**Eastern and Coastal Kent**

**Urgent Care Commissioning**
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19th June 2009

Paul Wickenden
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Kent County Council – Legal & Democratic Services
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Dear Paul,

**Assessment Beds Pilot – Eastern and Coastal Kent**

I am writing in response to your letter send earlier this year requesting an update by next month on the evaluation of the Assessment Beds Pilot and details of how this work is being taken forward.

Please see attached paper which gives an overview of the pilot and its evaluation. The paper also summarises some of the processes that are now being incorporated into the new Transfer of Care Pathway that is currently being developed. This pathway will be commissioned over the coming months, builds on the learning of the pilot and will include joint health and social care (whole systems) responsibilities along the patient pathway to prevent delayed transfer of care.

The recently completed NHS Eastern and Coastal Kent Urgent Care Commissioning Strategy (2009-2013) firmly outlines that one of its many commissioning intentions is to improve transfers of care.

If you need any further information in relation to this work please do let me know.

Yours sincerely

Zoe Fright
Senior Lead Commissioner Urgent Care

Eastern and Coastal Kent
Community Services

Eastern and Coastal Kent

**Assessment Beds Pilot**
**Evaluation and Way Forward**
**(Report for Health Overview and Scrutiny Committee)**

## Introduction & Context

Joint approaches to admission and discharge planning is key to ensuring that people move from and to the most appropriate setting at the point they are medically fit to do so. The planning of a patients discharge should happen at the point they are admitted and systems need to be in place to effectively 'in-reach' into acute hospitals to identify which patients may benefit from Intermediate Care to assist with reducing delays.

The (DOH 2003) in their document *Discharge from Hospital: pathway, process and practice* suggest that practices and processes must be in place to ensure the best outcomes and maximize independent living for all adults discharge from acute settings. It should be understood that:

"*Many people admitted to hospital fear the experience of hospitalization and of losing their autonomy; they want to return to their previous lives as soon as possible and every effort should be made to help them do so.*" and "*Acute hospitals should only be used for the delivery of services that cannot be provided as effectively elsewhere in the health service, social care or housing system.*" DOH (2003: 6)

Older people make up a large number of those whose discharge is delayed whilst awaiting other services, the Audit Commission (2000) report *The Way to go Home: Rehabilitation and Remedial Services for Older People* suggested that once a patient's medical condition has stabilised the full range of hospital services is not always needed and intermediate care could be used instead.

Discharge planning remains problematic and an area of concern despite much research and government legislation. Increasingly there is incentive and emphasis on managing acute hospital beds, targets to meet in accident and emergency departments and reduction in delayed transfers of care. At a nursing level the discharge planning process is not well understood and there is a need to educate nurses in the principles of the discharge planning process. Furthermore by having an 'in-reach' into acute hospitals identifying which patients may benefit from Intermediate Care may assist in reducing the length of patient stay.

**The "Assessment Bed Pilot" was undertaken as part of the Urgent Care Programme. The aims of the pilot were as follows:**

- Utilise community hospital beds / Kent Adult Social Services Registered Care Centre beds across East Kent, to support appropriate discharge from acute hospital beds when a patient is medically fit for transfer;
- Reduce the number of reportable delayed transfers of care;
- Facilitate improved patient outcomes;
- Reduce institutionalisation rates.

**The Pilot was tested across the Canterbury locality and covered the following sites:**

NHS

*Eastern and Coastal Kent*
*Community Services*

- Kent and Canterbury Hospital;
- Whitstable and Tankerton Community Hospital;
- Queen Victoria Memorial Hospital in Herne Bay;
- Ladesfield Registered Care Centre in Whitstable;
- Kiln Court Registered Care Centre in Faversham.

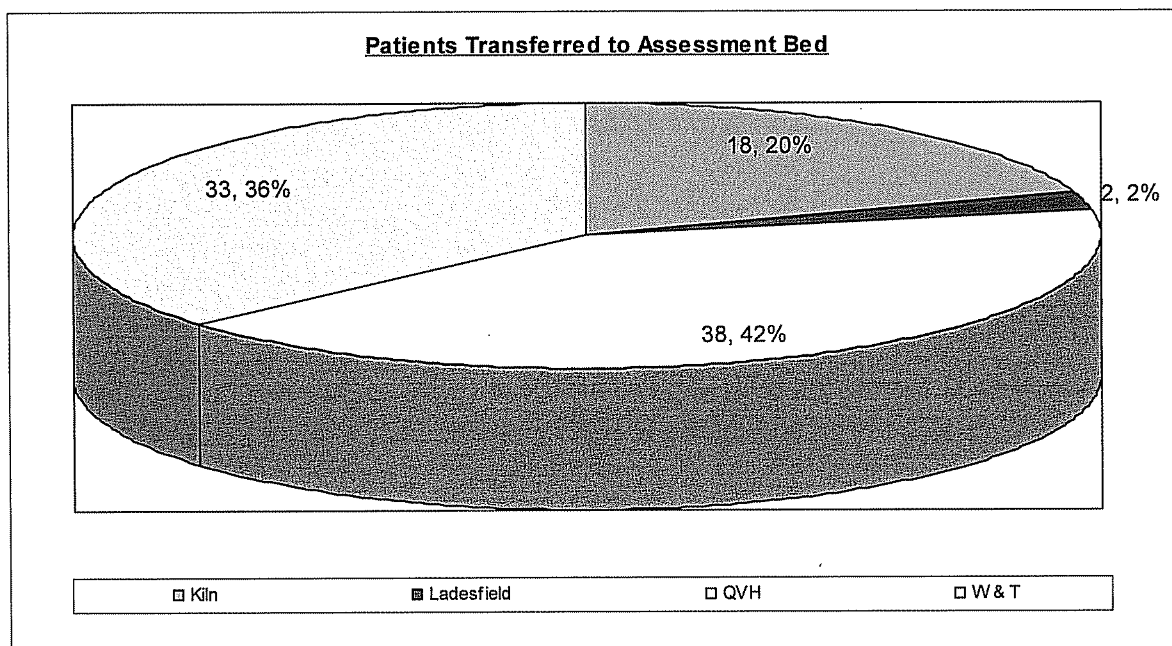
**Pilot timeframes**

- The Pilot ran for a 24week period from Monday 25th February to Sunday 10th August 2008.

The following outcomes were achieved as a result of this pilot in accordance with the stated aims.

**a) AIM: Utilisation of community hospital beds / Kent Adult Social Services Registered Care Centre beds across East Kent, to support appropriate discharge from acute hospital beds when a patient is medically fit for transfer.**

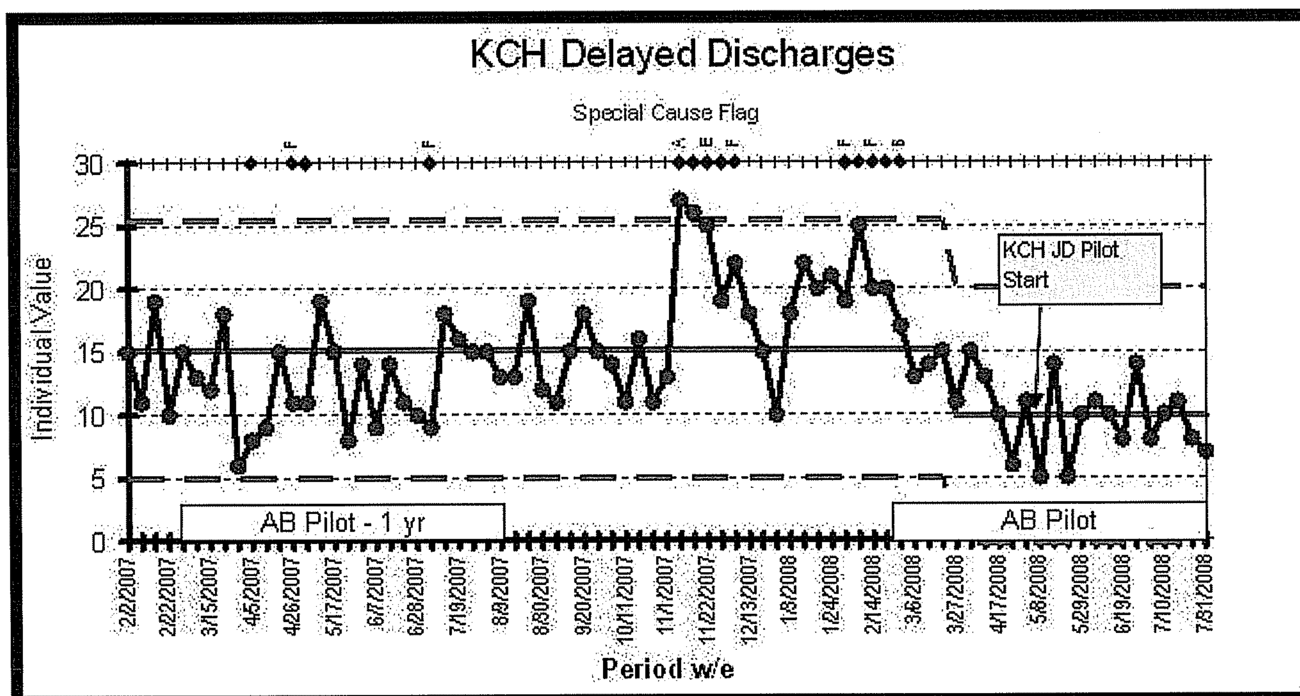
During the 24 weeks of the pilot 105 patients were accepted for transfer from the acute site at KCH to Assessment Beds in Community Hospitals and Care Centres. Of this number 91 (87%) were actually transferred to the sites shown below. All these patients would have remained at the acute site, although medically fit for discharge. Patients were transferred to Community Hospital beds prior to the pilot via other processes, and under different medical cover arrangements.




**b) AIM: Reduction in the number of reportable delayed transfers of care.**

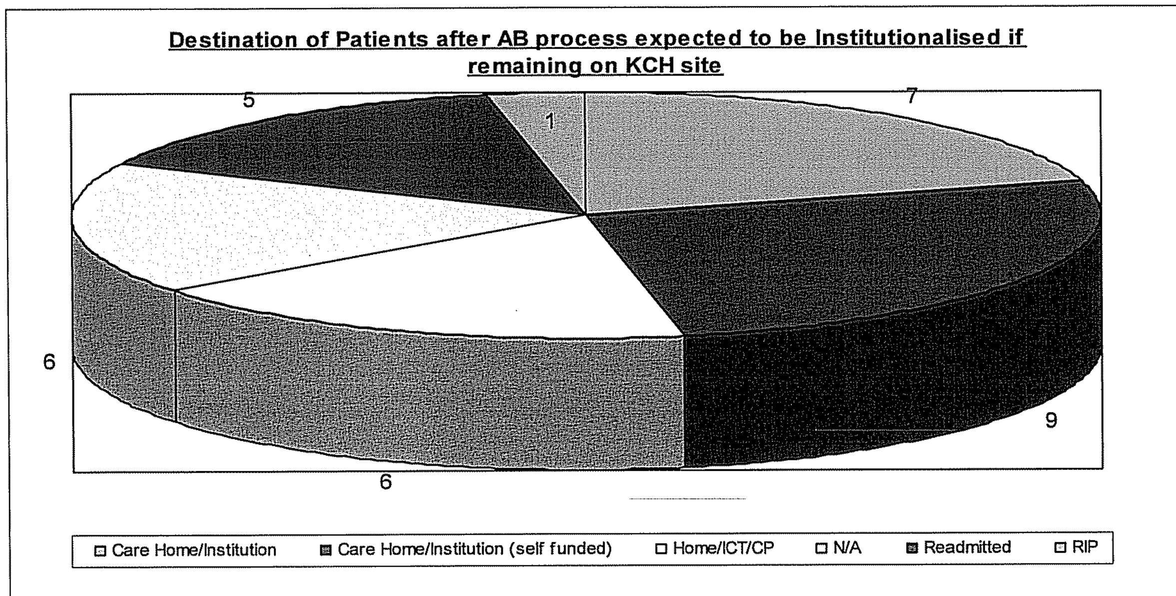
The numbers of Delayed Discharges at KCH has reduced from around 20 delays per week at the start of the pilot to an average of 10 per week (as shown by the green line) at the end of the pilot. Delays have reduced in the categories of choice and assessment. Of particular note are the self funding clients who often become a delay under choice health. Self funders were not excluded from access to assessment beds. The category of assessment has seen

reduced in as much as the assessment beds have provided opportunity to move some patients who have complex, fluctuating needs out of the acute setting. Being able to use the beds flexibly has definitely had an impact on delays, as has being able to transfer people from EEC and CDU, so that they do not even get into the main hospital system. It does have to be acknowledge that a number of changes occurred around about the same time. The introduction of a care management turn around team at the front door, and the discharge facilitation team (dedicated ICT lead nurse and care manager) started on the same day as the assessment bed pilot. In addition the Joint discharge team approach commenced within a few weeks, where early discussion about potential delays took place.




**c,d) AIM: Facilitation of improved patient outcomes**
**AIM: Reduction in Institutionalisation Rates**

34 of the patients who completed the Assessment Beds Pilot process had an expected discharge destination of a care home or other residential institution. Had the Pilot not been in place, therefore, all 34 of the patients, whose outcomes following the pilot are displayed below, would have been institutionalised. The chart shows that 6 of these patients (18%) were able to return home with an ICT care package, showing an improved outcome for these patients. N/A signifies that these patients (6) had yet to complete the pilot process to date.

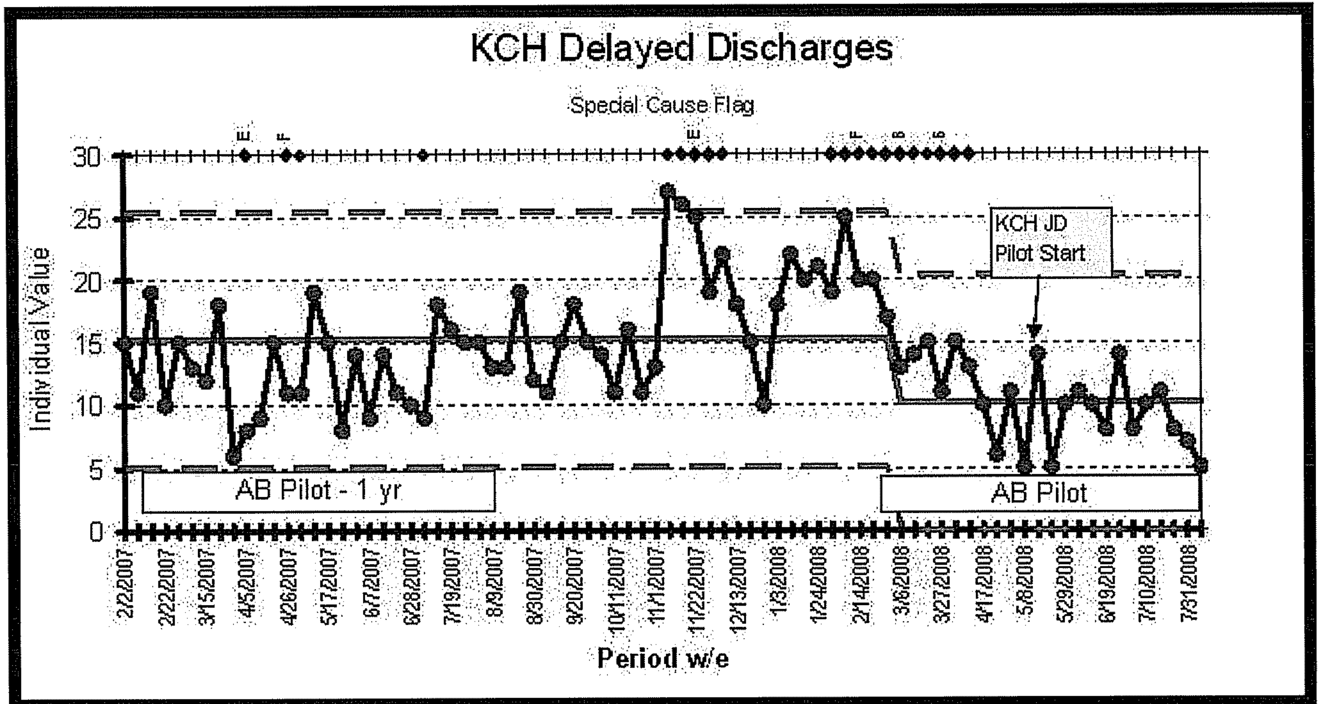



27 of the patients who completed the Assessment Beds Pilot process had an expected discharge destination of Home with a level of ICT care. Had the Pilot not been in place, therefore, all 27 of the patients, whose outcomes following the pilot are displayed below, would have been discharged home and a care package arranged. In addition, these discharges may have caused delays in the patients discharge whilst an appropriate care package was arranged.

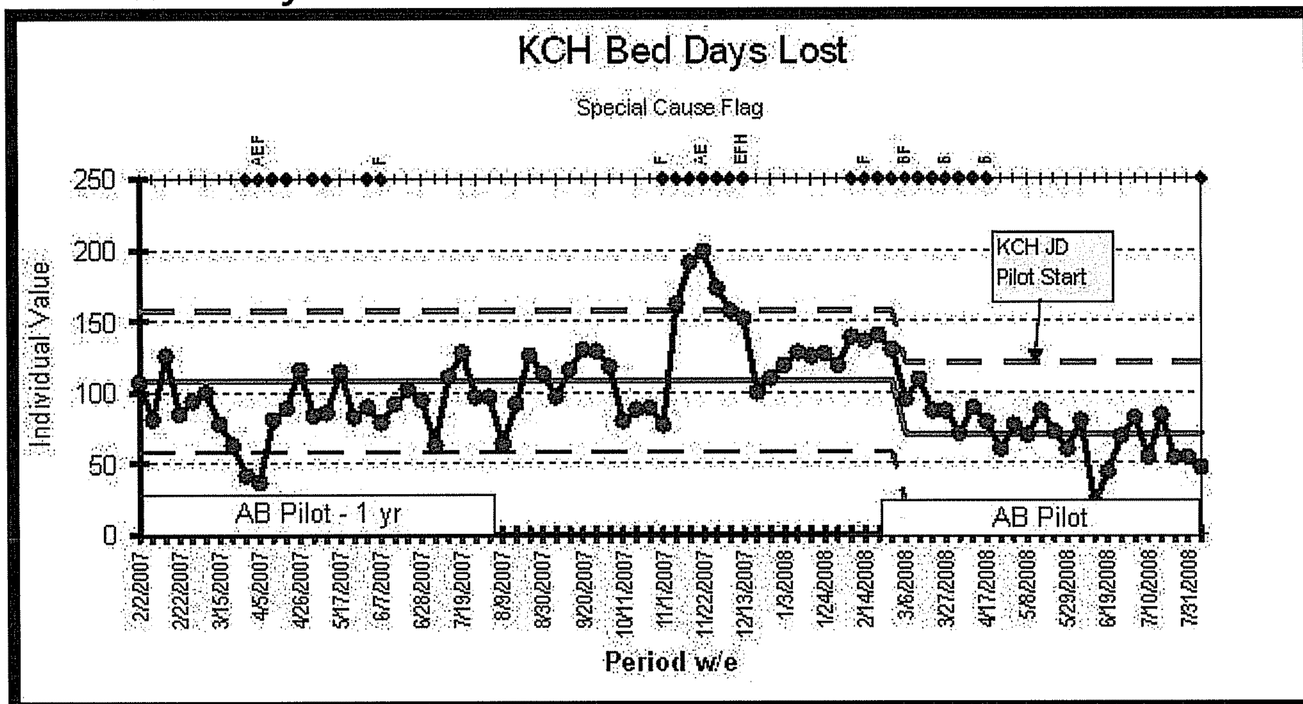
**DTOC/Delayed Discharges/Bed Days Lost**

**The 24 week pilot period is indicated by the [AB Pilot] box. The equivalent period last year is indicated by the [AB Pilot – 1 yr] box. The KCH Phase of the Integrated Discharge pilot runs concurrently with the AB pilot as indicated.**

- The numbers of delayed discharges and bed days lost as a result of delayed transfers of care **have reduced significantly from the beginning of the pilot, both at KCH and across all EKHT sites.** The 24 week period covered by the [AB Pilot] box illustrates the reduction from 20 at the start of the pilot (25th Feb) to 7 during the week ending 31st July. However the equivalent period last year (covered by the 16 week [AB Pilot – 1yr] box) shows a similar reduction during this time. This could be considered a seasonal variation, and not attributable to the AB pilot, however the reduction seems to have been sustained, and we also know there have been changes in the types of delay. The step-down as shown by the red dashed lines also coincides with the start of the AB pilot, and not with the start of the KCH JD Pilot.




**The number of Bed Days lost at KCH and across all EKHT sites shows a sustained reduction from the start of the Pilot** as shown in the step down on the 2 charts below. The equivalent period last year also shows an initial sharp reduction though the number of days lost then returned to average levels at the end of the 24 week period.


KCH Bed Days Lost
Special Cause Flag
Individual Value
250
200
150
100
50
0
KCH JD
Pilot Start
AB Pilot - 1 yr
AB Pilot
2/2/2007
2/22/2007
3/15/2007
4/5/2007
4/26/2007
5/17/2007
6/7/2007
6/28/2007
7/19/2007
8/9/2007
8/30/2007
9/20/2007
10/11/2007
11/1/2007
11/22/2007
12/13/2007
1/3/2008
1/24/2008
2/14/2008
3/6/2008
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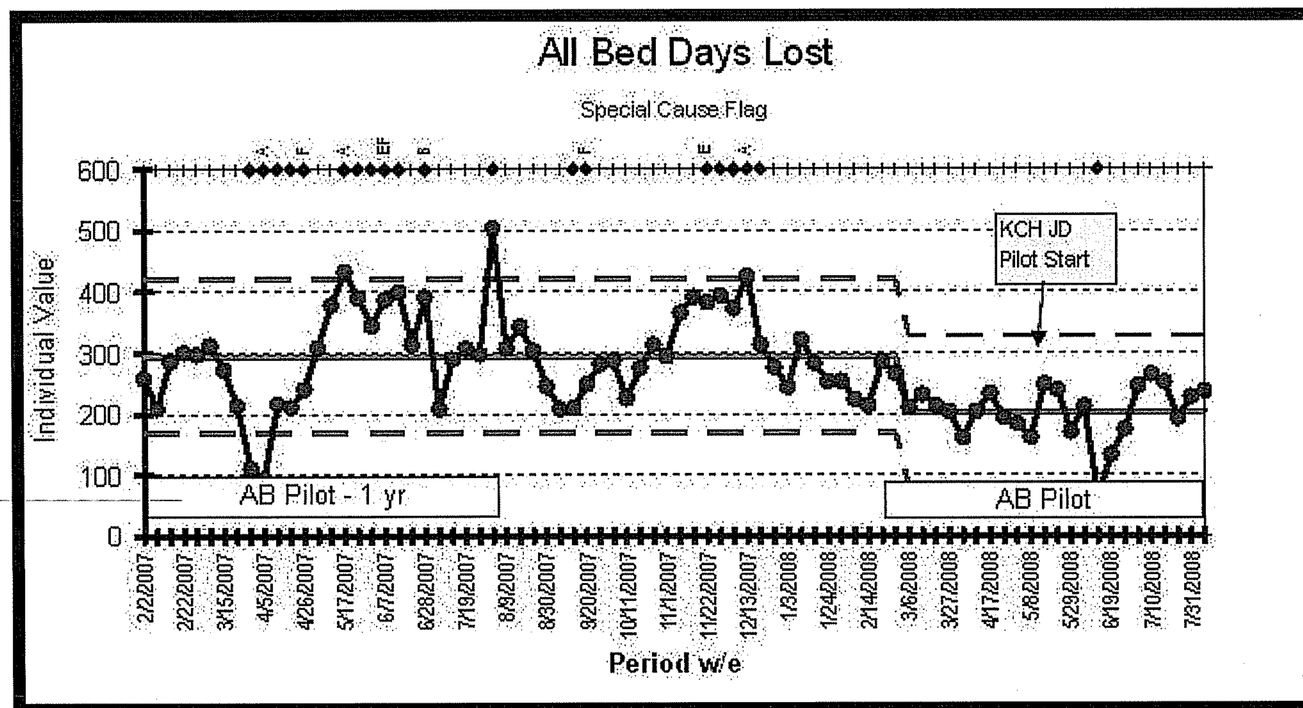
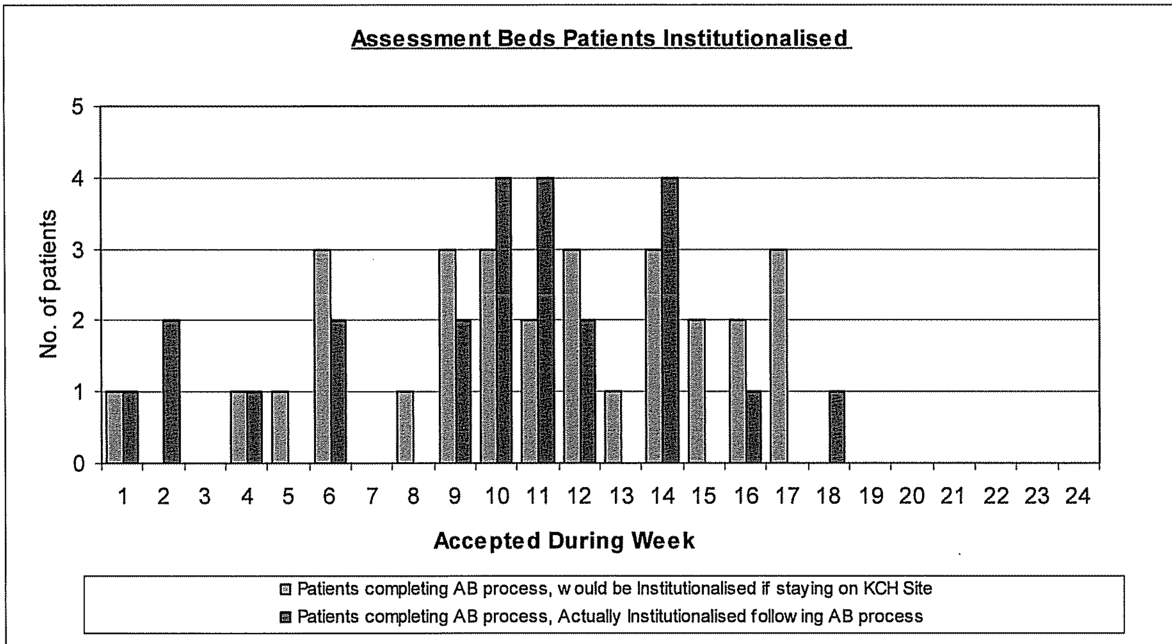
5/29/2008
6/19/2008
7/10/2008
7/31/2008
Period w/e

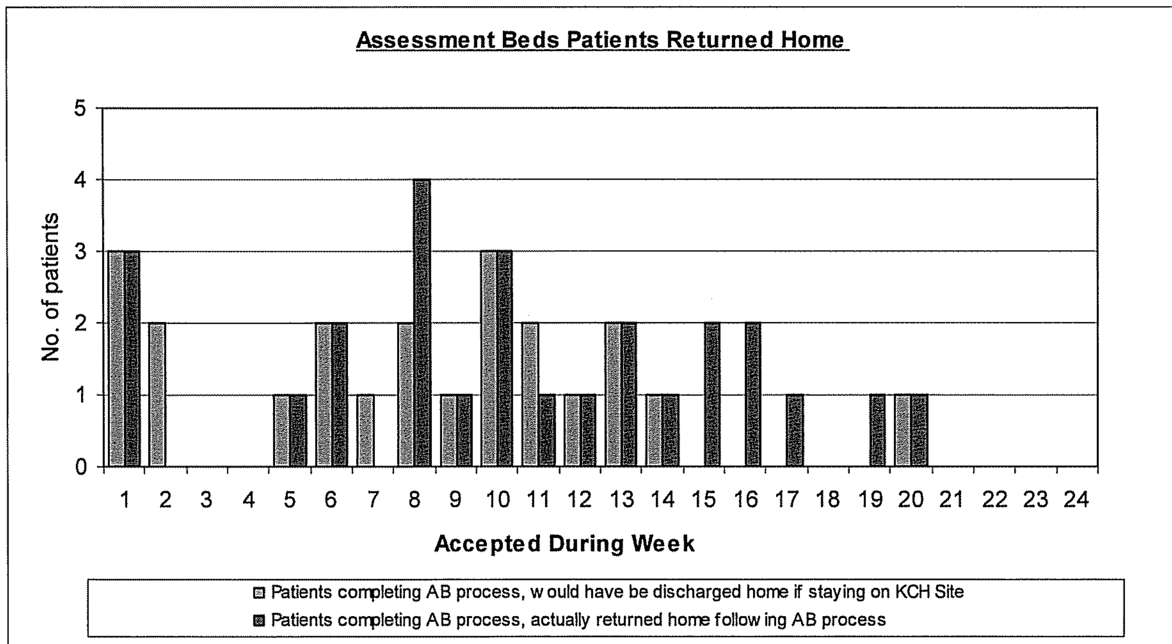

All Bed Days Lost
Special Cause Flag
Individual Value
600
500
400
300
200
100
0
KCH JD
Pilot Start
AB Pilot - 1 yr
AB Pilot
2/2/2007
2/22/2007
3/15/2007
4/5/2007
4/26/2007
5/17/2007
6/7/2007
6/28/2007
7/19/2007
8/9/2007
8/30/2007
9/20/2007
10/11/2007
11/1/2007
11/22/2007
12/13/2007
1/3/2008
1/24/2008
2/14/2008
3/6/2008
3/27/2008
4/17/2008
5/8/2008
5/29/2008
6/19/2008
7/10/2008
7/31/2008
Period w/e

**Outcomes of those in Assessment Bed Process**

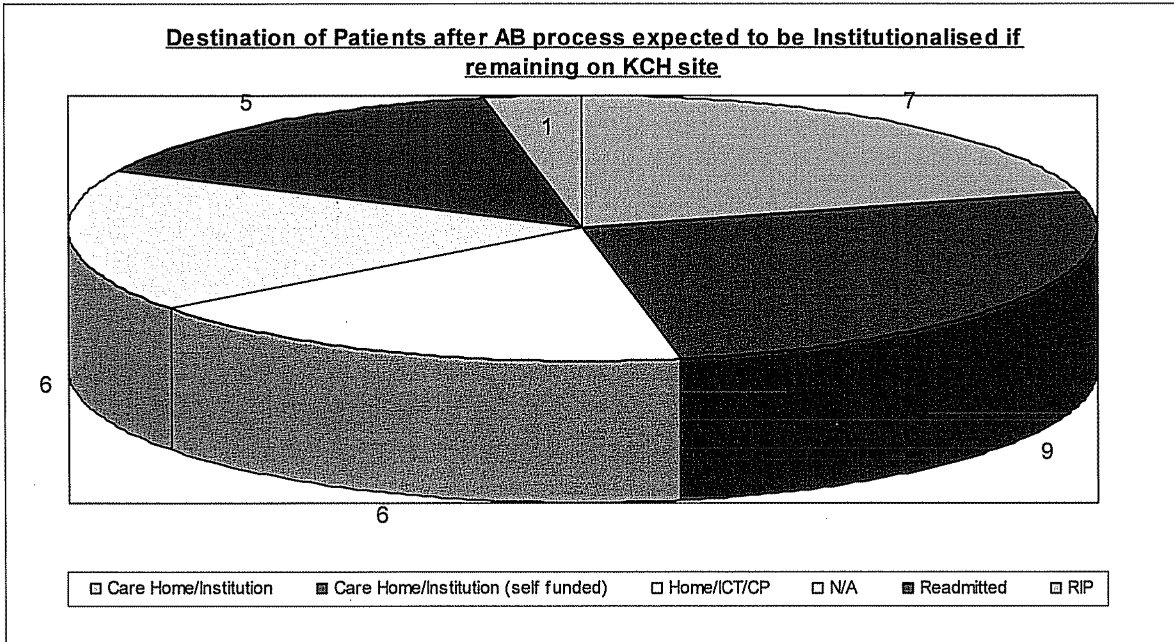
As a result of the assessment beds pilot, 5 patients who would have been placed into a care home setting were able to return home, with a level of ICT input. 5 patients who would have been placed into a care home setting were re-admitted.



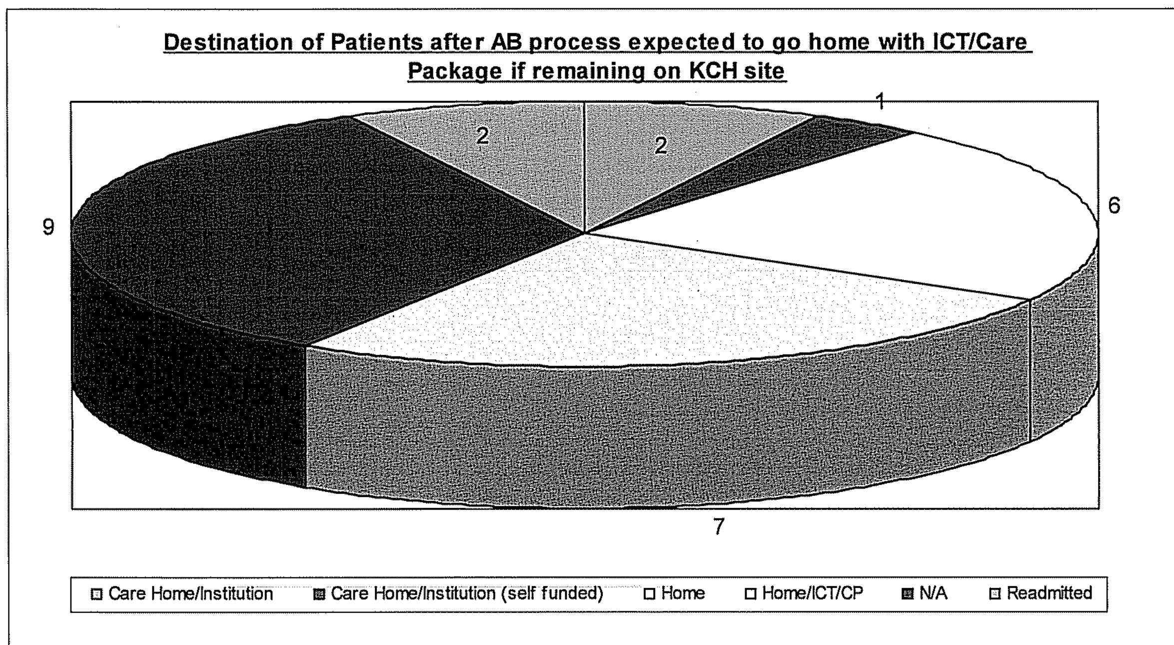

22 patients having completed the process would have returned home following discharge from KCH, 26 were actually able to return home following the AB process.




36 out of 91 patients going into an assessment bed were expected to enter a care setting while only 4 were expected to return home without ICT/CP input

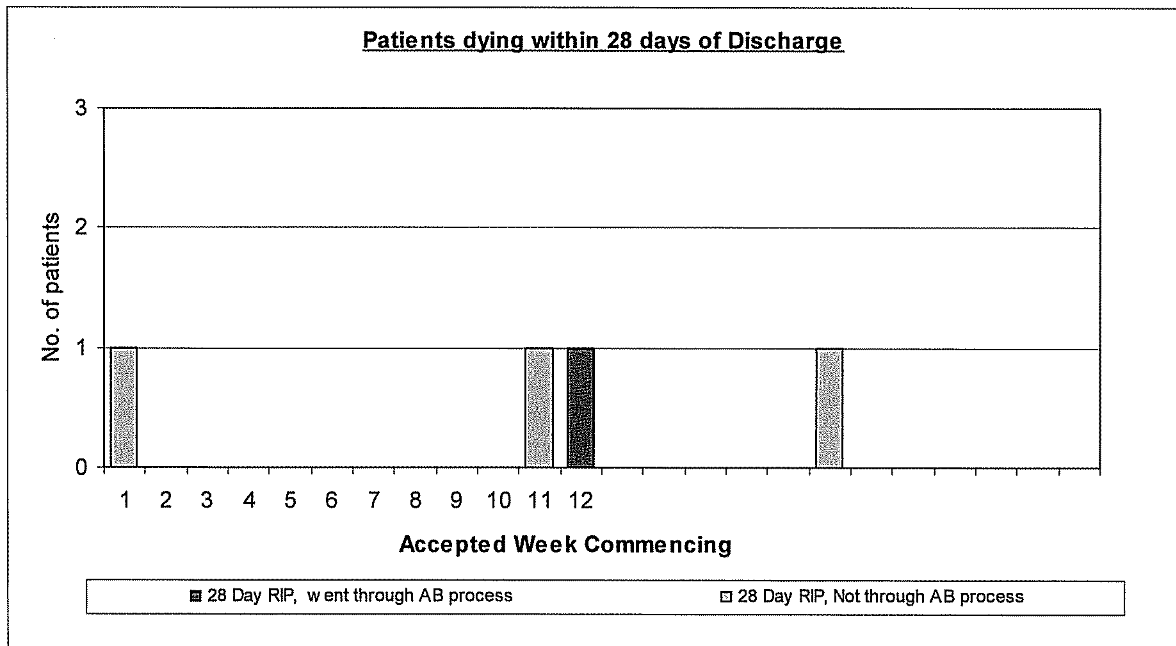



6 patients who would have previously required ICT/CP input at home were able to return home without this service. 3 of these patients was institutionalised. N/A = not completed AB process.



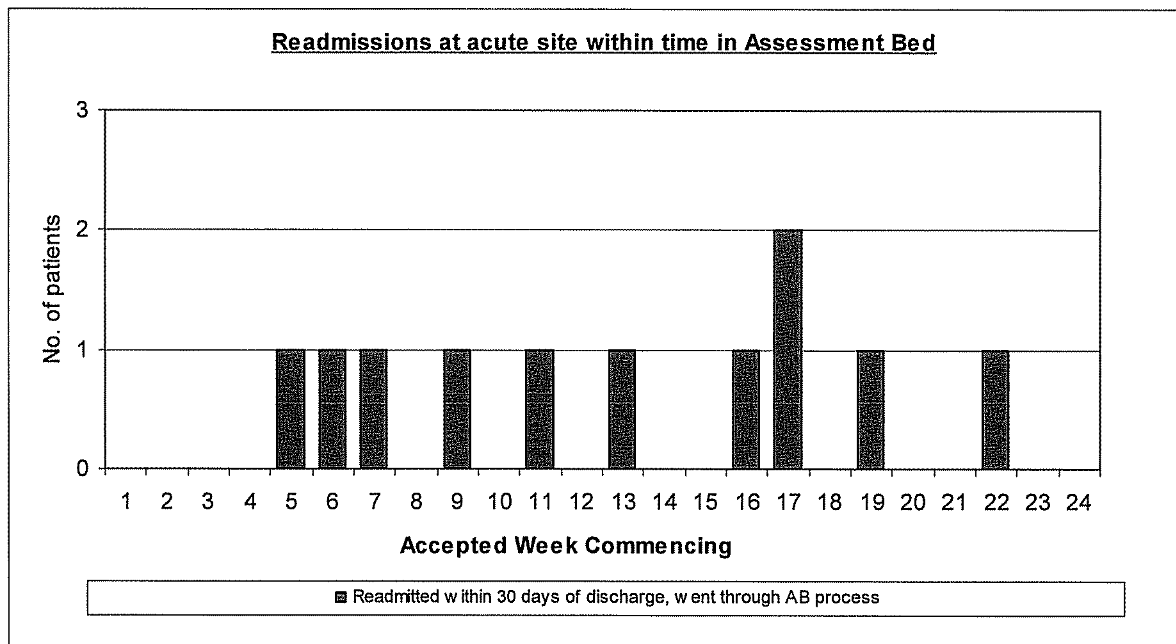
### 28 Day Mortality from date accepted for Assessment Bed

Across the pilot thus far there have been 4 deaths, 1 of which was within 28 days of acceptance. The latter patient was moved onto the Liverpool care pathway and remained at the community hospital.




### 30 Day Readmissions from date discharged from acute site

11 patients were readmitted. 1 patient was re-admitted due to bed closure at W&T, the others were readmitted as acutely unwell.



## Progress since the Pilot

Following the success of the assessment bed pilot the operational process and patient categories have been further developed.

Given the pressures seen on acute hospital beds over the last winter the intention is to progress the following process:

- Attention will be primarily be focused on CDU / MAU and the medical wards by Social Services Care Managers and Intermediate Care Nurses proactively 'case finding' patients who are >75 years or complex <75 years.

- Orthopaedics and Surgical patients will enter the process by way of referral from the Matrons, Ward Managers or Care Manager, for the flowing reasons:
    - Patient has been slow to recover following a complication as a result of surgery;
    - Patients with a complicating condition i.e. Dementia;
    - Patients who cannot return home (where ever that might be) due to complexity of current condition and longer term needs that are indicating the outcome may be - home to Residential Home, Residential Home to Nursing Home, or fully funded NHS Continuing Care.

Patient Categories:

| | | |
|---|---|---|
| **Category 1** | Requiring Rehabilitation / Recuperation will go home | Following an acute episode provided either at home or step down into an Intermediate care bed if still requiring 24 hour supervision for assessment & rehabilitation home the definite discharge destination |
| **Category 2** | Requiring 24 hour care (residential) or a high level social care package to get home due to functional ability | Following an acute episode step-down into a community hospital bed or Intermediate care bed in a care home for assessment and rehabilitation to improve functional ability to go home rather than Residential care or home with a reduced care package or Residential Care rather than Nursing Care |
| **Category 3** | Requiring 24 hour nursing care (nursing or residential) as a result of an acute episode | For step down into a community hospital bed/care home at the point of medical fitness & MDT decision for progress to INP for nursing home care or fully funded NHS continuing care |

- Patients to be actively 'case found' from CDU /MAU followed through the system if not able to be discharged after acute assessment, monitoring patients condition to enable early supported discharge or flagged to in-reach discharge team as potential for each of the 3 categories by the MDT/consultant/ward staff;
- Discussion with the Patient/family to agree to transfer into community setting;
- Simple transfer form / Intermediate Care Referral form to be completed as follows:

| Simple Transfer Form | Home with Intermediate Care<br>Step-down to Community Hospital |
|---|---|
| Intermediate Care Referral Form | OPDSU's & integrated care centres, Westbrook, Westview, Independent Care Homes |

- Patients transfer to be arranged as soon as possible to the agreed destination – preferably morning or early afternoon but not after 4 pm.

- Discharge from Domiciliary Rehabilitation/Recuperation/Step-down:
  - **Category 1 patients – at home/:** patients to continue rehabilitation /recuperation for an agreed period dependant on need once goals have been achieved patient must be discharged to allow continued through put;
  - **Category 1 patients – in step down:** patients to continue rehabilitation/recuperation with discharge planned with an EDD;
  - **Category 2 patients – in step down:** patients continue assessment and rehabilitation to attempt to improve functional ability to: reduce dependency on domiciliary care and therefore delay premature admission to long term care; prevent admission to long term care (residential) if possible supporting discharge home with a domiciliary care package or placement in Residential rather then nursing care;
  - **Category 3 patients – in step down:** patients to receive their individual needs portrayal (INP) within a step down environment to determine need for placement either in a n nursing home by KASS or fully funded NHS continuing care

These processes will be further defined through 'whole system' partnership working over the coming months and will be part of the newly commissioned 'Transfer of Care Pathway' (supported by additional community / Intermediate Bed Capacity as required). This commitment is outlined in the NHS Eastern and Coastal Kent Urgent Care Commissioning Strategy (2009-2013).

Improving Transfers of Care is a priority area and is recognised as essential to enable health and social care systems to effectively respond to winter pressures. A Joint Commissioner post is currently being recruited to work jointly with all agencies to develop integrated discharge planning processes and Intermediate Care services during 2009. Additional community bed capacity will be identified through a phased approach to enable timely discharges to and from the most appropriate setting of care.

**Sue Baldwin, Associate Director of Nursing and Adult Clinical Services**

**Zoe Fright, Senior Lead Commissioner Urgent Care**
**June 2009**