours
- Review steps in discharge process including panel process
- Increase focus on mental health within pathways as well as physical health needs
- Review accommodation options and address gaps in service to meet need
- Explore reablement for carers
- Increase capacity and skills in the community around nutrition, hydration, continence, and medication support
- Explore Care Navigator role to support individuals with complex needs through their journey from admission and post discharge

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