Item 8 – Delayed Transfers of Care

As a result of examining the issue during this meeting, the Committee is asked to consider what recommendations to make.

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Briefing Note

Delayed Transfers of Care

Introduction

"Delayed transfers of care" is where a patient remains in hospital waiting to move into a different care environment after an appropriate and agreed upon date. It is quite a wide-ranging term and refers to when a patient moves from one type of NHS care to another (e.g. inpatient surgery to recuperative care); moves from NHS care to have services provided by social services; or moves from NHS services to privately-funded residential or nursing care.

The Community Care (Delayed Discharges etc.) Act 2003

The Community Care (Delayed Discharges etc.) Act 2003 was brought in by the Government in an attempt to deal with the issue of delayed transfers of care.

The first part of the Act sets out the duties of local authorities and the NHS in relation to people in hospital. It also allows for local authorities to be fined either £100 or £120 (depending on geographical location) by the NHS for each day of delay solely attributable to them. In practice, alternatives to paying the fines of this reimbursement regime have been developed.

The potential effects of this reimbursement regime were offset by the introduction of the delayed discharges grant. For each year of the scheme so far, £100 million has been moved from the NHS to local authorities to help them meet the costs of reimbursement or to assist local authorities in dealing with the issue of delayed discharges. The amount received by each authority is based on the older people's Formula Spending Share. For Kent County Council in 2007/08, this grant totalled £2,477,136.

Kent County Council, in common with many other areas of the country, has come to an arrangement with the NHS locally to invest the delayed discharges grant in improving services and reducing delayed discharges.

The regulations implementing the Act specify that the reimbursements only apply to patients moving out of acute care. Acute care is defined as:

- "intensive medical treatment provided by or under the supervision of a consultant which is for a limited time after which the patient no longer benefits from that treatment." (The Delayed Discharges (England) Regulations 2003. SI 2277 2003).

The power exists under the Act to extend the regulations to other areas like maternity, mental health, palliative, intermediate and recuperative care but is restricted to acute care at present.

The Delayed Transfer of Care Process

Each hospital has protocols for assessing the needs of patients and for planning the date of discharge. A date will be specified soon after admission, but kept under

constant review. NHS bodies are required by the Act to inform the appropriate local authority of individuals who are likely candidates to need community care upon leaving hospital. They must also give notification of the proposed discharge date. The local authority is allowed a minimum of two days to consult with NHS professionals and draw up a discharge plan determining which services will be provided. Sundays and public holidays are excluded from the minimum period.

In East Kent delayed transfers of care are the responsibility of the Unscheduled Care Action Group (UCAG), which has been in place since December 2005. Its membership is drawn from East Kent Hospitals University Trust, Eastern and Coastal Kent PCT and Kent Adult Social Services. Meetings are held across the week at each of the three acute hospital sites across East Kent, the first being a discussion forum and the second a validation meeting. Issues are then moved on to the weekly UCAG meeting. UCAG also oversees the reimbursement grant relating to delayed transfers of care from EKHUT. Three pilot schemes are underway at each of the main East Kent Hospitals University Trust sites to trial different ways of working.

In West Kent three Whole Systems Groups have recently been established. These are based around the three main acute hospital sites – Kent & Sussex, Maidstone and Darent Valley. Each Whole System Group is responsible for looking at and resolving local transfer of care issues. If an issue cannot be resolved, it goes up to the Urgent Care Board (which is the equivalent of the East Kent Unscheduled Care Action Group). These Groups similarly include representatives from the hospital, social services and PCT. On 1 July 2008, a discharge planning pilot commenced at MTW with the aim of improving the process.

At these meetings, a situation report (usually referred to as a “sitrep”) is completed. Sitreps are required by Government and go on to form part of Unify 2 (the Department of Health’s web-based data collection system). As part of the sitrep, one of the following reasons is assigned for any delays to discharge:

A) Completion of assessment
B) Public funding
C) Further non acute NHS care
Di) Residential Home
Dii) Nursing Home
E) Domiciliary Care Package
F) Community Equipment
G) Patient or family choice
H) Disputes
I) Housing

A note is also made (where applicable) as to whether the delay is attributable to the NHS or social services singly, or both, jointly.

National Performance Indicators

There is a performance indicator related to transfer of care that forms part of the annual performance assessment of social care services carried out by the Commission for Social Care Inspection and the Annual Health Check of Acute and Primary Care Trusts by The Healthcare Commission. These indicators relate specifically to patients moving from acute care.

The delayed transfer of care indicator for the Annual Health Check sets a target of no more than 3.5% of patients in acute beds having a delayed transfer of care for any reason. The figure is derived from dividing the number of patients who occupied an acute hospital bed and had his or her transfer delayed and the total number of patients who occupied an acute hospital bed over the same period.

Latest figures (drawn from relevant Trust Board Papers):

Trust	August 2008	Year to date (i.e. from 1 April 2008)
Dartford and Gravesham NHS Trust	2.8%	3.0%
East Kent Hospital University NHS Trust	3.4%	3.4%
Maidstone and Tunbridge Wells NHS Trust	2.9%	3.1%

This is an improvement on the figures for the Annual Health Check for 2006/07, where only Dartford and Gravesham Hospitals Trust were rated as having "Achieved" this target of 3.5%. All the other Trusts in Kent "Under achieved" meaning a percentage of less than or equal to 5%, but greater than 3.5%.

The Annual Health Check for 2007/08 will be released on 16 October 2008. However, the Healthcare Commission has confirmed that for technical reasons there will be no scored rating for this indicator for 2007/08. An assessment using a different method will be produced separately.

The same data which is used for the Annual Health Check (drawn from the sitrep reports on Unify 2) are also used by the CSCI as part of their annual performance assessment of social care services. Again, the most recent report relates to 2006/07.

Overall, Kent adult social services were given 3 stars (the highest). They were rated "Good" for "Delivering outcomes" and "Excellent" for "Capacity for improvement". The portion of the summary report most relevant to this issue is as follows:

- "A variety of intermediate care services have been expanded this year, which has supported social care to keep delayed discharges from hospital at a reasonable level. However, delayed discharges from hospital due to health needs are still very high and evidence is available is to explain the position."

Intermediate Care

The aim of intermediate care is to provide short-term rehabilitation services to avoid unnecessary admission (or readmission) to hospital or facilitate timely discharges enabling a person to return and live independently in their own home. In some cases an individual may require additional assistance from social services.

The second part of The Community Care (Delayed Discharges etc.) Act 2003 relates to intermediate care. It states that intermediate care must be provided free of charge for six weeks, wherever it is provided. It is here that the role of community hospitals is discussed, as they are sometimes used for the purposes of rehabilitation.

Items of community care equipment up to the value of £1000 which a person is assessed as needing to return home must also be provided for free (this includes such things as shower chairs, walking sticks etc.)

The services provided and the organisation responsible depends on the individual needs assessment of the patient.

A Whole Systems Approach

Tackling the issue of delayed transfers of care is often referred to as requiring a 'whole systems approach', meaning any solution will involve more than one organisation. There are many different ways to reducing the numbers who are delayed. In a broad sense, these include:

- Preventative measures – broader public health initiatives and changes to the way health care is delivered to reduce the total numbers of people that enter hospital/need acute care.
- Process – looking at works to improve the way in which patients are assessed and how different bodies work together.
- Capacity – looking at whether the resources and infrastructure exist in the NHS, social services and elsewhere to deal with the needs of people as they leave acute care.

Appendix: Responses from Kent MPs

As part of the background research for this topic, all the MPs in Kent were written to and informed that the issue of delayed transfers of care was being examined. They were also invited to submit any information they had about the number of complaints received from constituents relating to this issue.

Six MPs submitted information on time periods ranging from several months to a year. Only two reported receiving any complaints about delayed transfers of care and they were all related to Medway, as distinct from Kent.

Tristan Godfrey
HOSC Researcher

From: Greg Clark, M.P.

HOUSE OF COMMONS
LONDON SW1A 0AA

17 July 2008

Paul Carter
Leader
Kent County Council
Sessions House
County Hall
Maidstone
Kent ME14 1XQ

Dear Paul

Delayed Discharges from Hospital

Over the last year, in meetings with MTW NHS Trust, West Kent PCT, the Strategic Health Authority and, most recently, Kevin Lynes and Oliver Mills from KCC, Sir John Stanley and I have been investigating delayed discharges from local hospitals. This work was prompted by constituent concerns and hospital visits which demonstrated the very difficult situation being faced by clinicians, particularly in A&E, when hospital beds were being used to capacity.

While we appreciate the progress that is being made, particularly by KCC, in addressing this problem, we believe that it would be exceptionally helpful if KCC's Health Overview and Scrutiny Committee were to examine the issue in greater detail. Both Sir John and I would wish to give evidence to the Committee and I would encourage other Kent MPs also to consider this.

Delayed discharges continue to be a significant issue locally and I am convinced a Scrutiny investigation could have a considerable impact in helping to resolve the problem.

Yours sincerely,

Greg Clark MP

cc Lord Bruce-Lockhart of the Weald
Kevin Lynes, Cabinet Member
Oliver Mills, Strategic Director
Rt Hon Sir John Stanley MP

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NHS
Eastern and Coastal Kent

DELAYED TRANSFERS OF CARE

Briefing

Health Overview and Scrutiny Committee

17th October 2008

FOR FURTHER INFORMATION PLEASE CONTACT:-

Simon Perks
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Eastern & Coastal Kent PCT
01227 795074

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1. DELAYED TRANSFER OF CARE

1.1 The term “delayed transfer of care” is used to describe a situation that occurs when an individual is ready to transfer from an acute care setting but continues to occupy an acute bed. An individual is ready to transfer when:

- A clinical decision has been made that an individual (described in the acute setting as a patient) is ready to transfer, and
- A multidisciplinary team decision has been made that a patient is ready to transfer, and
- The patient is safe to discharge/transfer.

1.2 Delays sometimes occur for some people once these three criteria have been satisfied. The reasons for the delays are numerous and complex, but may be summarised as:

- Inadequate and/or untimely assessment and planning for transfer
- Ineffective whole system working to enable timely transfer
- Insufficient placements of the right type for onward transfer from acute settings
- Innate expectations of patients and their carers, and
- Inadequate agreement about funding for ongoing care

1.3 Delayed transfers of care are a complex area of activity, given the critical need for health and social services to work very closely together, to ensure the right outcome for the patient, and their carer, where relevant. It can often mean that life-changing decisions have to be taken if people are to be transferred to residential or nursing care.

2. MEASURING DELAYED TRANSFER OF CARE

2.1 The Healthcare Commission sets a standard about delayed transfers of care. The standard includes the requirement that people should receive the right care in the right place at the right time. NHS commissioning organisations, with acute trusts and their community and social service partners must ensure that people move on once they are well enough.

2.2 The Healthcare Commission delayed transfer of care indicator measures the impact of community based care in facilitating timely discharge from hospital, together with the quality of service received in hospital and the mechanisms in place within the hospital to facilitate timely discharge. People should receive the right care in the right place at the right time and PCTs must ensure, with acute trusts and social service partners that people move on from the acute environment once they are safe to transfer.

2.3 The Community Care (Delayed Discharges, etc) Act 2003 facilitates joint working with social services and requires partners to identify the causes delay and the actions required to tackle delays within the local system but also to a safe environment, whether that is in their own home or another setting.

2.4 NHS Eastern and Coastal Kent (“the PCT”), working with Kent Adult Social Services and its major providers of health services, maintained delays in the

transfer of patients within limits set by the Healthcare Commission during 2006/07. Despite this, the placement within national rankings was poor (Eastern Coastal Kent ranking 140 out of 152).

During 2007/8, performance improved and as a result of renewed focus over the past year, with the introduction of new ways of working including a pilot of assessment beds, the percentage of delays reduced from 4.8% to 3.6% (as at August 2008). Nevertheless, intensive and sustained effort is required to bring the number of delays within acceptable limits (the aim is <3% for the year 2008-09) and ultimately to achieve the goal of zero tolerance of delays.

3. ENABLING SAFE TRANSFERS OF CARE

3.1 Delays in transfer for people ready to leave an acute setting may result in loss of independence, mobility, motivation and wellbeing and pose a risk of healthcare acquired infection. Delays also deprive others in need of acute intervention of the treatment they need. For these reasons it is important that people do transfer from an acute setting as soon as they are able to do so.

3.2 NHS Eastern and Coastal Kent (the PCT) invested an additional £1m with KASS in 2007-08 to facilitate effective transfers of care from acute health care settings. The PCT has also established a Group to oversee the governance of safe transfers of care as these affect the population of eastern and coastal Kent. The Group has a full membership from health and social care partners and has made three reports to the NHS Eastern and Coastal Kent Patient Safety and Quality Sub Committee since June 2008. These reports have been able to draw on the significant learning emerging from existing work in progress through the KCC/NHS Urgent Care Programme. This work, described in the Urgent Care Programme Assessment Beds Pilot Final Evaluation Report suggests further key enablers to minimise delays that are:

- The need for full understanding and engagement of individuals and their families and carers in the transfer process.
- The importance of having a single, agreed pathway and process for transferring patients from one setting to another – currently a number of inherited arrangements are in place, and these are being reviewed by the Group.
- The importance of having a shared understanding of the roles and responsibilities of each agency involved in providing care to each person being transferred.
- The importance of effective, multidisciplinary teamwork. Three pilot schemes have been established at each of the East Kent Hospitals University Trust sites to test best ways of working. The learning will be shared with partners including Medway Foundation Trust.
- The need for in depth assessment of each individual's capability and potential for rehabilitation once the need for an acute stay in hospital is past but when immediate return home is not yet possible, (see next section).
- The essential requirement for sufficient numbers of effective support packages for those who need continuing care in their own homes or in a care home setting.

- The importance of having sufficient numbers of effectively trained staff for those requiring continuing care once they leave hospital.

3.3 The Patient Safety and Quality Sub Committee will oversee the work programme embarked upon by the Transfer of Care Governance Group that will take account of these enablers.

4. ASSESSMENT BED PILOTS

4.1 Some people are not ready to return home when they are ready to leave the acute setting and need an opportunity for:

- More intensive rehabilitation to enable their going home
- More detailed assessment of their needs
- Arrangement of a care package and equipment to enable their transfer home
- Time to take a decision about a different place of long term care.

The provision of assessment beds, both within community hospitals and registered care centres run by Kent Adult Social Services, has been tested in a pilot scheme, and the successful result is informing future commissioning decisions about expanding the availability of assessment bed availability for the whole population of eastern and coastal Kent.

5. FUNDING

5.1 Funding arrangements are frequently cited as reasons for delayed transfers of care. A small number of people with complex health needs and those who are nearing the end of life may be eligible for NHS funded continuing health care. Others may be eligible for combined funding from both the NHS and social services, whilst others will fund their own care. NHS Eastern and Coastal Kent (the PCT) is committed to arrangements for funding to be agreed “away from the bedside” and should not delay transfer of individuals. The opportunity presented for expanding the direct payments scheme implemented through the “Kent Card” to health care as a result of forthcoming legislation resulting from the *NHS Next Stage Review (July 2008)* will be explored by the PCT and KASS working together.

6. CONCLUSION

6.1 In conclusion the PCT has an aim that is to work with all partners to eliminate all possible delays in transfer from acute care settings for individuals who are assessed as clinically fit to transfer and where it is safe for them to do so. The need is to ensure we build on existing arrangements and innovations, good will and hard work to ensure we have the best possible arrangements in place.

6.2 The outcome we seek is a fully integrated system with a single and agreed approach to assessment, care delivery, information management and record keeping; with sufficient capacity in the immediate, short, and longer term. There is a need to concentrate on excellent communication and information and to consolidating professional trust, to ensure effective joint working between health and social services.

6.3 People with complex needs, who are most likely to pose difficulty with transfer/discharge should be actively identified prior to admission wherever possible. People at high risk should have a case manager/community matron. Most people who pose challenges about transfer/discharge are well known in the "system" and anticipatory care needs assessment and care planning is a critical "step development" needed. Where this has not happened and the need for such a complex assessment becomes apparent while an individual is in the acute hospital, and especially where a decision is needed about a move to a care home, the individual should be able to transfer to an assessment bed to allow the appropriate arrangements to be set in place in a timely and sensitive manner.

6.4 Effective planning (and not fire fighting) is essential, with attention to the small changes that can make a difference. Once declared fit to leave an acute environment individuals should not be "lying in wait" for assessment; public funding for ongoing care; further but different NHS care; residential care; ongoing nursing care; community equipment; domiciliary care; awaiting the exercise of choice or disputes. All this should be undertaken (if not anticipated and in place ahead of time) in the assessment bed facility to a predetermined timescale.

Full details of the pilot scheme for assessment beds are available on request from:-

Anne Tidmarsh anne.tidmarsh@kent.gov.uk
Or
Sue Baldwin sue.baldwin@eastcoastkent.nhs.uk

For further information please contact the lead commissioner:-

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7 October 2008

NHS West Kent

Briefing Report to Health Overview & Scrutiny Committee

Delayed Transfers of Care

17th October 2008

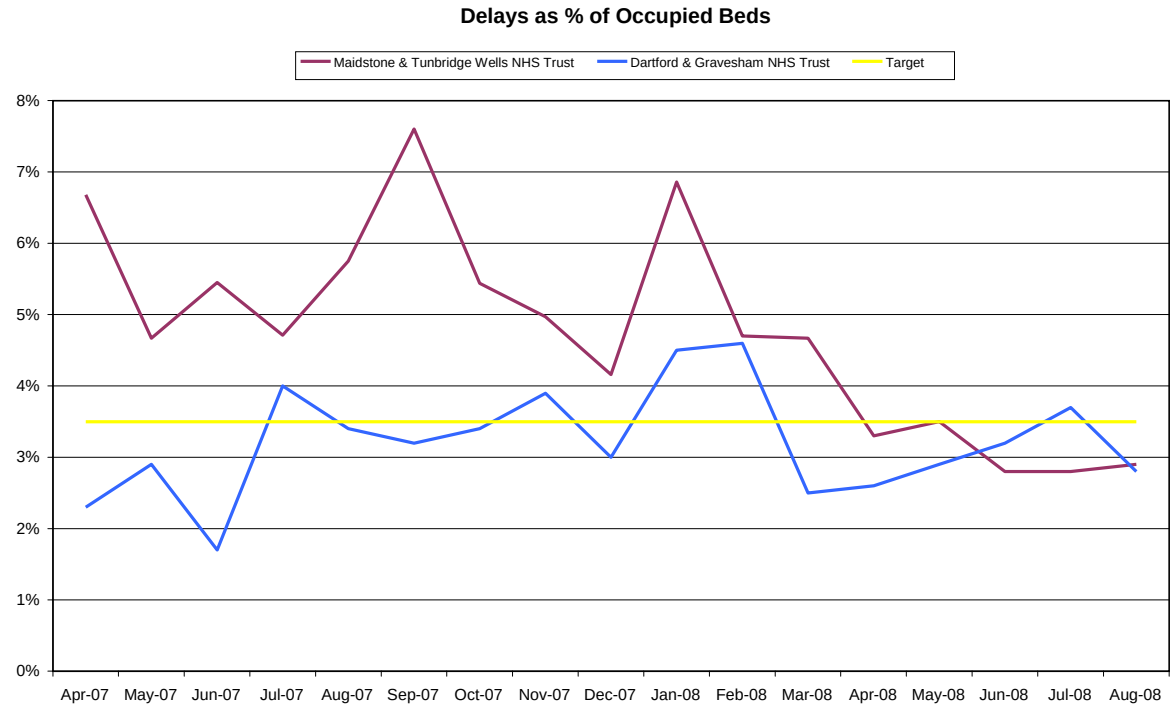
The reduction of delayed transfer of care remains an area of priority concern across the whole health & social care economy.

a) Latest Performance Data

The latest position is of an improving picture, with fewer people in West Kent experiencing a delayed transfer of care when leaving hospital. Both Acute Trusts are reporting delays below 3.5%. Performance for August 2008 was:

Dartford & Gravesham NHS Trust: 2.8% (year to date 3.0%)
Maidstone & Tunbridge Wells NHS Trust: 2.9% (year to date 3.1%)

This is a significant improvement on last year's performance which reached above 5.5% for Maidstone & Tunbridge Wells NHS Trust and over 3% for Dartford & Gravesham NHS Trust.



The graphs at the end of this document provide a snap shot of the reasons for delays to transfer during the 13-week period 23rd June to 21st September 2008, as reported in the weekly SITREP reports. The data reported includes all delays for West Kent patients only attributed to NHS and social care as reported by Dartford and Gravesham NHS Trust, Maidstone and Tunbridge Wells NHS Trust and West Kent Primary Care Trust for both acute and non-acute care. In each care type, the data is

displayed in two graphs, firstly by no. of patients, and secondly by no of days. Reimbursable delays which are the delays which are attributable to social services reasons, in Maidstone & Tunbridge Wells Trust remain negligible, with most delays attributable to NHS related issues (continuing health/residential care placements and patient choice).

b) Partnership Working

Local health and social care partners in West Kent continue to work collaboratively to bring about a sustained improvement in delayed transfers of care and to improve further the experience of patients leaving hospital.

At operational level, Whole Systems Groups now meet regularly in the three localities, to discuss and resolve local transfer of care issues. Chaired by PCT locality managers, the Groups consist of representatives from social services, ambulance service, mental health service, private and voluntary sector providers.

Over the past year there have been a number of developments in West Kent aimed at improving collaborative working 'on the front line' in assessing, planning and arranging a patient's transfer of care. These include:

Discharge Planning Pilot: This collaborative project involving the PCT, Maidstone & Tunbridge Wells NHS Trust and Kent Adult Social Services, involved piloting changes to the discharge planning process as recommended by staff, including those on the frontline, from all three organisations who attended a rapid improvement workshop held earlier in the year.

Its aim was to achieve a more co-ordinated/whole-systems approach to managing a patient's discharge, by providing clear dates and key actions for the multi-disciplinary teams to work towards.

The pilot ran during July and August 2008, and involved PCT community teams, KASS care management and MTW teams at both Maidstone Hospital and Kent & Sussex Hospital, across four medical wards, the Acute Assessment Unit and Medical Assessment Unit. The four key proposals being tested were as followed:

- **Patient Streaming** – early categorisation of anticipated length of stay, with patients being categorised as 'red' (complex) or 'green' (simple). All patients admitted through the MAU/AAU during the pilot period were streamed.

- **Robust estimated date of discharge (EDD) process** – based on 'streaming, which would be updated during the patient's episode of care.

- **Consistent multi-disciplinary team (MDT) assessment** – held weekly at ward level to agree discharge plans for complex patients.

- **Efficient transfer of care process** – community services involved earlier, awareness of potential patient end point from an early stage.

An analysis of the pilot has indicated that there is more to do to ensure that new processes are embedded into practice and undertaken in a systematic way. KASS and PCT teams at both sites committed fully to the pilots and attended every MDT

and participated fully in the discharge planning process. The pilot has shown that a multi-agency approach, with strong leadership at ward level, is essential to provide focus and direction when planning a patient's discharge.

Weekly SITREP Meetings: PCT managers now attend the meetings between the acute Trust and Social Services, at each of the acute hospitals to resolve transfer issues for individual patients.

Hospital Care Management Teams: All hospitals have a dedicated Hospital Social Services Team, whose role it is to facilitate discharges through working in partnership with ward and primary care staff. In addition to all the usual services provided by the Local Authority, these teams can access a range of step-down beds provided in nursing homes to assist with discharges, these beds are funded via reimbursement money. Each Hospital Social Services Team has a £52,000 annual fund to be used at the Team Manager discretion to aid specifically with managing hospital avoidance and timely discharge. This can be used to purchase services or placements to assist with timely discharges from acute beds.

Joint Agreement on non-weight-bearing patients: It has been identified that a small number of patients have remained in hospital longer than necessary. Because they are non weight-bearing, usually in plaster, they do not meet the criteria for rehabilitation or intermediate care in a community hospital, nor can they transfer to a residential home. West Kent PCT, Kent CC and Maidstone and Tunbridge Wells NHS Trust have jointly agreed to commission 3 nursing home placements in the Maidstone and Tunbridge Wells areas, for such patients until they are able to weight-bear. Therapy input and case management will be provided by WKPCT Rapid Response Team who will manage the patient's transfer to appropriate care, once fit to do so.

Reimbursement: The Department of Health provides Kent Adult Social Services with funds to help facilitate hospital discharge. In West Kent the total amount is £1.2m. In the MTW area £166,000 is used to purchase six nursing home beds which are solely for the use of Rapid Response Teams. The reimbursement money is used to fund a variety of schemes, all identified as crucial to effective discharge planning. Some of the money has been used to support additional WK PCT nursing and therapist posts. All schemes or posts funded through reimbursement have been commissioned in partnership with the NHS and have been evaluated to ensure that they are contributing to either admission avoidance or timely discharge.

c) Costs associated with delayed transfers of care

It is difficult to provide a single figure to represent the cost of a delayed transfer. It is dependent on several factors. Under 'Payment by Results' arrangements, hospitals receive a sum of money from the PCT for each activity/procedure they carry out. The price or ''tariff' is set nationally and varies according to the type of procedure/speciality or Healthcare Resource Group (HRG). Any admission may incur 'excess bed days'. These occur as a result of overstepping a trim point as defined in the National Tariff. There are different trim points associated with different types of treatment e.g. the trim point for a Primary Hip Replacement is 23 days. If a patient were to stay in hospital for 30 days say, this would equate to 7 excess bed days, valued at a unit cost. The unit cost also depends on the type of treatment. An average cost is around £200 per day.

If a patient was discharged before the trim point and received rehab or care from NHS community services, it could therefore be viewed as incurring additional costs to the PCT. The Acute Trust would be able to generate additional income by using that bed for another patient and assist in meeting the 18-week target for referral to treat. However it should be noted that not all delayed discharges will be treated as an excess bed day if they are discharged before the trim point.

d) Services provided for people leaving hospital

A range of services are provided to support people leaving hospital, including:

Community Hospitals: The PCT has increased the available community bed numbers to 132 and has altered its criteria for the use of these beds in order to ensure that this limited resource is used most effectively. They now provide inpatient care for those people needing either a step-up bed to avoid an un-required acute hospital admission or a step-down bed for patient requiring rehabilitation. This step up/step down model has allowed a greater throughput of people who can benefit from intensive therapeutic input. The average length of stay has been reduced from 24.9 days 18 months ago, to less than 18.0 days this year.

Nursing & Residential Care: Increasingly, the PCT have been using local nursing homes to place people who meet the criteria for NHS funded continuing care. Using a community hospital bed for such people would be inappropriate because they would not benefit from the intensive therapeutic input available there, but instead require an environment where they can receive more intensive long term support or end of life care.

Recuperative Care provided by Kent Adult Social Services: The is services provides up to 6 weeks rehabilitation therapies for people over the age of 55, provided in a residential setting. The aim of Recuperative Care is to provide a short period of intensive rehabilitation which will help people to regain the skills and confidence needed to return to living as independently as possible in the community. Provision is located in Dartford, Gravesend and Maidstone but accessible from people reside throughout West Kent.

Intermediate Care Teams including:

Community Liaison Teams appointed by West Kent PCT to provide support, advice and liaison between acute, intermediate, primary health and social care providers, including private sector care homes. Already established in the Dartford & Gravesham area, the PCT is in the process of recruiting further nurses in order to roll out this model to the rest of West Kent. The Teams work both in A&E to prevent unnecessary admission to hospital by identifying patients who could be managed in the community, and also as part of ward-level multi-disciplinary teams (including therapists, discharge nurses and medical staff) to facilitate timely discharge to community services)

Rapid Response Teams: which now provide a 24/7 service, including rehabilitation after hospital admission following surgery or falls. The focus is on promoting independence, risk reduction and promoting a healthier lifestyle.

Other Community Health and Social Care Supporting People Leaving Hospital

Community Nursing Service uses an individualised holistic approach to health assessments, identifying nursing needs and delivering a high standard of care to promote health and well being. Nursing services are also available during twilight/evening/night hours where required.

Community Matrons and Case Managers proactively respond to the needs of patients with complex needs, managing and supporting patients with long term conditions to enable independence and an improved quality of life.

Community Neuro/Rehab/Therapy Teams

Sapphire Wing Inpatient Neurological Rehabilitation Service (12 beds) is a nurse-led multidisciplinary service for adults who are medically stable but require inpatient rehabilitation of a neurological event. It works closely with the Community Neurological Rehab Team, Dartford and Gravesham NHS Trust, GP practices and other community health and social services. Medical advice is covered by a Consultant in Rehabilitation Medicine and dedicated GPs.

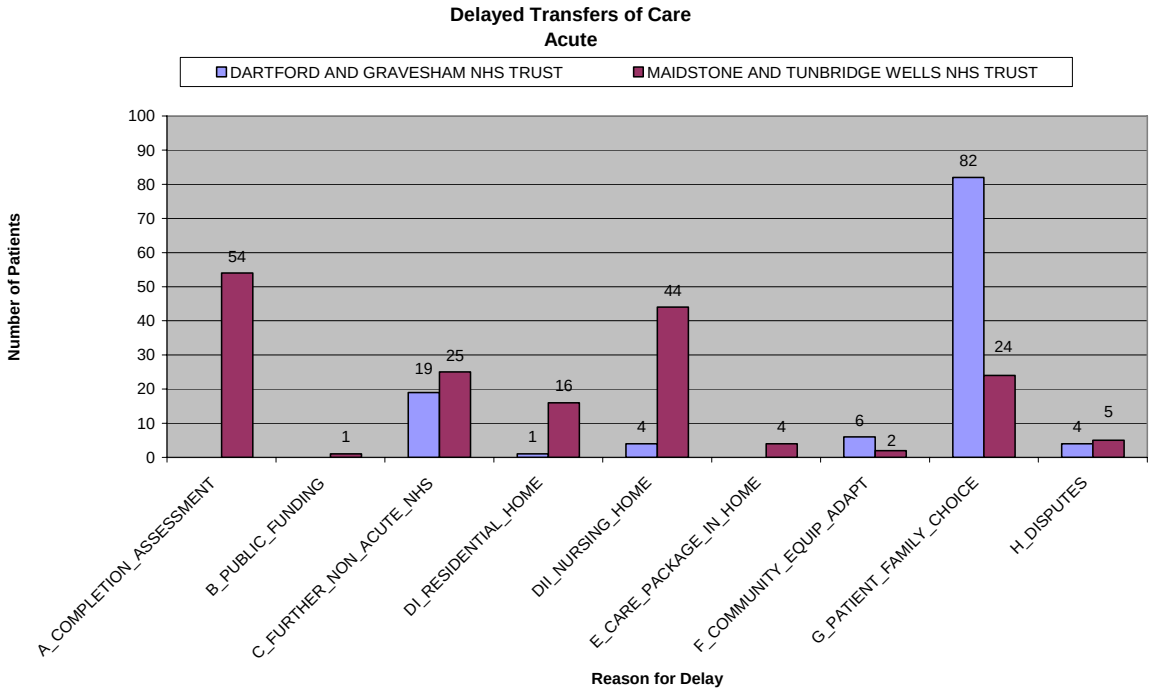
Specialist Nurses (including continence, tissue viability, heart failure, COPD) working with patients with specific conditions to enhance quality of life and to reduce hospital admissions.

Advanced Musculoskeletal Practitioner Service providing an interface between primary and secondary care for patients with musculoskeletal problems requiring physiotherapy extended scope practitioners.

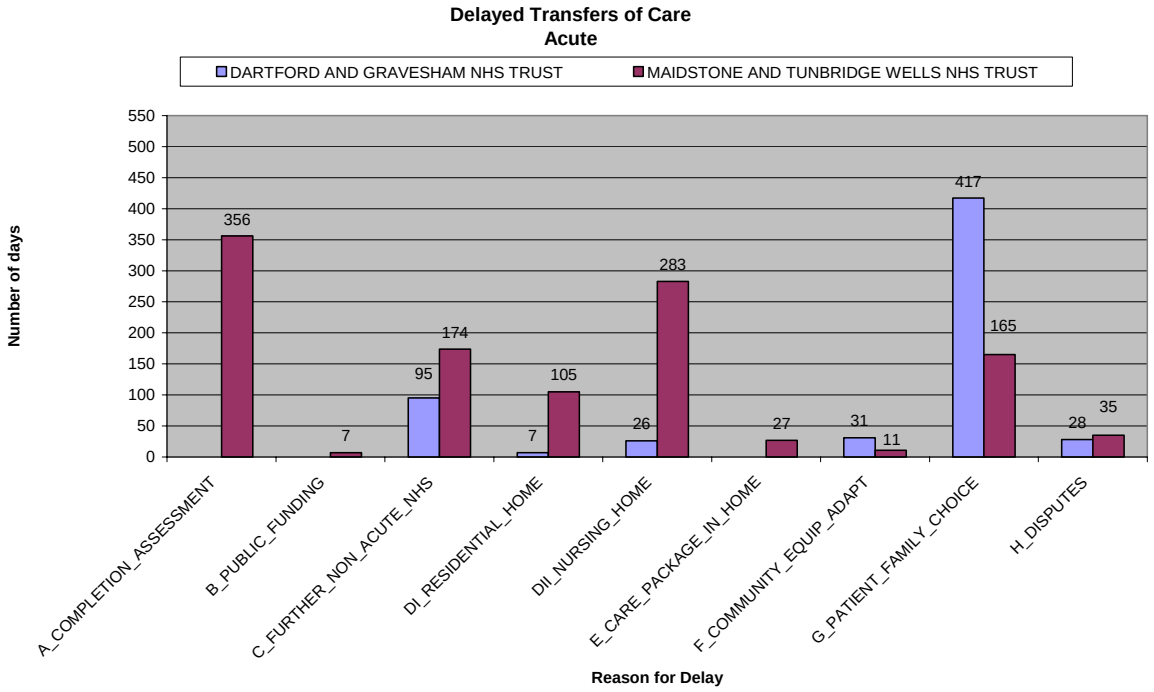
Integrated Community Equipment Service (jointly with Social Services) to enable people to be nursed or remain independent at home.

Active Care – community based service provided by Kent Adult Social Services: This is a short-term service of up to six weeks to enable people in their own homes to improve / maintain their daily living skills following a stay in hospital or some other change in circumstance. Referrals to Active Care will be via a Care Manager. A Home Care Supervisor will work with the individual to draw up their support plan and a team of recuperative domiciliary carers will visit to assist on a daily basis.

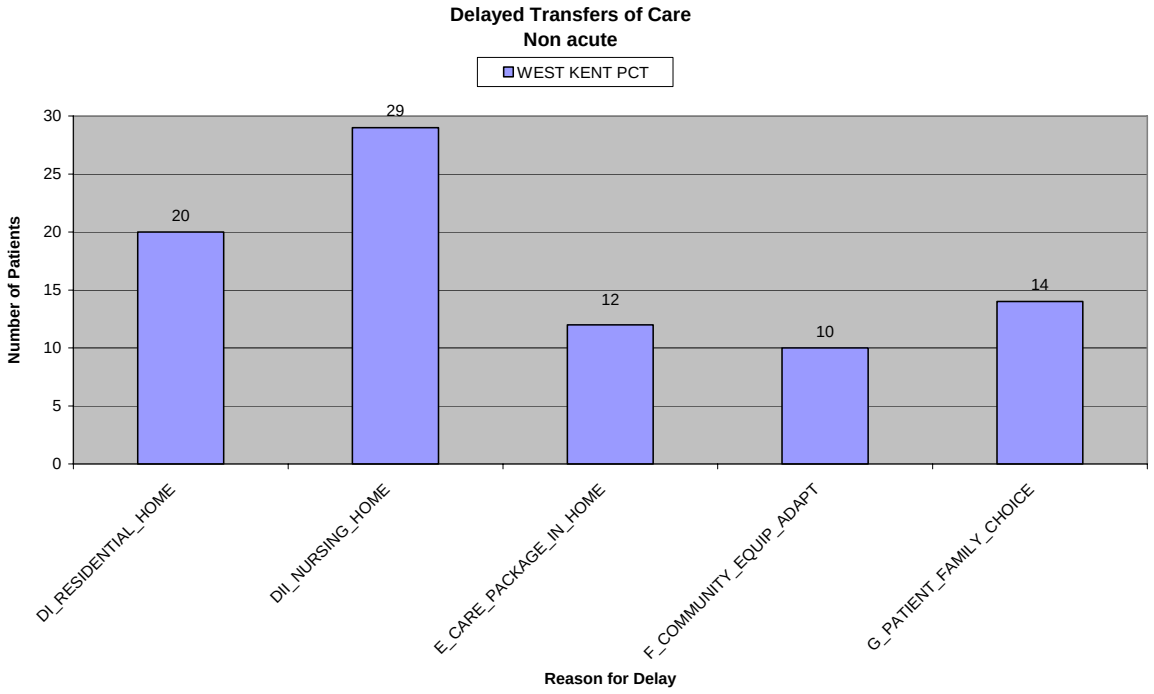
Telecare/Telehealth In partnership with Kent County Council and NHS Eastern & Coastal Kent, NHS West Kent is a national demonstration site for the use of technology in supporting people to keep well at home. The aim of the programme is to provide robust evidence base for the benefits of telehealth and telecare as an integrated element of health and social care services. Within the programme, existing work is being built upon to establish a Single Assessment Process and to pilot IT systems that enable information sharing across health and social care.



NB This chart relates to West Kent registered patients only. There were an additional 27 patients from outside West Kent who experienced a delayed transfer during this period at Dartford & Gravesham, and 48 at Maidstone & Tunbridge Wells.



NB This chart relates to West Kent registered patients. There was an additional 172 delayed bed days relating to patients from outside West Kent during this period at Dartford & Gravesham, and 219 at Maidstone & Tunbridge Wells.



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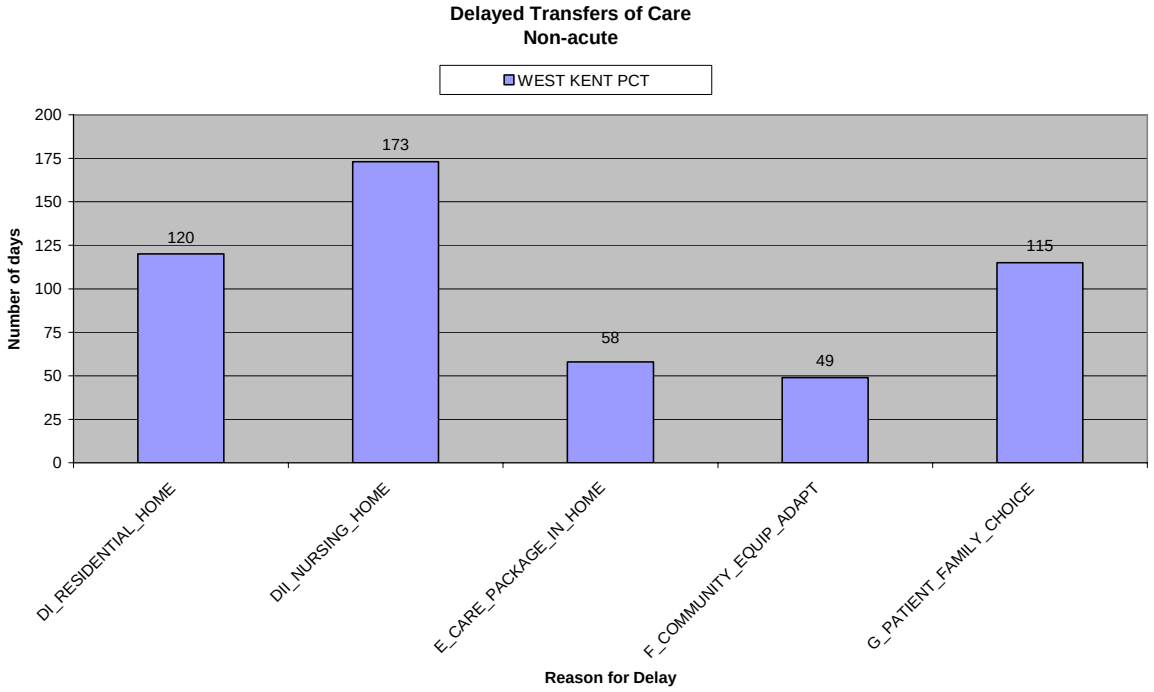

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PALS Report to Kent County Council

Issues Relating to Delayed Discharges through PALS
Oct 07 – Sept 08

Maidstone & Tunbridge Wells NHS Trust's Patient Advice and Liaison Service (PALS) was asked to provide a report to the KCC's Health Overview and Scrutiny Committee regarding concerns about delayed discharges. The KCC explained this was as they were keen to understand the inter-relationship between the Acute Trust, Adult Social Care and the PCT.

PALS looked at all the contacts they had regarding the discharge of patients.

It is noted that PALS also deals with advice, help and information, so not all matters raised related to concerns.

It is also recognised by PALS, that the service has a good relationship with Social Services. When cases are raised as a concern by relatives to PALS about such matters as care packages, Social Services respond quickly to the client or relatives.

Of approximately 3200 contacts to PALS, only 44 related to discharge arrangements.

	Kent & Sussex	Maidstone	Total
Advice	0	4	4
Comment or Suggestion	0	1	1
Help or Support	4	9	13
Complaint Informal	5	19	24
Complaint Formal	0	2	2
Totals	**9**	**35**	**44**

Of the 44 cases, 17 were requests for help or advice e.g. how does one obtain a care package for relative? etc.

The following demonstrates the reasons for the informal complaints:-

Concerns about Care Package and Support	8
Delayed investigations	1
Family does not feel patient is well enough for discharge	4
Delay with move to other hospital	1
Readmission within one month	5
Relatives not informed of discharge	1
Miscellaneous	2
Delayed release of drugs for patient to take away	2

It is noted that PALS figures for delayed transfer relates to what the patient or relative advises PALS in the first instance.

PALS also looked at overall figures of delayed discharges for the Trust for 2008. The Trust has been working on ways to reduce these figures, and this is demonstrated in the following:

Delayed Transfers of Care in Trust (occurrences)

	2008							
	January	**February**	**March**	**April**	**May**	**June**	**July**	**August**
Kent & Sussex	137	61	52	47	38	29	48	48
Maidstone	68	52	57	36	72	43	38	22
Trust Total	205	113	109	83	110	72	86	70

Delayed Transfers of Care is the number of patients occupying an acute hospital bed whose transfer of care was delayed as at midnight every Thursday, summed across all 52 weeks for the financial year.

Department of Health guidance says delayed transfers of care should be 'kept to a minimum'.

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