Safe and Timely Discharge Update

Report To (Meeting):	ONE Stockport Health and Care Board		
Report From (Executive Lead)	Philippa Johnson, Deputy Place Lead, NHS Greater Manchester		
Report From (Author):	Philippa Johnson, Deputy Place Lead, on behalf of Locality Leadership Sarah Dillon, Director Adult Social Care, Stockport MBC Jackie McShane, Executive Director Operations, Stockport NHS Foundation Trust Dr Viren Mehta, Primary Care Board Chair		
Date:	22 November 2023	**Agenda Item No:**	9
Previously Considered by:	N/A		

Purpose of the report:
To provide an update on progress of One Stockport Delivery Programme Priority 2: Safe and Timely Discharge. The report updates Board members on the current arrangements to support safe and timely discharge, and focuses on the collaborative programme to support improvement, as well as progress made over time.
Key points (Executive Summary):
• National guidance "Hospital Discharge and Community Support Guidance" July 22 sets out how local areas should adopt discharge processes that best meet the needs of the local population. • Stockport is compliant with the guidance with a 'discharge to assess, home first' approach. We work together across health, social care and Voluntary, Community, Faith and Social Enterprises (VCSFEs) to jointly plan, commission, and deliver discharge services, pooling resources where appropriate. • Good progress is reported in the paper, recognising all parts of the system are under pressure and there are resource and workforce constraints, however working together we can drive further improvement. • The work is supported by all partners as well as a leadership collaboration across partners including Deputy Place Lead, Director Adult Social Care, Executive Director Operations, Stockport NHS Foundation Trust, Stockport Primary Care Board Chair. • This work is in parallel to the Neighbourhood and Prevention Programme which focuses on developing our Neighbourhood Model of Care, and supporting residents to be happy, health and independent in their own home. • The work also runs alongside the Urgent Care Programme.
Recommendation:
The Board are asked to note the report and progress made.

Decision		**Discuss/Direction**		**Information/Assurance**	**X**

Aims (please indicate x)		
Which integrated care aim(s) is / are supported by this report:	People are happier and healthier, and inequalities are reduced	**X**
	There are safe, high-quality services which make best use of the Stockport pound	**X**
	Everyone takes responsibility for their health with the right support	**X**
	We support local social and economic development together	**X**

Conflicts of Interests	
Potential Conflicts of Interest:	N/A

Risk and Assurance:	
List all strategic and high-level risks relevant to this paper	• Delivery of plan within challenging timescales. • Resources available to deliver plan. • Conflicting priorities

Consultation and Engagement:	
Local People / Patient Engagement:	N/A
Workforce Engagement:	N/A

Potential Implications:						
Financial Impact: Please note - All reports with a financial implication require detail of the level of funding, funding stream and comments from Finance.	Non-Recurrent Expenditure	£nil				
	Recurrent Expenditure (please state annual cost)	£nil				
	Funding stream	Yes		No		
	Included in the s75 Pooled Budget	x				
	GM ICB (Stockport) delegated budget	x				
	Other, please specify					
Finance Comments:	N/A					
Performance Impact:						
Workforce Impact:						
Quality and Safety Impact:						
Compliance and/or Legal Impact:						
Equality and Diversity:	General Statement:					
	Has an equality impact assessment been completed?	Yes		No		N/A	X
	If Not Applicable, please explain why					

Environmental Impact:	General Statement:						
	Has an environmental impact assessment been completed?	Yes		No		N/A	X
	If Not Applicable, please explain why						

Safe and Timely Discharge Update Report
November 2023

1.0 Introduction

The “Hospital Discharge and Community Support Guidance” July 2022 states that local areas should adopt discharge processes that best meet the needs of the local population. This could include the ‘discharge to assess, home first’ approach. Systems should work together across health and social care to jointly plan, commission, and deliver discharge services that are affordable within existing budgets available to NHS commissioners and local authorities, pooling resources where appropriate.

Under the Discharge to assess, home first approach to hospital discharge, the vast majority of people are expected to go home (to their usual place of residence) following discharge. The discharge to assess model is built on evidence that the most effective way to support people is to ensure they are discharged safely when they are clinically ready, with timely and appropriate recovery support if needed. An assessment of longer-term or end of life care needs should take place once they have reached a point of recovery, where it is possible to make an accurate assessment of their longer-term needs.

Multi-disciplinary hospital discharge teams and transfer of care hubs, comprising professionals from all relevant services across sectors (such as health, social care, housing and the voluntary sector), should work together so that, other than in exceptional circumstances, no one should transfer permanently into a care home for the first time directly following an acute hospital admission. Everyone should have the opportunity to recover and rehabilitate at home (wherever possible) before their long-term health and care needs and options are assessed and agreed.

This approach reduces exposure to risks such as hospital-acquired infections, falls and loss of physical and cognitive function by reducing time in hospital, and enables people to regain or achieve maximum independence as soon as possible. It also supports hospital flow, maximising the availability of hospital beds for people requiring this level of inpatient care and elective surgery, such as hip replacements.

Health and care professionals who are facilitating hospital discharges should work together with individuals, and where relevant with families and unpaid carers, to discharge people to the setting that best meets their needs. This process should be person-centred, strengths-based, and driven by choice, dignity and respect.

The vast majority of people being discharged should go home without the need for ongoing support (Pathway 0). Of those that remain, the majority of supported discharges should be going home (Pathway 1), with only a small proportion of people needing short-term bed-based intermediate care (pathway 2). Only in exceptional circumstances should someone be considered to need long-term care at the point of discharge (Pathway 3). See Appendix 1 for further details about discharge pathways

If a person's preferred placement or package is not available once they are clinically ready for discharge, they should be offered a suitable alternative while they await availability of their preferred choice. People do not have the right to remain in a hospital bed if they do not need acute care, including to wait for their preferred option to become available.

Stockport partners have been working to the above guidance through the Safe and Timely Discharge programme which was established under one of the five priority pillars of the One Stockport Delivery Programme.

Previous presentations to the Locality Board described our intermediate care model and developments to support people in the community in a bedded facility or at home. Since April 2023 the Stockport system is operating (in line with the guidance) with the following elements:

- Transfer of Care hub at Stockport Foundation Trust
- Multi-professional and multi-organisational teams support across all pathways
- Pathway 1 Reablement support
- Pathway 2 Bedded provision for short term placements across 4 units (1 run by SFT, 3 run by private care homes in Stockport) with primary care support
- Pathway 3 access via ASC

2.0 The Journey to date

From April 2023 a group met on a weekly basis as a response to significant pressure. Whilst this helped us achieve improvement and better working together as system partners it was in reactive mode and did not support a more forward-looking transformational approach that was required. Despite our progress and the arrangements, we had put in place we experienced significant challenges including:

- Too many people in hospital that should not be there (No Criteria to Reside- see Appendix 3 for definition).
- Too many people waiting for a long time once ready for discharge (No Criteria to Reside).
- Challenges to delivering a "home first" ethos because capacity to support people at home on pathway 1 appears not sufficient to meet demand, despite additional temporary support.
- Potential overprescribing of care: people getting temporary support from adult social care when it is perhaps not needed. (Pathway 1 when Pathway 0 would suffice).
- Over-reliance on community beds compared to other systems. Bedded care should only be used where a patient cannot get home as many studies show that getting home provides the best opportunity for recovery, and lessens the chance of acquired infections. It is also expensive and in turn leads to too many people in permanent residential care.
- Underutilised capacity in our community beds due to providers not being able to meet the needs of increasing complexity.
- Significant delays in discharging residents from neighbouring Integrated Care Partnerships with Derbyshire being the most challenging.

- Stockport Foundation Trust (SFT) has three unfunded escalation wards open to enable flow.
- National bed occupancy targets (92%) at Stockport Foundation Trust cannot be met if there is delayed discharge and poor flow.
- National Emergency Department targets (76% patients wait less than 4 hours) are difficult to achieve when there is poor flow.
- National Ambulance handover targets (30 mins for Cat 2) are difficult to achieve when there is poor flow.
- Lack of parity for mental health discharge with less focus, increasing numbers of people ready for discharge and increasing Out of Area Placements as no local mental health bed available.

In September 2023 to respond to the challenges, Stockport partners came together to reset our ways of working and provide more focus on this challenging area. We set up a Steering Group comprising the Deputy Place Based Lead (as Chair and Senior Responsible Officer), project support and senior team members from NHS Greater Manchester Locality team, and senior representation from Stockport Foundation Trust, SMBC Adult Social Care, Voluntary, Community, Faith and Social Enterprise (VCFSE), Mental Health, Primary Care and Healthwatch.

The steering group identified the following responsibilities:

- Set the vision: define what we are aiming for as a system.
- Define what good looks like.
- Include system culture, values and behaviours.
- Ensure a strength-based approach.
- Track progress.
- Unblock issues/ barriers.

We also set up workstreams with leaders and operational colleagues close to each of the pathways driving the work, including:

- System Operating Model.
- Pathway 0 – Improvement.
- Pathway 1 – Improvement.
- Pathway 2&3 – Improvement.
- Mental Health.
- Out Of Area Discharge.
- St Thomas`: future partnership model for intermediate care.

The leadership team is supported by a GMCA sponsored and Health Innovation Manchester delivered leadership programme called “Shifting Things That Move.” This is a new and experimental leadership programme focused on supporting leaders to identify and remove barriers to change.

3.0 Key Targets

The key target associated with safe and timely discharge for SFT is 12.5 % (73 patients) - No Criteria to Reside (NCtR) by March 2024.

After a focused piece of work across NHS Greater Manchester called “NCtR sprint” in summer we agreed as a system to a stretch target of 60 patients with No Criteria to Reside.

Targets for mental health differ slightly in terminology and are called “Clinically Ready for Discharge”. The targets for Mental Health discharge are set at a provider level between NHS Greater Manchester and Pennine Care NHS Foundation Trust, as the mental health bed base operates across a five borough footprint. The targets are in the process of being set and systems put in place to monitor at a Greater Manchester (GM) level starting from 17 November 2023.

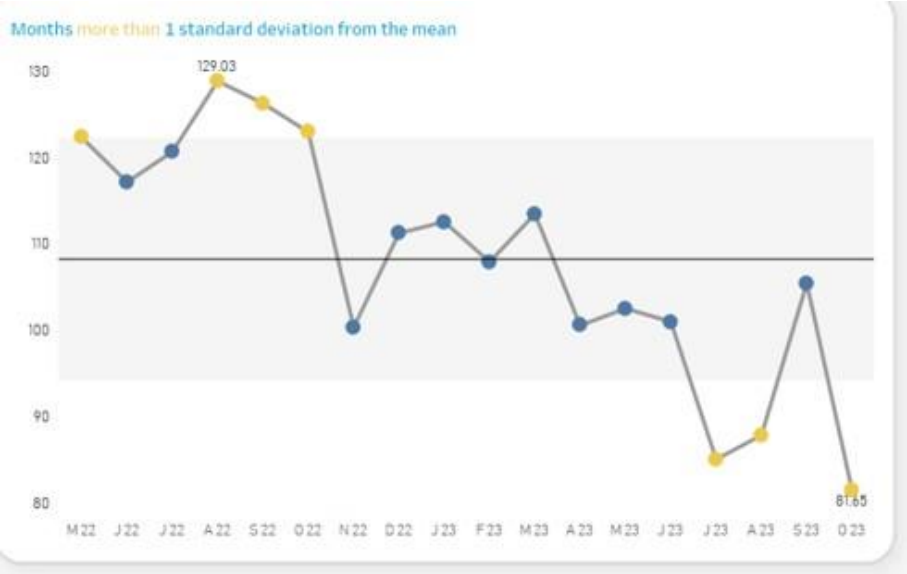
In addition, we review long length of stay in acute beds, long length of stay in community beds, overall bed occupancy in acute and community beds, and percentage flow into each pathway against national standards.

The data to support our understanding of the position in each of these areas, whilst improving, is not completely clear and easily available yet. The team are working with GM business intelligence colleagues to continue to improve the data and reporting.

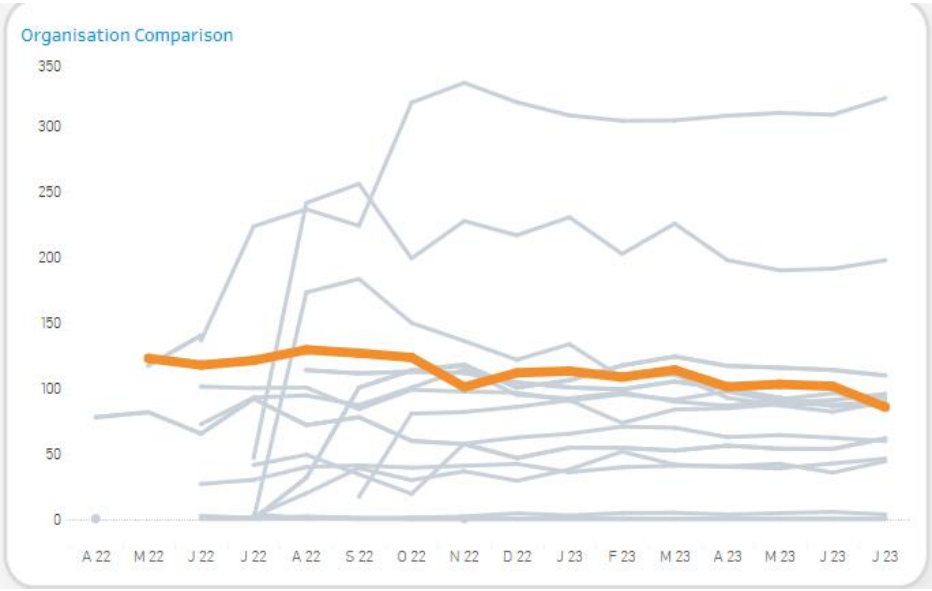
4.0 Progress report

Thanks to the hard work and collaboration, some examples of which are detailed below in the pathway report, we can see an overall downward trend for No Criteria to Reside. We know there is much more work to do and areas for improvement, which all partners are committed to, together. The second chart shows Stockport Foundation Trust relative to other Trusts within NHS GM.

Number of patients NCTR at SFT (total)



Number of patients NCTR SFT compared to GM localities.



5.0 Workstream progress reports

A summary of progress for some of the workstreams is as follows which covers August to November 2023. Progress is driven through the Steering Group and a system escalation meeting held weekly to help unblock any issues across any pathway, raised by any partner.

5.1 Pathway 0

SFT has made huge progress on improving flow through the hospital for those patients not needing any additional support, increasing the number of people going home on pathway 0.

This workstream will also focus on discharge of homeless residents, which is an increasing number. This will link with NHS GM Homeless workstream and other localities that are finding ways to support homeless residents better at the point of discharge.

5.2 Pathway 1

A reablement summit was held at the end of September 2023, which brought together partners involved in the pathway 1 process. The team presented a proposal to redesign the pathway 1 process to drive efficiency, and release capacity to provide for those residents that need support for an interim period.

The number of people in SFT with No Criteria to Reside on Pathway 1 has reduced significantly.

5.3 Pathway 2

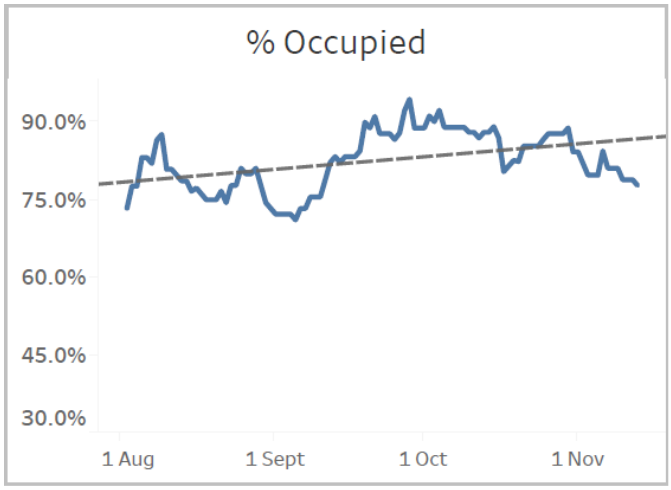
This workstream aims to:

- Increase acute flow and reduce hospital length of stay by accessing appropriate and timely bed placements for rehabilitation and complex discharge planning.
- Ensure appropriate effective community beds provision.
- Ensure appropriate community bed utilisation and length of stay by working with providers and system partners to ensure flow into and out of community beds.

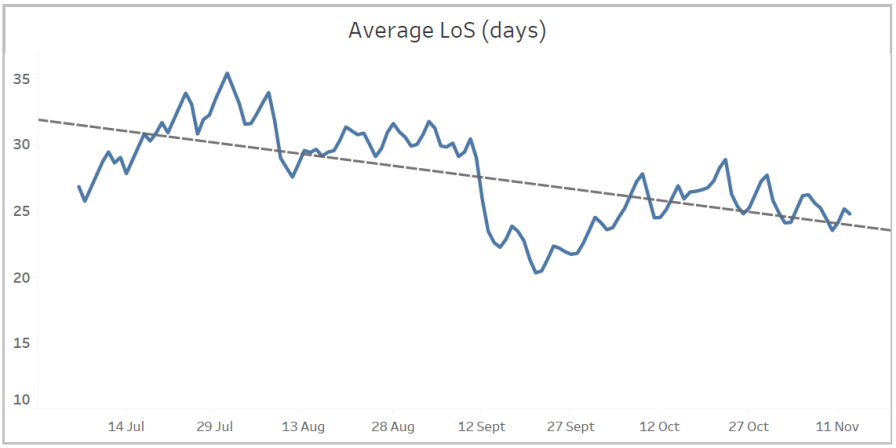
Key progress:

- The criteria for each bed base are under review with a view to standardisation to ensure we can meet the referral needs.
- Bed base contracts are under negotiation to ensure appropriate bed numbers and type are available to enable flow and providers are incentivised to keep occupancy high.
- Long length of stay in community bed base are now constantly reviewed and delays escalated to weekly flow meeting.
- Mental Health support in D2A placements is being sought.
- The flow into and use of mental health beds (Saffron ward). Is being reviewed.
- A trusted assessor model to reduce the number of people assessing the care needs is being trialled.

The D2A bed occupancy has improved: see table below



And the D2A Bed Length of stay has reduced: see table below:



5.4 Out of Area workstream

Key aims and objectives:

- Establish Leadership links with Derbyshire for escalations and resolutions.
- Agree and start to use formal escalation protocols with Neighbouring Trusts including East Cheshire/ Tameside Glossop/ Manchester.
- Agree wider scope of Out of Area workstream to include Mental Health, with key contacts in place able to report to Safe and Timely Discharge Steering Group.

Key achievements and successes August to November:

- GM Out of Area Patient policy has been adopted and is in place with Derbyshire colleagues - this has supported a positive relationship to address the ongoing challenges we jointly face.
- As a consequence, the ongoing number of long length of stay / no criteria to reside patients is reduced.
- Where we have escalated pressure levels, Derbyshire colleagues have joined calls to support and share their pressures.

- Derbyshire leadership team meeting has been established every 4 weeks with workstream Sponsor.

6.0 Other related activity and key relationships

The Safe and Timely discharge programme has a key relationship and dependency with other key programmes in our locality plan, namely

- Urgent and Emergency Care programme
- Neighbourhood and Prevention programme

The Urgent and Emergency Care programme includes 10 High Impact areas required to support Urgent Care activity. This includes areas we have identified as priority for development in Stockport including Same Day Emergency Care, Acute Respiratory Hubs, Virtual Ward, Single Point of Access and winter plans. Reports on progress in these related areas will come to Locality Board through the Urgent Care updates.

The importance of prevention and proactive care through our neighbourhood model is aimed to support residents to stay healthy and independent at home as far as possible. Reports to Locality Board come through the Neighbourhood and Prevention programme.

The above programmes are supported by all partners working together and making information, advice and guidance available to residents, as well as access to care in the community to meet needs locally and prevent unnecessary demand on our A&E at the hospital.

Healthwatch Stockport is supporting the work on Safe and Timely Discharge and has instigated a focus group with members to understand perspectives and feed in to all our work.

7.0 Communications

Local communications are an important part of this work programme. Work is progressing on winter resilience and ensuring Stockport residents are supported to prepare well for winter and understand the offer in the community as an alternative to A&E. As an example, NHS Greater Manchester run the “Know Where to Go” campaign and SMBC runs the “warm and well” winter communications plan. Healthwatch Stockport and Sector 3 are key partners.

The recent press coverage following the BBC Radio Manchester interview with Cllr Holloway highlighted that Stockport Foundation Trust was the worst performing Trust in the country for delayed discharge. The coverage also sighted care home capacity issues and ASC vacancies as contributing factors.

The data source for this report was known to be subject to some data quality issues which the NHS GM team are working on with acute trusts.

The above performance report shows the actual picture in Stockport which is improving.

Recommendation

The Board are asked to note the report and progress made.

Appendix 1: Discharge Pathway Definitions

Pathway 0

Likely to be minimum of 50% of people discharged:

- simple discharge home.
- no new or additional support is required to get the person home or such support constitutes only:
    - informal input from support agencies
    - a continuation of an existing health or social care support package that remained active while the person was in hospital.

Pathway 1

Likely to be minimum of 45% of people discharged: able to return home with new, additional or a restarted package of support from health and/or social care. This includes people requiring intensive support or 24-hour care at home.

Every effort should be made to follow home first principles, allowing people to recover, reable, rehabilitate or die in their own home.

Pathway 2

Likely to be maximum of 4% of people discharged: recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, before returning home.

Pathway 3

For people who require bed-based 24-hour care: includes people discharged to a care home for the first time (likely to be a maximum of 1% of people discharged) plus existing care home residents returning to their care setting (for national data monitoring purposes, returning care home residents will count towards the 50% figure for pathway 0).

Those discharged to a care home for the first time will have such complex needs that they are likely to require 24-hour bedded care on an ongoing basis following an assessment of their long-term care needs.

Appendix 2: Criteria to Reside – maintaining good decision-making in acute settings

Every person on every general ward should be reviewed on a twice-daily ward round to determine the following. If the answer to each question is ‘no’, active consideration for discharge to a less acute setting must be made:

- requiring ITU or HDU care?
- requiring oxygen therapy/NIV?
- requiring intravenous fluids?
- NEWS2 greater than 3 (clinical judgement required in persons with AF and/or chronic respiratory disease).
- diminished level of consciousness where recovery realistic?
- acute functional impairment in excess of home/community care provision?
- last hours of life?
- requiring intravenous medication > b.d. (including analgesia)?
- undergone lower limb surgery within 48 hours?
- undergone thorax-abdominal or pelvic surgery with 72 hours?
- within 24 hours of an invasive procedure? (with attendant risk of acute life-threatening deterioration).

Clinical exceptions will occur but must be warranted and justified.