North and Mid Hampshire Integrated Care Partnership

Rapid Insight into the changes made to respond to the challenges of COVID-19

Discharge Case Study

July 2020

The Rapid Insight programme is jointly funded through Q by the Health Foundation and NHS England and NHS Improvement

Contents

Insight summary

During March and April 2020 the N&MH system collectively rose to the challenge and uncertainty of covid-19 and **'revolutionised' discharge from hospital**. From being a system with historically high numbers of delayed discharges they moved **from having 61 acute beds occupied by delayed transfers on 13th March to 9 beds** on 10th April and have maintained this.

The system had the relationships, common purpose and a workforce prepared to lead and change how they worked to achieve this. **Individual and team roles changed a lot.** People describe feeling proud of being part of this and of what they've achieved. Recent improvement work in the system helped the rapid response, including the Single Points of Access (SPoA) designed by the Hampshire Together team and the Single Assessment Template (SAT) developed by Hampshire Hospitals.

The system agreed with a Hampshire wide view that it would be better to allow longer than 3-hours to implement **discharges to care homes**. Instead, it agreed that these discharges should happen within 72 hours and a safe discharge protocol was agreed to consistently support this..

There is a **high degree of agreement amongst operational leaders and clinicians about the benefits** of how discharge is happening now. A commitment to maintain and build on this – and not go back to long delays in hospital. They describe it as a model that "pulls" from the community rather than "pushes" from the hospital.

People in the system also describe **a new and positive collective culture** with a unified approach, strong system relationships and shared responsibilities unrestrained by funding or organisational barriers. This supports better care and discharge for patients.

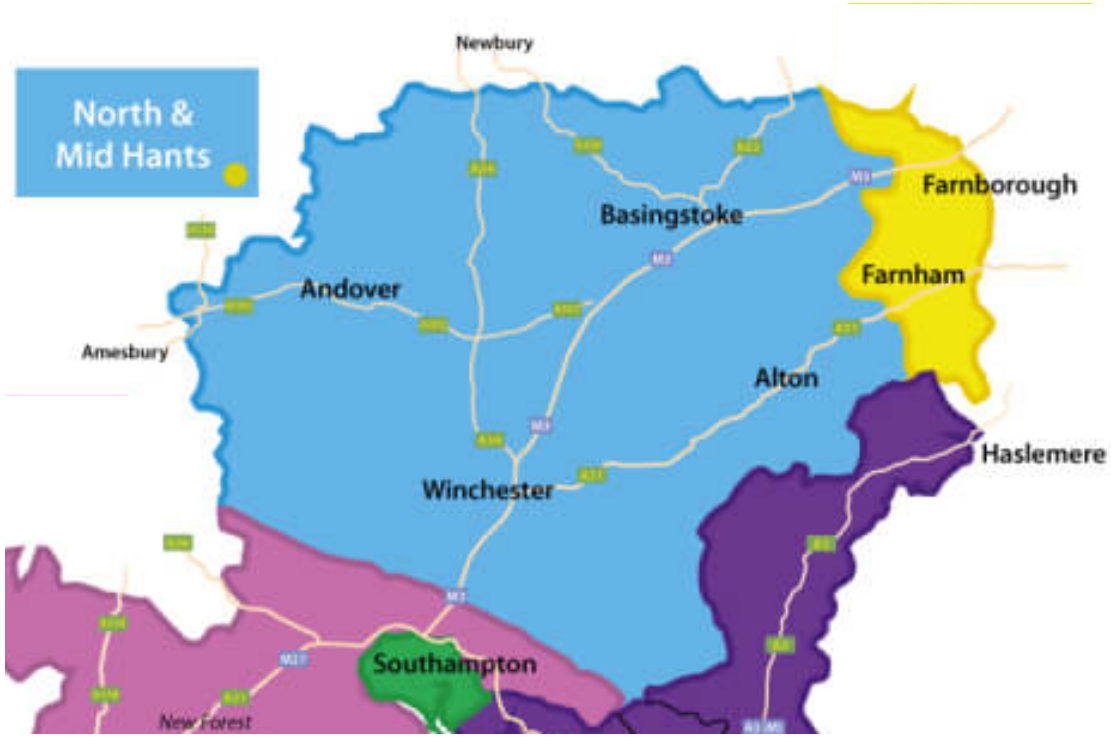
Interviews with four patients found that they were **mostly happy with their discharge** and understood the rationale for this being expedited and, in some cases, going to a care home first. There were concerns about the **limitations on involvement and communication with their family** which clinical staff recognised was an issue.

As this case study is written up in July 2020, the big issue is what the future arrangements for discharge will be as they move beyond the covid-19 crisis response period and secure the improvements for the long term. The AHSN facilitated a large virtual workshop of leaders from across the Hampshire and Isle of Wight STP system in June where there was **a common strong desire to maintain the benefits from this period of rapid change**. Key next steps included agreeing the post-covid funding for system discharge, appointing to key posts substantively and securing greater 7-day decision making and discharge.

Introduction

North and Mid Hampshire (N&MH) is a large Integrated Care Partnership (ICP) with a population of 570,000. The key partner organisations are:

- Hampshire Hospitals NHSFT
- Southern Health NHSFT
- Hampshire County Council (HCC)
- 10 Primary Care Networks
- West and North Hampshire CCGs
- South Central Ambulance Service
- 3 District and Borough Councils



Responding to the challenges of covid-19 has required the system to make **rapid decisions about reconfiguring how health and care is provided and to implement these quickly**. From the outset the system partners recognised that the way they were working together and the rate at which change was happening was unprecedented and the leaders wanted to capture the **learning so they could maintain the improvements**.

Wessex AHSN established a new **rapid insight** approach to work alongside the system to capture and play back their learning as they continued to respond to covid-19. The AHSN has a lot of experience in undertaking formal evaluations of new care models and the challenge here was to be able to design a new approach that could offer actionable insight much quicker.

Two large virtual workshops for systems leaders (28 participants) and clinical leaders (55 particpants) were held at the end of April to explore the changes they would want to maintain and develop. From these, **two case studies** were identified for further exploration – **discharge** and **remote consultations**.

How covid-19 changed hospital discharge

Discharge from hospital has been a perennial issue for the health and care sectors in most parts of the country. The policy drive for patients to leave hospital and continue their recovery as soon as they are medically fit to do so has been long running. Delayed Transfer of Care (DTOCs) targets and fines, new models of care, the Better Care Fund, process redesign and improvement programmes have all worked to affect a change in timeliness of discharge. Evidence of the risk of poorer clinical outcomes for patients whose time in hospital is extended[1] has tried to drive this case for change.

Faced with the risk of NHS hospitals being overwhelmed by the the casualties from the covid-19 pandemic and the heightened risk of inpatients contracting the virus – the Government issued **COVID-19 Hospital Discharge Service Requirements** on 19th March 2020[2]. It starts with the clear statement that "Unless required to be in hospital, patients must not remain in a hospital bed".

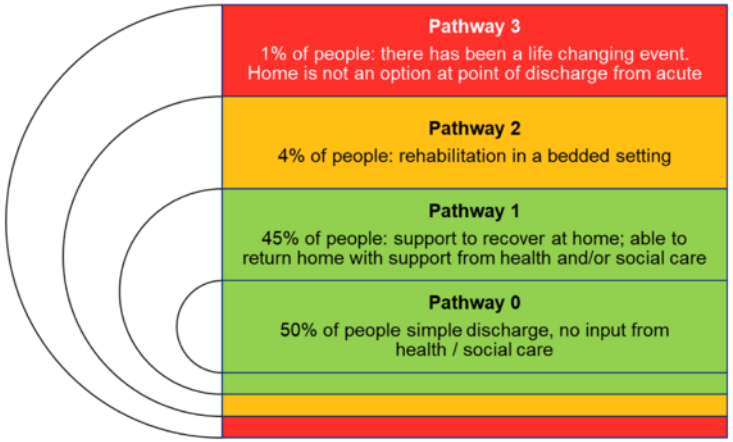


Figure 1: Discharge to Assess model

The instruction was that all health and care systems in England should rapidly implement a **Discharge to Assess (D2A) model based on four pathways**.

Importantly – the guidance suspended the need for Continuing Health Care (CHC) assessments, choice of nursing home and said that the NHS will fully fund the additional costs in health and social care.

Summary COVID-19 Hospital Discharge Service Requirements

- All patients to **leave hospital within 3 hours of decision to discharge**
- Implementation of **discharge to assess model** with assessments and planning for ongoing care to take place at home or in community setting. Principle of **'home first'** for all patients.
- Every discharged patient to be **followed-up within 24 hours** of discharge by a lead professional or community MDT (ideally same day)
- **7 days per week** for all planned discharges between **8am and 8pm**
- If care cannot be organised within 3 hour discharge window, need **short-term interim arrangement** (an interim bed in a community facility up to 28 days, Bridging support at home (< 1 week))
- Acute hospitals responsible for **Pathway 0 discharges** (simple discharges)
- Community providers responsible for **Pathway 1-3 discharges** (complex discharges)
- Requirements for **multi-agency collaboration** to support process with **single points of access and co-ordination** to streamline processes
- System-wide **view of available bed capacity** in care homes, community beds and hospices

A revolution in discharge from hospital in N&MH

A summary of the detailed changes that were quickly designed, agreed and implemented.

A note on Hampshire Together

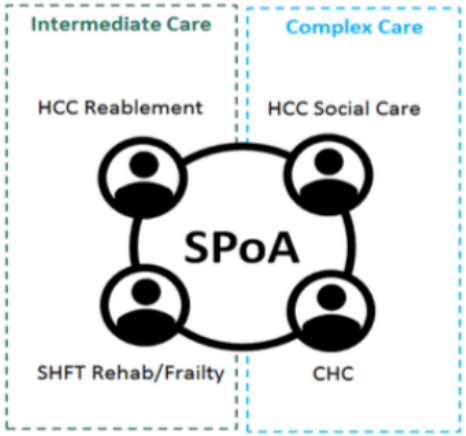
Hampshire Together is a joint health and care programme and team established in 2018 to redesign and transform discharge across Hampshire – which historically had some of the highest levels of delayed transfers of care (DTOCs) in England. Before covid-19 the team were supporting the comprehensive roll –out of an Integrated Intermediate Care service that included aspects of the national requirements. They have provided an expert resource to the three local systems across Hampshire as they've worked together to respond to covid-19 and meet the national requirements.

An initial drive to create capacity

In mid-March, N&MH had the highest levels of DTOCs in Hampshire and it was agreed that the system's first focus had to be a drive on bringing this down and creating capacity where it could. For the first 2-weeks, teams mobilised around identifying and safely discharging as many patients as possible – to their own homes, care homes and reablement services. By the end of March/beginning of April the level of DTOCs had reduced and the system felt it was ready to begin implementing the key elements of the new architecture for discharge.

Single Points of Access

People describe these as the focal point for the system's changes to discharge. There are two SPoAs based around the two acute hospitals – North-SPoA for Basingstoke and North Hampshire Hospital and Mid-SPOA for the Royal Hampshire County Hospital in Winchester.



They bring together the senior operational managers from CHC, HCC Social Care, HCC Reablement and SHFT rehab to meet daily, virtually, for 2 hours, 7-days a week to review all of the patients ready for discharge, collectively agreeing their discharge plan (which pathway) and monitoring its implementation.

It is universally acknowledged to have been transformational – and has succeeded in switching discharge from something that was being "pushed" from the hospital, to being "pulled" from the community. The leadership and staffing of the SPoAs has been vital to its success. The system identified 12 people who were good decision makers and collaborators. All of their work together has been done virtually. They are described as being patient centred, able to be collectively creative about meeting a patient's needs – and as being role models.

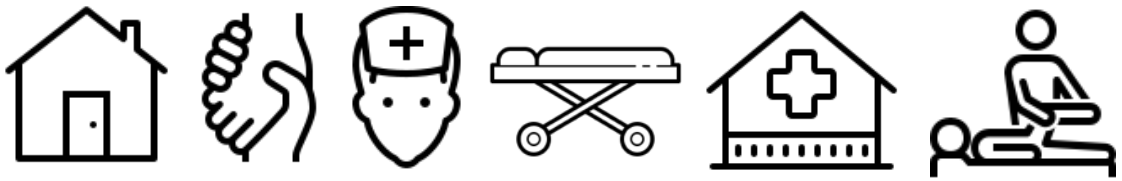
A revolution in discharge from hospital in N&MH

At the moment, most of the SPoA team have been diverted to do this – helped by the national suspension of things like CHC assessment and choice.

Single Assessment Tool

The Single Assessment Tool (SAT) for recording all of the information needed to support a patient's discharge from hospital has proved invaluable.

The SAT template needs to have enough information for the SPoA to be able to make the right, safe decision on the patient's discharge. The HHFT Complex Discharge Team (CDT) explained how their role has changed – from several weeks-worth of planning and implementing discharge while the patient is in hospital ("push") to training and supporting the ward teams to complete these SATs to a high standard as soon as their patient is judged to be medically fit (Medically Optimised for Discharge). This is working.



Discharge to Assess Pathways

There are important principles underpinning the Discharge to Assess (D2A) model. Patients should leave hospital when they no longer need the level of care of an acute hospital (they are medically optimised). If longer is needed to assess their ongoing needs, then this should happen in their home or in an interim placement (community bed or care home). Another important principle is Home First – and if patients are discharged to an interim placement the aim should still be to get them back home.

The CHC and HCC Adult Services teams took joint responsibility for pathway 3, the complex patients, and SHFT, HCC Adult Services and HCC Reablement teams together for pathways 1 and 2. They sourced care, arranged the discharge and followed up the patients afterwards (including the Care Assessment).

3 additional rehabilitation beds were opened at Alton Hospital, 20 additional care homes beds were available and hotel beds were used for post-covid-19 rehabilitation for up to 10 patients at a time.

Changing the target for discharging to care homes

The system agreed with a Hampshire wide view that it would be better to allow longer than 3-hours to implement discharges to care homes. Instead, it agreed that these discharges should happen within 72 hours and a safe discharge protocol was agreed to consistently support this.

A revolution in discharge from hospital in N&MH

Checking on patients after discharge

The SPoA team take responsibility for following up with patients 24 hours after discharge. For complex discharges social workers and senior case workers undertake onward care assessments at 3 days after discharge. These are done virtually (MS Teams or phone call) with staff and patients, using the patient's SAT and if necessary accessing their health record.

Information trackers

The system introduced three information tracking systems using Excel. The Bed tracker provides daily updates on all of the beds available in community hospitals, care homes and hotels. The SPoA Operational tracker monitors the discharge decision and implementation for each patient. The Patient tracker covers what happens to patients after they have been discharged including changes in their support and feedback from their onward reviews.

Substantial changes for teams and staff

Teams and staff at all points on the discharge pathway had to change the way they worked and for many this included their role and purpose - in addition to moving to remote working. Here are some examples:

Continuing Healthcare (CHC) team. With the suspension of CHC assessments this team have been moved to arranging the placements for complex patients on pathway 3. They are leading discussions with care homes and care at home providers to make safe placements and following up with patients 24 hours later. The clinical leads take their turn chairing the two SPoAs 7 days a week and the manager is part of the SPoA leadership team.

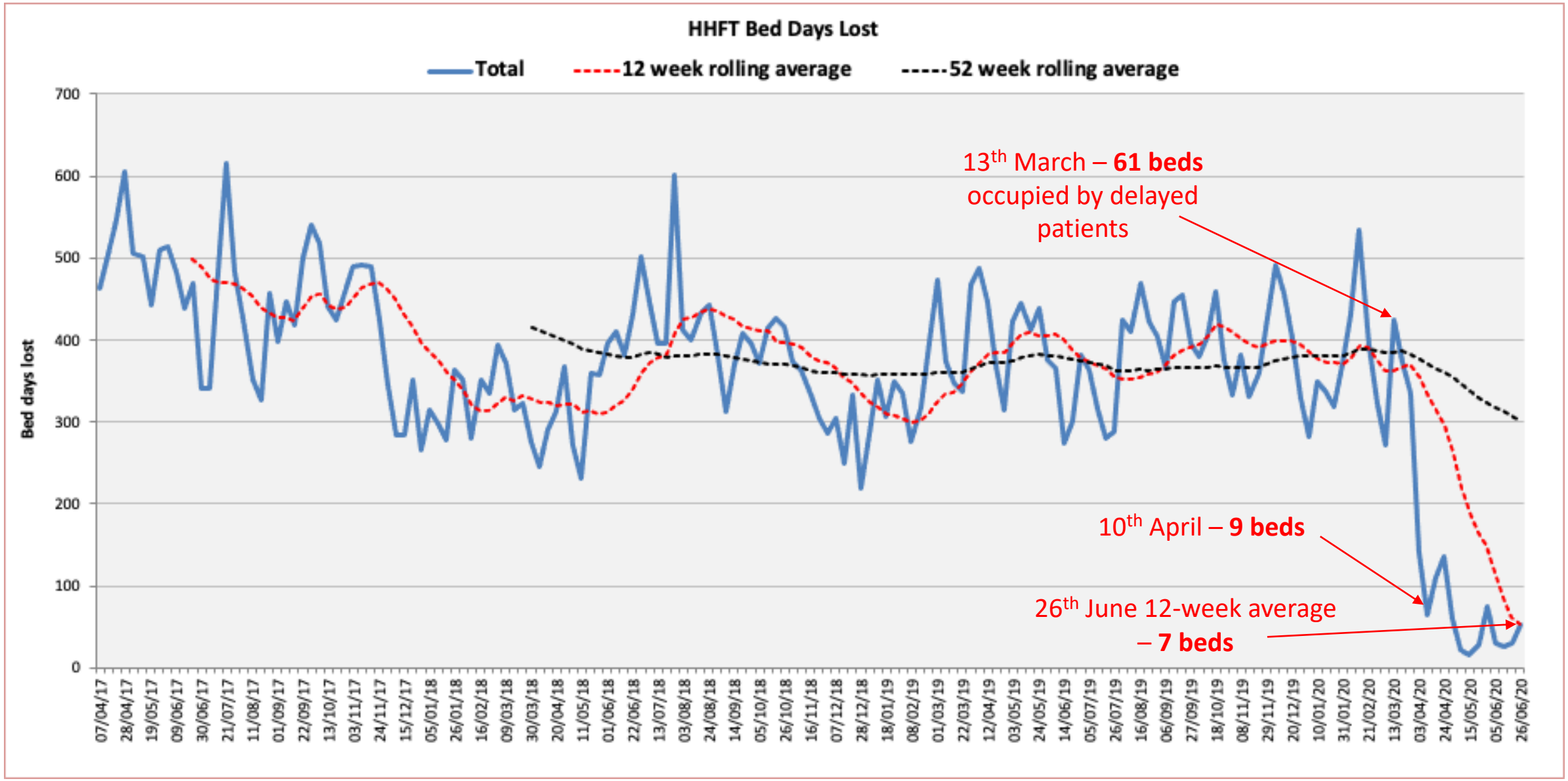
HCC Hospital Discharge Team. Team managers and senior practitioners are helping deliver the two SPoAs 7 days a week. The hospital social work team is taking the lead for discharges requiring residential care and packages of care at home (pathways 1 and 2). They also provide the link role with patients discharged to the hotel and the onward care reviews for patients 2-weeks after discharge.

The HHFT Complex Discharge Team. A large re-orientation from progressing discharges from the hospital ('pushing') to supporting the wards to complete high quality SATs to support discharge ('pull').

Southern Health Community Teams. Supporting leadership and delivery of SPoA and focused work on Anstey ward at Alton to support discharge.

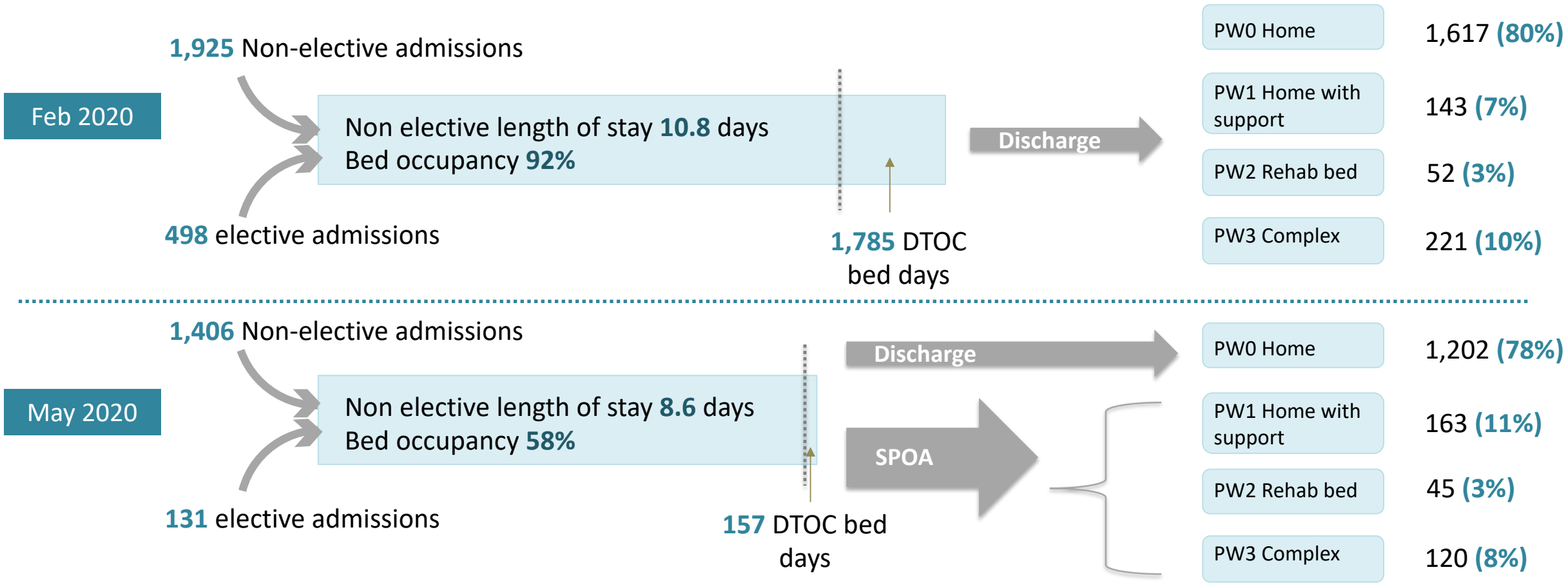
A dramatic reduction in delayed discharges

This graph shows the dramatic reduction in the number of acute beds occupied by patients whose discharge was delayed:



A big change in patient flow through the acute hospitals

The pattern of activity and flow through the 2 acute hospitals changed a lot. This diagram compares activity, length of stay, bed occupancy, delayed transfer bed days (DTOCs) and discharge destinations – between February and May 2020.



Feb vs May

↓ 27% NEL

↓ 74% EL

↓ NEL LOS 2 days (20%)

↓ DTOC bed days 91%

Similar destinations

Focus groups with operational leads, clinicians and professionals

The following slides are based upon insights collected during two on-line workshops held in June 2020 and summarised below. A total of **29 staff** participated contributing **188 comments**

	No. of participants	Insight questions	Responses
Clinical Focus Group	15	• What changes have you made to discharge that you want to continue after the crisis? What changes do you want to stop? • What has been the impact of these changes on your patients? • What has been your experience of clinical and professional leadership of change during the COVID 19 response? • How have staff felt about the changes and what are the implications for future workforce needs and plans?	84
Operational Leaders' Focus Group	14	• What changes have you made to discharge that you want to continue after the crisis? What are you hoping to develop or improve? • What has been your experience of decision making around the discharge changes? • How have staff felt about the changes and what are the implications for future workforce needs and plans?	104

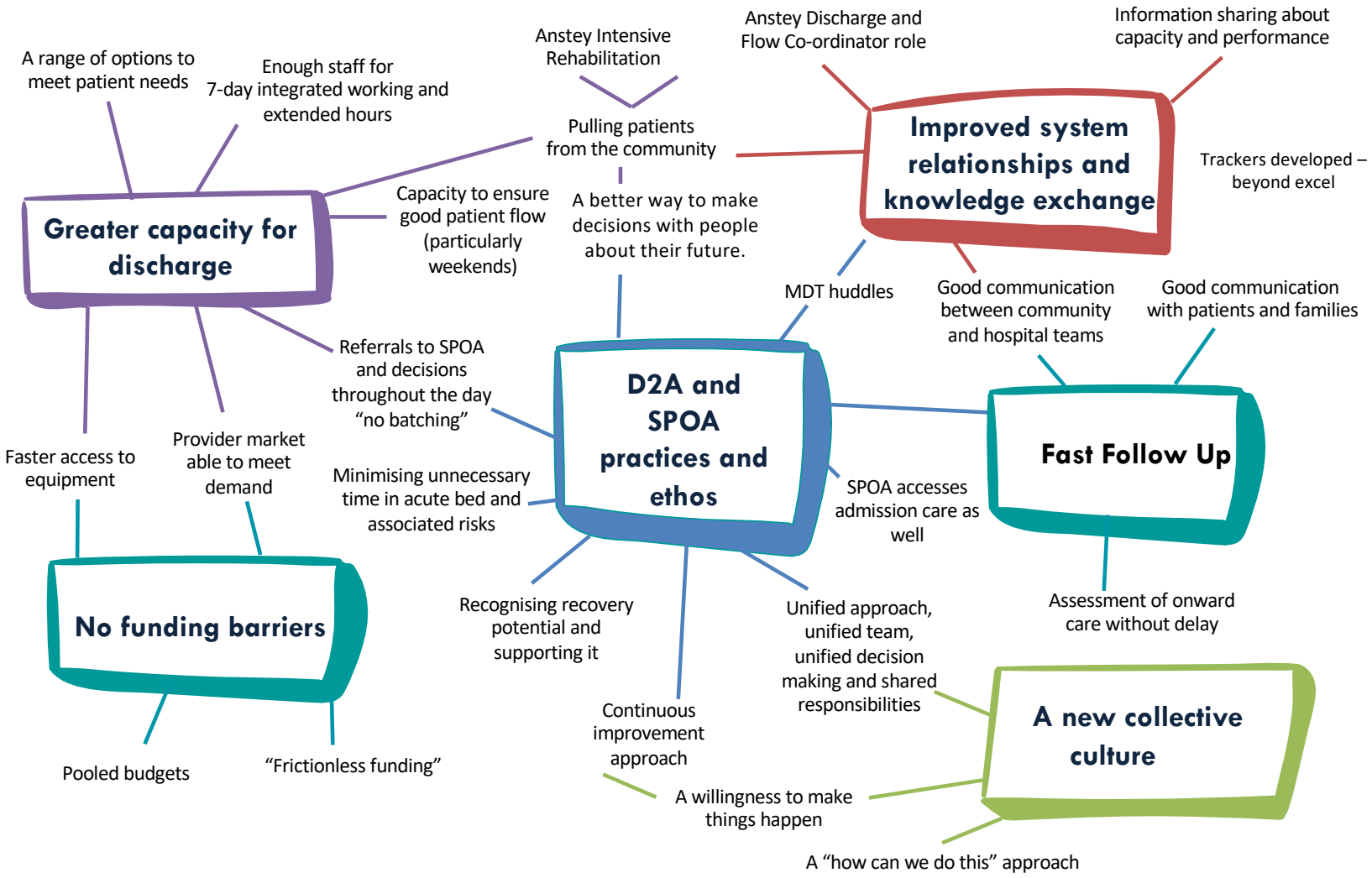
How we identified the **key themes** from the participants comments

- 29 participants attended the on-line workshops
- Participants contributed responses via 'Chat' (large volume)
- Analysed by two AHSN staff
- Systematic process of thematic analysis including:
  - → Familiarisation with the chat transcript
  - → Describing the responses (coding the content)
  - → Searching for themes in the codes (interpreting the data)
  - → Reviewing and defining the themes (both analysts)

Operational leaders, clinicians and professionals

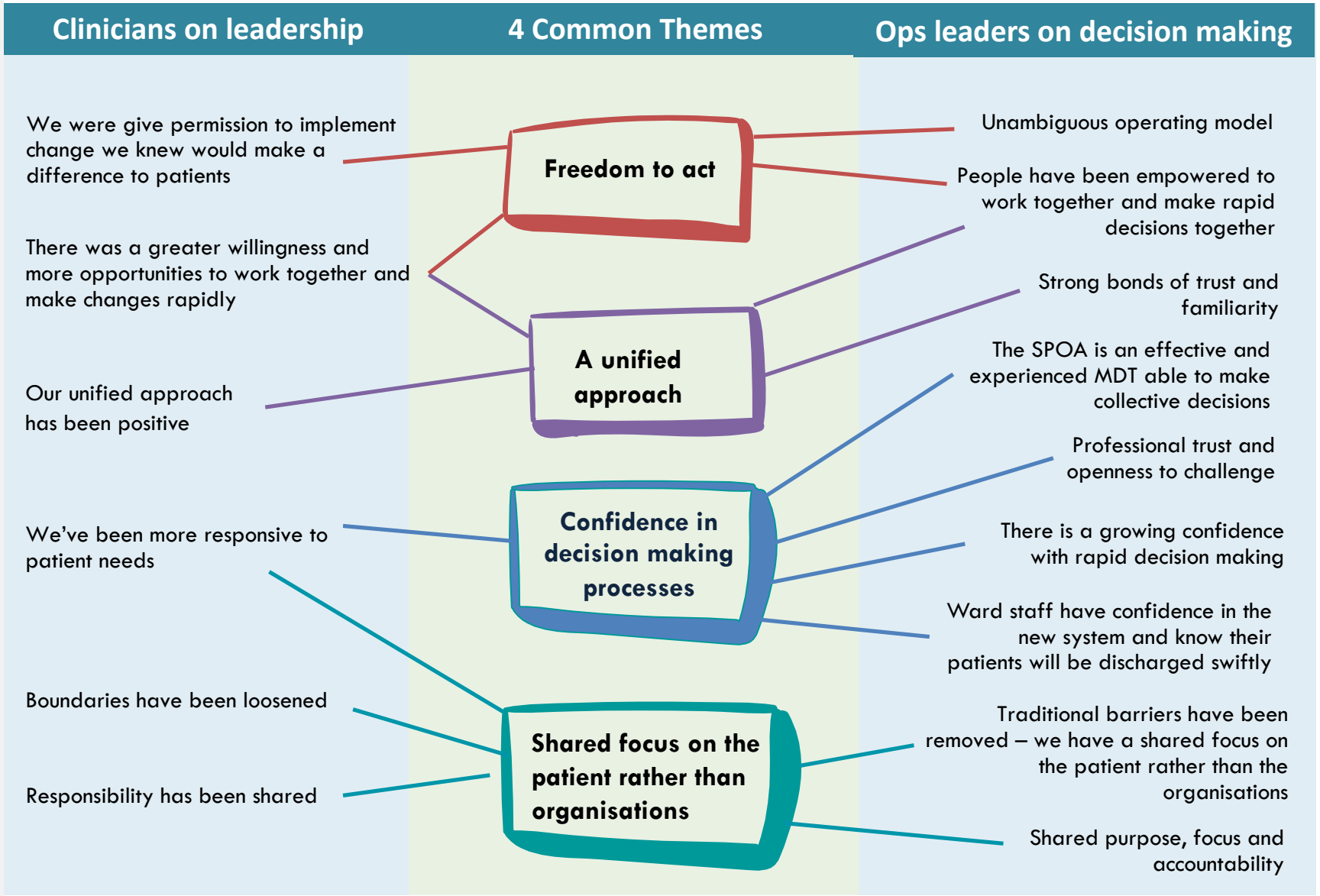
How should discharge from hospital in N&MH look going forward?

'A better way to make decisions with people about their future.' Clinical and operational leaders have embraced the practices and ethos of D2A and SPOAs. They described a future model for discharge that builds on the changes made during the crisis; minimising acute stays, pulling patients from the hospital and fast follow up. They want to maintain a collective culture with a unified approach, strong system relationships and shared responsibilities unrestrained by funding barriers. They are ambitious to improve discharge capacity, smooth patient flows and operate over 7 days with extended hours.



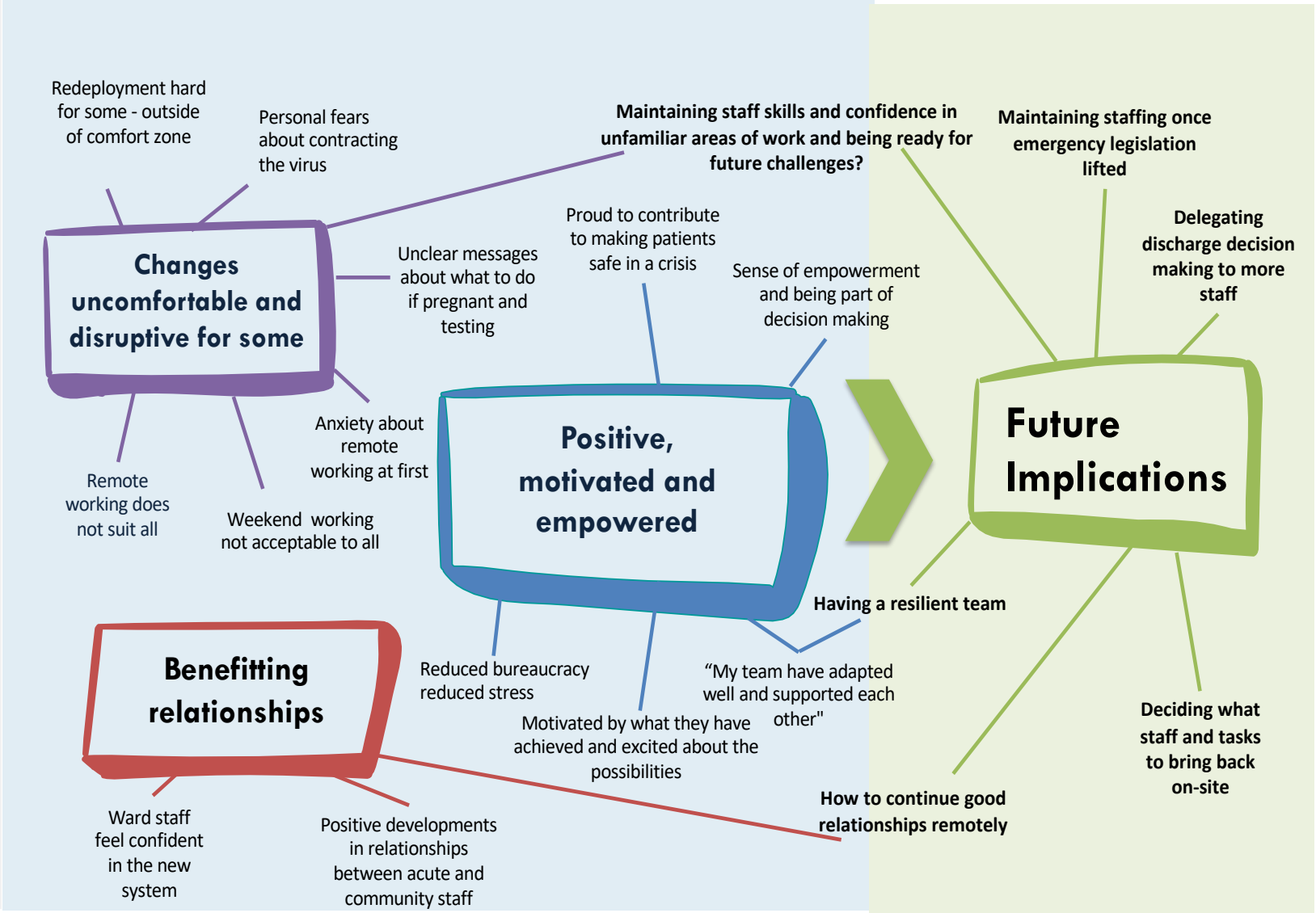
Operational leaders, clinicians and professionals
Their experience of leadership and decision making

Clinical and operational leaders described four themes that were common to their experiences of professional and clinical leadership and decision making. They perceived a 'freedom to act' that enabled change leadership and empowered decision making. They described evidence of 'a unified approach' such as effective MDT working in the SPOA. And expressed their own, and others', 'confidence in decision making' that has a shared focus on the patient, unimpeded by organisational barriers.



Operational leaders, clinicians and professionals
What does it mean for staff?

Clinical and operational leaders described four themes that were common to their experiences of professional and clinical leadership and decision making. They perceived a 'freedom to act' that enabled change leadership and empowered decision making. They described evidence of 'a unified approach' such as effective MDT working in the SPOA. And expressed their own, and others', 'confidence in decision making' that has a shared focus on the patient, unimpeded by organisational barriers. The changes were uncomfortable for some.



What was the experience of patients?

Interviews with 4 patients identified the following key messages:

- **They were mostly happy with their discharge to the care home and their own home**
- **They mostly understood the rationale for discharge and were ready to go home, or understood the rationale for going to the care home, and felt informed.**
- **All were happy with the care they received in hospital and at the care home.**
- **One patient raised a concern about the need for more communications with their family about progress with their discharge "you are going now".**
- **The three covid-19 free patients were unconcerned at anytime along their pathway about the threat of covid-19**

Patient 1 commented on being discharged to the care home – "I think it was the right thing to do At the time they weren't sure what was going to happen, and they were just making contingency plans in case it got worse."

Patient 1 - aged over 60, admitted to hospital with multiple conditions including kidney failure and postural hypertension and being unable to walk. They were in hospital for 3 weeks and discharged on pathway 2 to a care home for rehabilitation. There for 3.5 weeks before going home, where they live alone. Had support at home at first, now living independently.

Patient 2 – 76 years old, admitted to hospital with syncope and a fall. In hospital for 2 weeks and discharged to care home. Didn't want to go to care home and can't remember much about it. Happy to be at home where they live alone.

Patient 3 – 89 years old. Can't recall why admitted to hospital or for how long. Discharge directly home where they live alone. Limited recall.

Patient 4 – 42 years old, admitted to hospital with covid-19. In hospital for 6 weeks, including 4 weeks in ICU. Discharged to a care home for 1 week before returning home to their partner.

With this rapid insight approach there are limitations to the conclusions or themes that can be drawn from a small sample of patient interviews.

What the clinicians and professionals thought patient experience has been

Clinicians perceived both positive and negative impacts for patients. Positives slightly out-weighed the negatives. Taking long-term decisions out of hospital (D2A) gave patients and families more time to plan their future, led to fewer 'changes in plan' and gave people 'credible opportunity to get home.' However, the limited contact between patients and families to keep people safe, and limited understanding of the new discharge processes, affected how staff could engage patients and families in decision making and how patients felt without family contact.

Discharged sooner when medically fit

Reduced risk from long hospital stays

More time to plan their future

"Credible opportunity to get home"

Fewer changes of plan' and confused messaging than before D2A

Daily rehabilitation helping progress towards goals and independence

Time to engage in rehabilitation because of fewer visitors

✗ Limited patient/family contact, and lack of understanding of the discharge process, affected decision making

✗ Loneliness

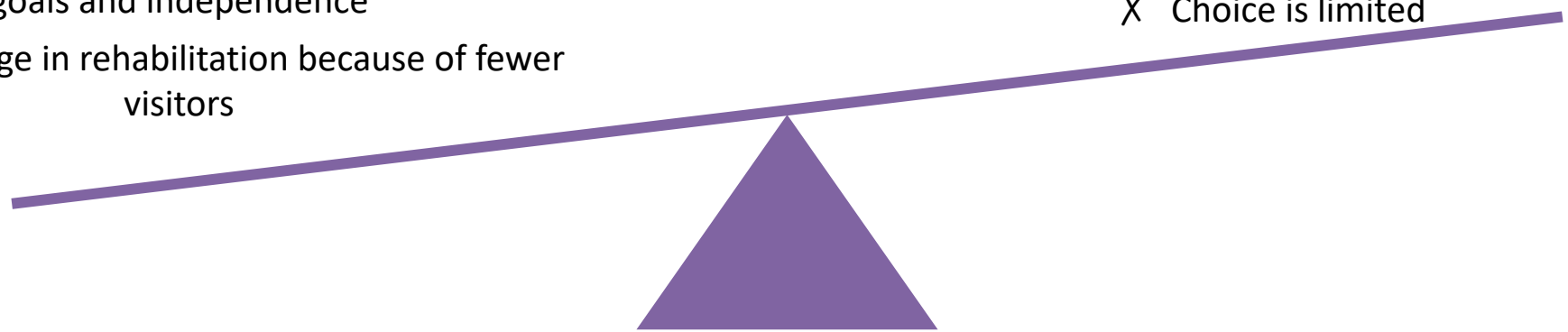
✗ Some patients need a face to face assessment

✗ Some patients moved too many times

✗ Some patients moved too soon

✗ Some patients readmitted

✗ Choice is limited



Planning the long-term future for discharge in Hampshire and IoW

N&MH is one of four local systems in the Hampshire and Isle of Wight (HIOW) STP who are working to revolutionise discharge from hospital as part of their response to covid-19.

At HIOW level, health and care organisations are having important discussions about how they move beyond the covid-19 crisis response period and secure the improvements to discharge long term.

To support this, Wessex AHSN designed and delivered a large **workshop of more than 60 key leaders and decision makers** on 15 June 2020. Like the focus groups held in N&MH system for this case study, these participants described a strong desire to maintain the benefits from this period of rapid change, to:

- Discharge patients when they are ready without delay
- to the place and support that best meets their needs
- by teams working with common purpose and good working relationships
- without the old bureaucracy and barriers
- with enough capacity 7 days a week.

A report of the outputs of this workshop is available from the Hampshire Together team.

The **key next steps** identified by this leadership group were:

Agreeing the post-covid funding for system discharge – the quantum and budgets are shared to make discharge 'frictionless' (see next slide)

Appointing to the key SPoA posts substantively

Securing greater 7-day decision making and discharge

Agreeing the 7-day capacity needed for discharge in all pathways and working to deliver it

Building the perspectives of patients and families into future plans

The financial model for discharge is the most important decision that needs to be made

An overriding factor in the decisions that the system takes on the future model for discharge is what it means for costs and their attribution to the NHS and HCC. Through this case study, people have described both potential additional costs and potential savings. It is important to bottom these out together now and to understand whether at system level (NHS and HCC) this new model for hospital discharge is affordable – and if it is how the costs can be pooled.

During the development of this case study the HIOW system hasn't made the progress it had wanted to on this issue and recognise that they need to assign the task and resource to bottoming this out as a priority.

The following diagram describes the key cost dynamics in play:

↑ Assessment time at home or in placement
↑ Risk that less patients are discharged home
↑ Acuity of care in the community
↑ Charge for care home and support packages

↓ Delays in acute beds
↓ Delays in community beds
↓ Costs of high occupancy (agency, outsourced elective etc.)

Acknowledgements

This case study was co-sponsored by Dr Lara Alloway, Consultant in Palliative Medicine and Chief Medical Officer and Julie Maskery, Chief Operating Officer, Hampshire Hospitals NHS Foundation Trust.

The work was overseen by the Rapid Insight Steering Group chaired by Alex Whitfield, Chief Executive, Hampshire Hospitals NHS Foundation Trust.

Thank you to the patients who agreed to be interviewed by Wessex AHSN as part of this study.

Thank you to all staff members who participated in the focus groups, and to those staff who were interviewed individually about the changes in discharge.

Rachel Dittrich, Governance & Assurance Senior Officer, Adults' Health & Care and Siobhan Laws, Consultant Surgeon, HHFT provided letters of access for Jackie Chandler, Evaluation Programme Manager to undertake the patient interviews.

This report was produced by Andrew Liles and Philippa Darnton, Wessex AHSN.

References

1. **Kortebein et al (2008)** found that 10 days of bed rest led to a 14% reduction in leg and hip muscle strength and a 12% reduction in aerobic capacity: the equivalent of 10 years of life.
2. COVID-19 Hospital Discharge Service Requirements. 19 March 2020. HM Government.

Limitations to this work

This work describes the outputs of a Rapid Insight project, designed to capture the experiences and learning from the client's response to covid-19 and their views about what to maintain and develop in the future. The outputs are intended to inform future planning locally, and with the client's permission, will be shared with others with an interest in the learning from covid-19.

The findings are not conclusive but indicative of a complex landscape of interacting health services delivering high quality patient care at a certain time, within a certain region, and with a group of informed system leaders. Indicative findings are drawn from a limited set of data that was collected and analysed over a short timescale to enable rapid learning.

The findings cannot be extrapolated to a broader population of users and/or applied to settings or contexts other than that described here. Nor can it be assumed that the findings are applicable to a similar setting or context. Participants in the study were not randomised. Any participants who were service users did not receive any changes to treatment, care or services as a result of their participation. The impact of potential conflicts of interest within participant groups was considered by the project team.

For the purposes of service delivery decisions, these indicative findings should be used alongside other learning obtained from available service evaluation and research.