Hospital Discharge Scrutiny Inquiry Progress Update on Recommendations Progress Report

Select Committee Inquiry Report Completion Date: March 2017
Date of this update: May 2018
Lead Officer responsible for this response: Debbie Richards (CCGs), Natalie Fox (BHT) and Karen Jackson (BCC)
Cabinet Member that has signed-off this update: Lin Hazell, Cabinet Member for Health & Wellbeing
Inquiry Chairman: Brian Roberts
Select Committee Support Officer / Adviser (Extension): Liz Wheaton (ext. 3856)

Accepted Recommendations	Original Response and Actions	Progress Update at 12 months	Committee Assessment of Progres
That BCC, BHT and the CCGs continue to work together to drive forward improvements to the patient discharge pathway. **The Inquiry Group recommends that this includes the following:** **1a. Developing a seamless patient pathway with standardised and computerised paperwork across the whole system;**	**Agreed:** The Buckinghamshire System continuously strives to review and improve on the pathway for patients and residents of Buckinghamshire.	A joint report was taken to the Health and Wellbeing Board on 9 March 2017, from the Council, Buckinghamshire Clinical Commissioning Groups and Buckinghamshire Healthcare NHS Trust, as a statement of intent for more integrated working between health and social care organisations in Buckinghamshire. It set out the opportunities for local integration to deliver joint outcomes for the health and wellbeing of Buckinghamshire residents and better manage demand on services. The Health and Wellbeing Board will retain on-going oversight of the delivery plans and progress towards integration by 2020. These include developing more integrated provision, with fewer hand-offs for patients, supported by improved data sharing. Evidence of data sharing is the My Care Record (MCR) which is a web based system where A&E staff, Adult Social Care and Primary care can look at a patient's case records. The intention by April 18 is to give Oxford Health Foundation Trust and 111 access to the system The system is committed to reducing the need for hospital admission through providing better and more responsive services in the community. This is central to our approach to health and care integration. Work across partners to develop seamless pathways and joined up services is supported through collaborative work on the Local	

		Digital Roadmap within the ICS (Integrated Care System) Work that has been developed by partners to develop "Discharge to Assess" services, for both at home as well as within care homes, has helped to alleviate some of the pressures within the health and social care system. This has been in operation from October 2017 and to April 2018 has supported 389 patients who have had their needs assessed in their usual place of residence, or own home, as soon as they are medically ready and safe to leave hospital. Responsible Officer: G Quinton, BCC & NHS Senior leaders. Action by: Ongoing	
1b. Jointly leading on a piece of work with care providers to develop and implement the "Trusted Assessor" model to an agreed timescale;	**Partially agreed:** Health and social care partners are proactively looking at learning from New Models of Care and the Vanguards. We are grateful to the Enquiry for highlighting the model that has been implemented in Hertfordshire. Commissioners are reviewing best practice models on trusted assessors and will be bringing options back to partners for decision.	As requested by HASC, ASC has had detailed discussions with Vanguard Authorities – Hertfordshire & Lincoln to identify how their Trusted Assessor models work and the benefits to all partners of this approach. Both Authorities used Trusted Assessors who were employed by the local trade associations within each area. Both Vanguard Authorities informed ASC that these Trusted Assessors did reduce the number of different providers who previously were required to assess any individual patient before an appropriate care home was identified and in doing so reduced the time taken to find an appropriate placement. ASC has established a regular older people's care home forum with health commissioners invited to attend. The last meeting in April discussed ways in which the health and social care system including the independent sector could work in a timely manner to ensure safe and appropriate discharges. Work currently being undertaken jointly by partners to develop Discharge to Assess (D2A) Models, as detailed in section 3b below has as one of its priorities the development of Trusted Assessors within Multi-disciplinary Teams to maximise both skills and resources for the benefits of patients and staff. Health and Adult Social Care have agreed the D2A model and have used much of the Vanguards principles to implement a Buckinghamshire D2A model. Both health and social care have developed a single assessment process; however there is more work to fully imbed this process to ensure universal recognition.	

		Responsible Officer: J Bowie, BCC Action By: Trusted Assessor model investigation - **Completed**	
1c. Undertaking a piece of work to gain patient and family/carer feedback on their experience of the discharge process – before and after discharge from the Hospital setting. The results to be used by those involved in the discharge process; **1d. Strengthening the mechanisms for recording and sharing patient and family conversations to minimise the risk of misunderstanding and duplicate conversations taking place;**	**Agreed:** As a useful exercise that would complement the national Inpatient Survey which runs across all healthcare Trusts and has discharge experience as a key line of enquiry. A full survey will be designed with partners in Q2 17/18 and run across a sample of hospital and community discharges before the end of Q3.	A full discharge survey was designed with partners in Q2 (in addition to the standard national survey). This ran across a sample of both hospital and community services through to the end of December. Two specific patient experience groups, focused on discharge have been held, one with 8 patients discharged from hospital in the 12 months preceding, using an 'emotional mapping' technique and a joint staff /patient workshop. The themes from these have been fed into the BHT multidisciplinary group reviewing the processes of safe flow within the hospitals. Participants from these sessions have been invited to form an ongoing patient reference group. Responsible Officer: BHT Action by: **Completed**	
1e. Introducing a module within the induction programme (and ongoing training programme) to increase the Hospital nursing staff's understanding of the community teams and to aid closer working;	**Agreed**: To be included in the hospital nursing induction programme and refresher training for all staff run on a quarterly basis	This has been implemented for all new starters. The community services team is also holding briefing sessions on a regular basis for matrons. A single point of access has now also established for all community referrals from the hospital. This in place and has been implemented. Responsible Officer: BHT Action by: **Completed**	
1f. That commissioned services specify seven day cover within the contracts and access to services is seven days a week;	**Agreed**: Over the last 3 years we have increased the number of services providing a 7 day response. Responses from commissioned services from the independent sector can vary outside the standard operating week – individual	All of our ASC contracts allow for 7 day working in relation to resources that would facilitate and support Hospital Discharges. The CHASC Hospital Discharge teams based at Stoke Mandeville Hospital have now established seven day working as business as usual, and are able to expand and contract this service according to service demand. This enhancement to BHT has been widely appreciated and recognised as a positive step forward in building resilience within the Integrated Care System (ICS) in Bucks.	

	limited capacity to offer this option. Commissioners will discuss with BHT while being mindful of budget and capacity constraints. CCG's to liaise with Arden Gem NHS, the provider of CHC services in Buckinghamshire, to establish opportunity for CHC assessments to be carried out over 7 day service.	Systems have also been set a national standard of **less than 15% of full NHS Continuing Health Care assessments to take place in an acute hospital setting by March 2018.** The CCGs are ahead of the planned trajectory for achieving this target. Responsible Officer: CCG Action by: Ongoing	
1g. That a question on patient transport be included as part of the joint assessment form;	**Agreed:** Implemented Q1 by BHT	This action has been completed. A Single Joint Assessment form has also been rolled out to ensure a collaborative approach from all partners, so everyone is now using the same paperwork for the start of the patient's discharge planning. In addition to this the CCG have developed a RED BAG model of support for all residents of care homes being admitted to hospital where essential information needs to be exchanged to ensure patient safety and effective discharge back to the care home. This pilot has now been rolled out to 16 Care Homes in Bucks and is expected to expand further as the scheme becomes more successful. Responsible Officer: BHT Action by: **Completed**	

1h. That the process for TTOs is streamlined to speed up the issuing of TTOs.	**Agreed:** Performance data to be routinely published at ward and hospital level with improvement plan clearly set	TTO (To take out medication on discharge) process mapping session was completed 04/10/17 and was fed into a TTO workshop held on 20/10/17 and attended by the full Multidisciplinary Team (MDT). Key members from all disciplinary teams have co-designed a new process for the rapid completion of TTOs: • Pharmacy providing consistent ward cover, and the IT systems changed to allow pharmacists to pre-write TTOs – launched on 15 November in the acute assessment wards • Medical ward rounds standardised so one member of the team is allocated to support the TTO process early in the morning • Significant increases in pre-prepared TTO packs (Nov 17) • A second, 6 month review of TTO packs required in progress (April 18) • Team providing medication in advance of discharge day. Responsible Officer: BHT Action by: **Completed**	

2a. That Buckinghamshire Healthcare Trust removes the requirement for Buckinghamshire County Council to pay reimbursement fees for social care delays.	This is already agreed as at 10.2.2017.	BHT has not charged ASC any reimbursement fees during 2017/18. Responsible Officer: S Westhead, BCC Action by: **Completed**	
2b. That Adult Social Care negotiates the removal of reimbursements with other neighbouring Trusts.	**Agreed:** This will be taken forward for local NHS trusts. These negotiations have been attempted previously and were unsuccessful. We will commence this piece of work immediately with a view to completion by the end of July.	In 2014/15 we were charged £32,040, in 2015/16 £72,620, and in 2016/17 we were charged £14,440 ASC has not paid reimbursement fees for 2017/18 to any Trust. Responsible Officer: S Westhead, BCC Action by: **Completed**	
3. That BCC, BHT and the CCGs strengthen and accelerate the plans for health and social care integration through the following: **3a. Co-locating the Hospital discharge team and the ASC discharge team together;**	**Agreed:** see Q1 response **Agreed:** BHT to identify a site – this has been an ambition of the system for some time but there has been difficulty in identifying a suitable room/s	BHT to identify a site – this has been an ambition of the system for some time but there has been difficulty in identifying a suitable building space. BHT and Adult Social Care expect to resolve this issue by September 2018. Key stakeholders from BCC, CCG and BHT meet on a monthly basis to discuss, agree focus areas and update on each of the 8 High Impact Changes. This was highlighted as an important aspect in order to establish a truly integrated discharge function. Pressure is being applied by BCC and CCG lead representatives through the A&E delivery board to resolve this by September 2018. Responsible Officer: BHT Action by: Ongoing, September 2018	
3b. Developing a specific joint action plan for bringing the "Delayed Transfers of Care" Better Care Fund performance indicator out of "red".	**Agreed:** The Delayed Transfer of care performance across the whole system is very good. As a system we are	The system has developed and submitted its Better Care Fund Plan for 2017-19 in line with national guidance and timetable. The system was advised on 27th October that following the regional assurance process our plan was approved. This means that the IBCF (Improved BCF) funds announced as part of the spring budget will now be released to the Local	

	comparator group of 16 Local Authority areas. The ASC performance is currently the top performance across the same comparator group and the Buckinghamshire system is the 10th top performer nationally. However the system is committed to do better. The A&E delivery board oversees delivery of an action plan which is jointly owned across the system and is driven and monitored at the Monthly Board meetings. The system is currently self-assessing itself against national high impact standards and when this is finalised it will feed in to the action plan The BCF indicator measures the delayed transfers of care against occupied bed days and is specific to a trust not a system. Therefore we need to work with colleagues from other LA's and CCG's (in particular Oxfordshire, Hertfordshire), and to influence their performance in relation to the impact on the Buckinghamshire System. The system is committed to reducing the need for hospital admission through better and more responsive services in the community. This is central to our approach to health and care integration.	Authority. As part of the BCF plan, we have refreshed our reducing DToC plan. DToCs are measured by provider Trust and by Local Authority area. The plan is delivering improved performance with BHT and there have been improvements in joint working and sharing of information with neighbouring Trusts particularly Frimley (Wexham Park Hospital). Responsible Officer: K Jackson (BCC); D Richards (CCG); N. Fox (BHT) Action by: Ongoing During winter 2017/2018 the system invested transformation funds to implement a Discharge to Assess (D2A) programme. D2A is primarily about patients having their needs assessed in their usual place of residence as soon as they are medically ready) and safe to leave hospital. It is about not making a patient wait unnecessarily for assessment and support that should be able to be provided out of hospital. The introduction of the D2A scheme has supported a reduction in medically fit patients waiting in hospital for assessment or further care. These patients are supported through the provision of interim care in their own homes or in care homes according to their needs. D2A requires a joint approach between the Acute Trust, the community health provider and Adult Social Care as well as the independent sector. Although the system has not consistently achieved the BCF DToC trajectory identified, the DToC rates have not deteriorated. The system has recorded a 6.7% reduction from April 17 baseline to Feb 18 latest reported month (daily average per 100,000). The system recognises the increased challenges associated with Milton Keynes Hospital and Frimley Health NHS foundation trust delayed discharges. There are pro-active groups and measures in place to help support the more effective flow of patients to leave hospital in a more timely manner. The system is fully committed to preventing DToCs so is therefore additionally focusing on patients known as "medically fit for discharge" or "stranded patients". This approach requires operational leads across the system to take a citizen-centred approach to addressing barriers to discharge and also includes escalation triggers to senior leaders when required. Some delays are a result of Continuing Healthcare (CHC) processes. This is now a national priority.	

		A twice weekly call has been instigated across the system which reviews all patients who have a length of stay greater than 7 days to see what the system can do collectively to ensure we have an agreed discharge pathway for the patient. Bucks system members also participate in similar calls with other Trusts for Buckinghamshire patients. The system is committed to reducing the need for hospital admission and to getting people home more quickly when they no longer need hospital based care through better and more responsive services in the community. This is central to our transformation plans and approach to health and care integration. Responsible Officer: G Quinton, BCC and NHS Partners Action by: Ongoing	

RAG Status Guidance (For the Select Committee's Assessment)

	*Recommendation implemented to the satisfaction of the committee.*		*Committee have concerns the recommendation may not be fully delivered to its satisfaction*
	*Recommendation on track to be completed to the satisfaction of the committee.*		*Committee consider the recommendation to have not been delivered/implemented*