Derby City Council

ADULTS AND PUBLIC HEALTH BOARD
14 July 2014

ITEM 8

Report of the Strategic Director of Adults, Health and Housing

Supporting timely hospital discharge and good quality recovery for frail older people

SUMMARY

1.1 This report sets out the progress that the Council is making in partnership with local NHS organisations to improve opportunities for Derby's frail older people to make the fullest possible recovery when they have suffered an illness or an injury that has required hospital treatment.

1.2 This has involved a challenging of traditional assumptions about the type of assessment that is needed to help older people leave hospital safely, using an approach called "Transfer to Assess".

1.3 The report explains the "Transfer to Assess" approach and sets out the complementary initiatives on which the Council is working with the NHS and other local partners, to give Derby's most vulnerable older people the best opportunities possible to live safely in their own homes in accordance with their wishes.

RECOMMENDATIONS

2.1 To note and support the Council's joint work with local NHS organisations in relation to "Transfer to Assess" and the complementary initiatives in support of frail older people set out in paragraph 8.3.

2.2 To agree any further reporting in relation to this partnership work.

REASONS FOR RECOMMENDATIONS

3.1 Partnership work on the "Transfer to Assess" project will result in larger numbers of frail older people being able to live safely in their own homes and will have a considerable impact on health and social care delivery in Derby.

SUPPORTING INFORMATION

4.0 Understanding frailty

4.1 A frail older person is prone to sudden changes in physical and mental health. Even a relatively minor illness can cause a frail older person to decline very quickly, perhaps through suddenly not being able to walk, or through becoming likely to fall, or through becoming confused. Sometimes frailty can result in symptoms that seem vague and difficult to explain, like weight loss, or extreme tiredness, or repeated infections. Frailty can often exist alongside dementia.

4.2 In Derby, health professionals have defined the following populations as particularly likely to indicate frailty:

a. Being over 65 and living in a care home
b. Being over 75 and having fallen
c. Being over 75 and having an episode of acute confusion
d. Being over 85 and having four or more health conditions

4.3 A frail older person can be very vulnerable, and many will need support both to recover from a sudden loss of health and to keep as healthy as possible for as long as possible afterwards. However, many of the symptoms of frailty mentioned above do not need care in a hospital bed to help them improve. Sometimes a prolonged stay in a hospital bed can make them worse.

5.0 The need to change our traditional approach

5.1 The conventional approach to allowing a frail older people to leave hospital requires the older person to complete a series of ward-based assessments to identify what kinds of support they will need. The older person is only discharged from hospital once all of these assessments are complete.

5.2 There are two problems with this approach from the point of view of the older person themselves.

- Firstly, when we put ourselves in the shoes of an older person who is in hospital, it becomes clear that the hospital ward is not the best place to see how they get on in their own kitchen, bathroom or bedroom. This means that, no matter how experienced or skilled the assessor is, the risk of an inaccurate assessment remains.
- Secondly, the extra time that it takes to assess a frail older person in hospital often creates further risks for them. They may well lose further confidence outside their familiar environment and they risk picking up infections from other patients who are being treated in hospital.

5.3 There are also problems for the NHS and for Derby City Council from the conventional approach.

- Most obviously, older people stay in hospital beds for longer. This costs more, and also creates pressure in the hospital which may need these beds to treat people who are still acutely ill.
- As above, older people can often lose independence from staying in hospital longer than they need to, or through being assessed in hospital without proper understanding of their home circumstances. Family and informal social support can also be lost or undermined. This means that on discharge they need more support than may well have been the case if they had been supported to leave hospital earlier. The most revealing example of this is the number of nursing home placements that are made from hospital. Derby and Derbyshire both make significantly more nursing home placements than comparable Councils. This also causes extra costs for the NHS in terms of Continuing Healthcare.

6.0 **The benefits of "Transfer to Assess"**

6.1 Dr Ian Philp, for 8 years the National Clinical Director for Older People in the Department of Health and now the chief medical officer for Hull and East Yorkshire Hospitals NHS Trust, says "*We need to turn this system on its head – discharge to assess, rather than assess for discharge*".

6.2 In Derby we have decided to use the word "transfer" rather than "discharge" because it better reflects the move from one form of support (in hospital) to another (in the community). The "transfer to assess" approach states that the best way to understand the longer-term needs of a frail older person is by working with them and their circle of support in their home or in a setting as close to this as possible. Only by doing that can we be really clear about their capabilities and the actual risks they face. This has been found to be especially true of older people living with dementia.

6.3 Therefore the role of any assessments undertaken in hospital is to do "just enough" to transfer the frail older person home, or into as homely an environment as possible. "Just enough" means ensuring the older person stays safe and comfortable, with sufficient support to allow further, tailored assessments to be undertaken. Further assessments, based on observing the older person at home or in a more homely setting, will provide the best possible idea of what is needed to keep them healthy and well.

6.4 A number of areas have worked hard to embed the “Transfer to Assess” approach over recent years.

- In 2012, the Frailty Unit in Sheffield saw a 34% increase in patients being discharged on the day of their admission or the following day, with no increase in the proportion of patients readmitted to hospital.
- South Warwickshire NHS Foundation Trust use an emergency community response team to provide a transfer to assess service, then hands over after two or three days to social care reablement and community health services. There were initial views that this approach would not be safe, but South Warwickshire have seen high patient and family satisfaction, a reduction in mortality rates and 0.1 per cent readmission rate, compared to the national average for older people of 5-6 per cent.
- Other areas, for example Hull and Sunderland, have also made significant progress on Transfer to Assess outcomes.

6.5 The following case example has been provided by the Sheffield Frailty Unit.
Mr D went home the day after he was ready for discharge – the one day delay was because his wife was unwell – and following his home assessment, was provided with a hospital-style bed and visited by carers three times a day. Under the conventional system, his team assessed Mr D would have been in hospital for a further 12 days. Sheffield conservatively estimated that for these 12 days, his home care package cost around £2,000 less than the equivalent care in hospital. More importantly, he spent this time where he wanted to be – with his wife.

7.0 Better outcomes for frail older people

7.1 From the viewpoint of a frail older person, the key principles behind Transfer to Assess are that:

a. I have the right to hospital treatment for as long as I need acute care
b. I must not stay in hospital for longer than I have to
c. I must be given the best chance to regain my former level of independence
d. You must get to know me and understand my strengths as well as the challenges I face
e. I must have the support I need to get better, whether I am in the hospital, at home or elsewhere

7.2 From the viewpoint of a frail older person, Transfer to Assess should result in the following outcomes:

a. My acute symptoms are effectively treated
b. I feel fully involved in discussions about my future needs
c. I don’t have to stay in hospital for longer than is needed to treat my acute symptoms
d. I feel happy about my hospital stay
e. I am able to safely manage at home with support, and only have to move to residential or nursing care as a last resort
f. I don’t have to come back to hospital unless I need further acute treatment
g. I feel happy about my life and the arrangements I have to support me when I leave hospital

7.3 The success of Transfer to Assess as a whole will be measured by bringing together the individual outcomes listed above. The most important performance measures for the frail elderly target population are as follows:

a. An increase in self-reported patient satisfaction with both hospital and community support
b. A reduction in hospital bed days
c. A reduction in hospital re-admission rates
d. A reduction in the use of permanent residential and nursing home placements

8.0 **Improving community support**

8.1 As above, “Transfer to Assess” is built on the principle of improving outcomes for frail older people living in Derby. For the great majority of older people, once acute illnesses have been treated, their own home is going to be the place that they recover best. The more quickly they are returned to familiar routines and surroundings, the more likely there will be a full recovery.

8.2 When recovering after illness or injury frail older people will chiefly draw upon on their own personal resilience, and the support of the family and informal networks that surround them. It is also vitally important that community health and social care services are there when needed, to help keep the situation safe and prevent any avoidable deterioration.

8.3 The Council and NHS partners have been working hard to further develop this community support.

- Southern Derbyshire Clinical Commissioning Group (CCG) have funded "Community Support Teams" attached to GP surgeries that will create the infrastructure to knit health and social care services together in support of the most vulnerable residents in every neighbourhood
- The CCG have also worked with the Royal Derby Hospital and the City Council to develop a "single point of access" where GPs and other health professionals can refer older people at imminent risk of deterioration, so health and social care can be quickly arranged to alleviate the risk of a crisis occurring.
- The Royal Derby Hospital are working with health and social care partners on an Integrated Therapy Review to improve the focus and capacity of Occupational Therapists and Physiotherapists to support older people in achieving rehabilitation goals both when they are in hospital and when they are back at home.
- Derby City Council have restructured social work and occupational therapy support so that most staff are deployed on a locality basis, to make strong connections with Community Support Teams, other NHS staff and local resources in neighbourhoods that will ensure the best possible support can be built around each frail older person in their own home.
- Derby City Council and the CCG are investing in further "Local Area Coordinator" posts to work in neighbourhoods and build up both individual and community resilience.
- Derby City Council and NHS organisations are working with voluntary and community organisations in a number of ways to support and sustain the many informal networks of information, advice and support that operate across the city.

8.4 The Council is also working with NHS and community partners to improve public information about sources of support within neighbourhoods. It is recognised that access to the right information and advice at the right time is often key for frail older people and their families in deciding whether they can continue to manage at home.

9.0 Ensuring discharges from hospital are as safe as possible

9.1 It is vital that the Council and NHS partners maintain a focus on patient safety and dignity in all hospital discharges. The "Transfer to Assess" approach will only have sustainable benefits if frail older people, their family members and involved professionals feel confident that they will be safe to leave hospital, and supported in such a way that they are given the best chance of recovering and getting back to their normal life.

9.2 The Council is playing an active part in a Discharge Experience Group that has been set up by the Royal Derby Hospital and chaired by its Chief Nurse to keep track of the experiences of people who have been discharged from hospital, good and bad, and to improve services in response to this. The group is attended by key organisations representing health and social care customers and carers like Healthwatch Derby and the Derbyshire Carers Association as well as front line health and social care staff and clinical leaders. The group will ensure that all improvements in supporting discharges from hospital are supported by the actual experiences and views of patients themselves.

OTHER OPTIONS CONSIDERED

10.1 Doing nothing will continue the status quo: significant numbers of older people will stay in hospital for much longer than they need to, reducing in their confidence and capability to the point when a return home will not be perceived as a viable option. Derby will continue to make significantly more residential and nursing home placements than many other authorities, with low satisfaction for older people who could have been supported at home and poor value for money to the Council.

This report has been approved by the following officers:

Legal officer	Robin Constable
Financial officer	Toni Nash
Human Resources officer	Liz Moore
Estates/Property officer	Steve Sprason
Service Director(s)	Phil Holmes, Perveez Sadiq
Other(s)	

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Background papers:	None
List of appendices:	Appendix 1 – Implications

Appendix 1

IMPLICATIONS

Financial and Value for Money

1.1 The “Transfer to Assess” approach will support the Council in delivering already agreed 2014-15 savings in relation to reducing the numbers of older people who need to be supported in residential and nursing care.

Legal

2.1 No legal implications

Personnel

3.1 No Personnel implications

IT

4.1 No IT implications

Equalities Impact

5.1 No adverse equalities implications

Health and Safety

6.1 No Health and Safety implications

Environmental Sustainability

7.1 No environmental implications

Property and Asset Management

8.1 No property implications

Risk Management

9.1 Risks in relation to this workstream are being managed by a multi-agency steering group.

Corporate objectives and priorities for change

10.1 This workstream meetings the following Council Plan objectives:

- Better outcomes for our communities
- Improved value for money for our customers
- More efficient and effective processes
- A skilled and motivated workforce