LONG STAY PATIENTS IN WEST MIDDLESEX UNIVERSITY HOSPITAL: REVIEW
FINAL DRAFT

1. INTRODUCTION

1.1. Purpose of Review

The purpose of the review was to:

- "Examine the factors involved in lengthy in-patient episodes for some patients (defined as lengths of stay of 20 or more days). The brief set out the task as follows:
  - "A detailed examination at patient level of the discharge pathway, identifying delays, responsible agencies and make recommendations as to how these delays can be minimised or eliminated. This will include an assessment of the “medically unfit patients” to bring clarity to the definition of medically unfit for all parties;
  - Critically review the protocol for the Delayed Transfers of care at WMUH;
  - Critically review the resources available to all parties in respect of discharge including, RADIATE, CC Team, Community rehabilitation resources and specialist rehabilitation;
  - Assess the need for intermediate care in Hounslow;
  - Consider areas where integration of services would reduce delay and improve patient flow and experience”.

The information required for the review was identified in the brief (see below).

- "Case notes of patients whose discharge process will be examined
- Excess bed day data
- SitRep data on reported delays
- Joint Protocol for delayed discharges
- Social services review 2006
- IARDS Terms of reference, operating framework”.

Documents and data obtained is summarised in Appendix 1.

1.2. Revisions to the Brief

Whilst initially the focus was on carrying out a small number of informant interviews with key stakeholders in each of the agencies (WMUH, PCT and Social Services in the two Boroughs), it was agreed, following completion of a number of interviews with Hounslow stakeholders that this part of the review should be broadened out.
The majority of WMUH patients (around 70%) are from the catchment of London Borough of Hounslow. From initial contact and communication, it became evident that there currently exists a degree of mistrust between agencies at different levels in the Borough on how the ‘problems’ of acute admission, discharge and lengthy episodes of acute care are perceived and managed. Moreover, agencies have been developing their own solutions to the problems as they perceive them, and this is occurring in a context where each agency is under considerable financial pressure. Since there is a necessary inter-dependence between health and social care agencies in terms of the problems – and solutions – around the acute/intermediate/community health and care interfaces, such approaches are unlikely to be productive.

It order to build up a clearer picture from each agency in the Borough about their conception of the interface ‘problem’ and how their perception of need and service gaps are shaping priorities for service development, the number of informant interviews with Hounslow stakeholders was extended to include commissioners and providers at strategic and operational level. 24 individuals participated in interviews, either one to one or in small groups. Additionally I attended the Hounslow multidisciplinary meeting with social workers, continuing care nurse and senior nurse practitioners.

Relationships between WMUH and Richmond borough did not appear to exhibit the same level of strain; in part reflecting the considerably smaller contribution it makes to the WMUH patient population. As well as seeking the same kind of data from stakeholders here, I attended a routine team meeting with the Richmond Hospital Social Work Team.

In this report, I have not attempted to present the different perspectives from stakeholders. I do want to emphasise, however, that across all of the interviews was an expressed commitment from individuals and agencies to making things better for patients, albeit balancing a patient-centered approach, increased need and budgetary constraints was an ongoing challenge.

I have sought in this report is to address the issues identified in the review brief and in the stakeholder interviews through the prism of patients’ experience as they journey through hospital. It therefore focuses on the process of discharge planning; the meaning of ‘fitness for discharge’, negotiations around and resources available to facilitate discharge, including intermediate care provision. This qualitative picture, based on case papers, is supplemented and contextualised by drawing on the wealth of quantitative information provided by staff across agencies and services relating to activity and service provision, and to current policies and procedures.
2. LONG STAY PATIENTS: DOCUMENTING THE PATIENT JOURNEY

2.1 Method and Approach

I have examined a random sample of case papers relating to 53 patients who experienced a lengthy in-patient episode to WMUH between October 2007 and March 2008. These included both Richmond and Hounslow patients. Around half of them (24) had previous in-patient episodes in the 12 months prior to the current event and these episodes were also included in the analysis. The focus was to examine in detail the patient journey into and through the hospital including the factors that contributed to the admission and the destination on discharge. The aim was twofold: to seek to identify “windows of opportunity” at different points in the patient pathway that might indicate the need for organisational, procedural or practice changes that could reduce long in patient stays, and to examine in practice the meaning of “fitness for discharge” and “medically unfit” as applied to these patients.

The analysis and conclusions are based on the information available within the case notes and to that extent are dependent on the quality and detail of what is recorded. It was not always clear, for example, when patients were moved between wards; less evident as well was the content of decisions flowing from ward rounds and multi-disciplinary meetings. This may reflect recording practice. However, as considered in more detail in the paper; in some cases it appears to reflect a lack of focus on developing a concerted plan of action with allocated responsibilities for different professionals and agencies to carry it through.

Generally, the daily chronology of medical and therapy action and interventions, as well as the mobilisation of informal, psychiatric and social care knowledge and input provided a clear enough picture of the trajectory to emerge, with one proviso. The chronology does not include nursing interventions since these are recorded and kept separately from the medical notes. It is not evident from what is recorded there how and in what ways nursing staff contribute to the assessment of need and discharge planning, even though their understanding of the patient from day to day contact and professional knowledge offers a unique perspective and is an essential part of the process of assessment, treatment, care and discharge planning. This has significant implications for multi-disciplinary working and decision-making.

Recommendation: Ward Procedures and Processes

Review the approach to recording action and decisions relating to individual patients. The aim should be to develop a recording system that reflects the multi-disciplinary input from all professionals including nursing staff within a common set of patient notes.

The overwhelming impression from the case notes and how they are recorded is of a rhythm of organisation life that assesses and measures change on a daily basis. Whilst understandable in the context of short, intensive interventions to manage acute medical problems, it is more problematic in respect of the kinds of complex, co-morbid conditions that have a chronic as well as acute manifestations common in advanced older age. This is an issue I return to in the report.
I have structured the paper around the sequence of the patient journey and although there may be particular issues relating to individual experiences, my focus is on general patterns. I do however draw on individual patient journeys as illustrative of these general patterns.

2.2. Setting the Scene: Lengthy In-Patient Episodes
To set the case paper analysis in context, I examined the pattern of 20+ days in patient episodes between January 2006 and June 2008, taking the same date in each month as the point of comparison. Three points emerge from this. First, although there was a slight reduction in the numbers of patients with such episodes between January and August 2007 compared to the same period in 2006, there has been an increase over the latter months of 2007, compared to the same period in 2006. Thus, overall, the average number of patients with long stays for 2006 and 2007 is similar (mean: 85.75 and 85.83 respectively). Second, whilst there is some variation from month to month, the points of highest risk are the spring months (although this may simply reflect more sustained action over the winter). The mean number of patients with 20+ days for the same six month period January to June in the three years 2006, 2007 and 2008 respectively is 89, 89 and 101. Third, whilst generally, the proportion who are medically unwell has varied between a fifth and a third (higher in the winter months); this has increased to nearly half from October 2007. This may reflect more accurate recording during the winter months. Even so, the pattern indicates the need to examine the patient journey in some detail with the aim of identifying areas for common action.

3. COMING INTO HOSPITAL
3.1. Context of Admission
In terms of the nature and severity of the illness event that brought them into hospital patients included in the analysis can be broadly categorised as follows:

1) Those who have experienced a major trauma resulting in extensive neurological damage requiring lengthy rehabilitation (they tend to be younger – between 25 and under 50, but also include younger-old previously fit and active that have suffered an extensive CVA);

2) Frail older people experiencing a sudden trauma (fracture, particularly neck of femur) in the context of pre-existing multiple health problems, often linked with delirium/acute confusion;

3) Those with recurrent medical symptoms/conditions (diarrhoea, vomiting, abdominal pain, UTI), often with a co-existing dementia;

4) Those with a chronic illness/disability with a deteriorating trajectory (Parkinson’s, cardiac disease, COPD);

5) Those with a malignancy.

Box 1 below provides a pen picture of patients in each of these categories (pseudonyms have been used and some biographical details changed to protect anonymity). With a couple of exceptions, all were emergency admissions – generally coming in by ambulance.
Box 1

1. Mr. Sanders (25 years) was admitted to WMUH from a central London hospital having suffered major brain trauma following a road traffic accident.

2. Mrs Bennett (90 years), widowed and living alone had a fall and was admitted to A&E via ambulance. This was the most serious of a series of falls that had resulted in A&E admissions on several occasions within the previous six months. Assessment and x-ray revealed a fractured neck of femur. She presented as confused and disoriented.

3. Mr Martin (65) had a fall and was unable to get up. He attracted the attention of a neighbour who called the ambulance. There was no obvious injury on examination. However, a grade 2 ulcer was noted in the pelvic area; he tested positive for a UTI; was very agitated and aggressive with staff and information gathering revealed he was known to psychiatric service with early onset Alzheimer’s.

4. Miss Pettigrew (86 years) has suffered from cardiac disease for some years. She was found by the home carer too weak to move from her chair and in respiratory distress. Admitted via ambulance, she had several pressure sores, apparently the result of prolonged sitting.

5. Mrs Arthur (87) was admitted for elective surgery for malignancy – previously she was fit and active and the main carer for her spouse.

I return to some of these patients later to illustrate some general themes regarding their journey through acute care.

3.2. Diversion at A&E

For some types of events there clearly exists no alternative to acute in-patient admission (for example 1 and 5 above). For others, diversion may be possible. Many of the patients here who had arrived following a fall, UTI or abdominal pain were assessed by Radiate either in A&E or in the Medical Assessment Unit. Many of those who experienced previous events had been assessed and diverted at A&E or at MAU, through intervention by Radiate. What were the key differentiating factors in this current event that contributed to admission on this occasion? Could admission have been avoided?

Differentiating factors were of three broad types, often operating in combination: the need for surgical intervention; the severity of the event; and contextual factors.

- Where a previous fall had not resulted in injury requiring surgery (bruises and lacerations; a public ramie fracture) and the patient was oriented even if slightly confused or they had access to informal support, they were discharged with assistance if needed (for Richmond patients this might mean an admission to the community hospital depending on severity and frailty).

- Where surgery was required as for example with a fractured neck of femur; admission proceeded.
- If the UTI was accompanied by other symptoms deemed to require further investigation or could indicate other problems (irregular pulse, low blood pressure, PR bleed), or the patient was assessed as very confused, disorientated and lived alone, MAU admission occurred. Depending on the outcome of investigations, ward admission was indicated or diversion via Radiate could also occur at this point.

Fitness for discharge was based on the person not requiring medical intervention in an acute setting and deemed functionally safe to manage within the environment from whence s/he came (this would differ as between a person returning alone to their own home, to a shared household or to residential or nursing care). For a frail older person living alone, for example, this would be: ability to stand, steady mobilising (including with aids), and a level of confusion that reflected ‘usual self’. For someone coming from residential care, it would mean mobilising with assistance of one person.

3.3. Practise and Resource Issues: Co-Morbid Physical and Mental Health

Assessment of Delirium/Acute Confusion

Both at the A&E and MAU gateways and recurring at subsequent points in the patient journey, is the problem of assessing the nature and level of confusion that some patients present and which affects decision making about risk. Does the degree of confusion and behavioural problems (agitation, aggression, hallucinations) manifested by some patients reflect an acute state or acute confusion on chronic dementia? There is considerable research evidence to suggest that incidence of acute confusion or delirium is associated with trauma, such as hip fracture, as well as with orthopaedic surgical procedures common in later life (Bruce et al, 2007), and that this has adverse effects on morbidity, mortality and length of in-patient stay. From the Radiate intervention documented within the general case notes, the extent of specialist mental health involvement at this point is not clear (I did not examine documentation that Radiate holds on cases referred). What is evident is that acute and acute on chronic confusion recurs as a major risk factor contributing to uncertainty about ‘functional’ fitness and a systematic approach to assessing it is required.

Recommendation: Procedures and Process

Consideration should be given to the use of a standard assessment tool (Confusion Assessment Method Scale (CAM) or similar) that might indicate need for further investigation and intervention regarding acute confusion/delirium.

The contribution of mental health professionals in assessing need and risk in Radiate is essential – both in terms of direct involvement and in providing advice and support to other professional colleagues. A review of how this should most effectively be carried out should be undertaken as part of a wider review of the model of liaison mental health in treatment, care and discharge planning.
Cognitive problems/dementia

Whilst the evidence here suggests that the Radiate and MAU gates operate to divert a large proportion of those referred to them from A&E (see below), the height of the gate depends on the kinds of resources that can be mobilised to effect discharge of those on the margins.

Radiate can mobilise time-limited social care support for both Richmond and Hounslow patients (although the number of packages is relatively small compared to the numbers of patients dealt with (see 3.4). In Hounslow, this is provided by the Local Authority Assessment and Re-Enablement Team (ART). In Richmond, it involves spot purchase of home care from independent agencies. During the winter of 2007 and extended into summer 2008, the commissioned service Medihome, accessed via Radiate additionally provided short term nursing interventions (for example, intravenous IVs) that extended the options for diversion of more patients.

One area of unmet need that emerged however relates to older people with cognitive problems. The specific needs here include intensive home based assessment of capacity to manage within a familiar setting; and short term skills development to sustain continued living within the home. In Hounslow, whilst ART is based on an enabling model, it is not clear whether it can or does meet this specific need. The concept of trial accommodation in Hounslow also, whilst of value for patients with physical needs is more problematic for those with cognitive problems since the key task is developing and embedding daily life routines within a familiar environment.

In Richmond, reliance on traditional home care provision that ‘does things for’ people, does not meet this need. Eligibility criteria for the Richmond Intermediate Care Team would also tend to exclude such patients – an issue that has been identified in policy and research as operating more generally. For example, research on intermediate care (for example, Godfrey et al 2005; Barton et al 2006) suggests that older people with cognitive problems do not access these services. In part this reflects the fact that the form of service provided needs to take into account the specific needs of people with dementia, with particular consideration given to content, location and duration of support. It also requires that appropriate training is given to staff to enable them to support people with dementia (Alzheimer’s Society 2002).

Recommendation: Resources

The Medihome experience attests to the value of a service that broadens the scope of short term, nursing interventions in the patient’s home, beyond those traditionally offered by district nursing. The range of interventions and how these might be provided over the long term to extend the potential for diversion at A&E requires consideration.

As part of a broader review of intermediate care provision, consideration needs to given to support aimed at the needs of older people with cognitive problems: specifically intensive home based assessment of capacity to manage within a familiar setting; and short term skills development to sustain continued living within the home.
3.4. Diversion by Radiate: Pattern of Activity

Activity data provided by Radiate places the qualitative picture above in context.

- During 2007, Radiate dealt with an average of 156 referrals a month, the majority of which resulted in diversion from acute admission (over four fifths). In the first four months of 2008 there was an increase in the monthly referral average to 163 (from 143 for the same four month period in 2007), and the proportion of patients diverted from ward admission was similar to that for 2007.
- The bulk of referrals relate to those over 50 years (99% in 2007 and 98% in 2008).
- The pattern of referral for Hounslow and Richmond, equates approximately to the overall patient profile for each borough (70/30) – although with a slight over-representation of Richmond patients.
- The proportion of patients for whom a package of social care is provided is relatively small. In 2007, it was 13% of those dealt with by Radiate (251 of 1873 referrals). Generally, each package involved around ten visits, providing in total some six to ten hours support. Hounslow provides proportionately more in the number of packages provided than might be anticipated from their patient profile (79% of all packages in 2007 compared to 19% for Richmond).

In summary, Radiate comprises one of the most developed of the intermediate care components, reflecting considerable investment through delayed discharge funding and facilitating the diversion of patients from both Hounslow and Richmond.

3.5. Impact of New Service Developments on Radiate

The development of an integrated Rapid Response community based service, currently operating as a pilot in part of Hounslow borough may over the longer term impact on the numbers and characteristics of patients that get to the A&E door. It is not likely to effect change in the short term even in the context of its extension across the borough as a whole. In part, this is because the model of service will need to secure the engagement of GPs - seen as a major challenge in parts of the borough; in part because there will have to be a testing out of different approaches to pro-actively identify those at risk of acute admission and the kinds of community based interventions that can appropriately prevent them.

The Rapid Response service is aimed at targeting prevention upstream i.e. of people within the community who may be at risk of acute admission. A feature of the service as it develops is the expansion of the number and role of community matrons to enable pro-active case finding of people at risk – for example those with multiple A&E admissions. Its success in diverting people from A&E will depend not only on its capacity to identify people at risk but on the resources that can be mobilised to respond to the needs identified. These include the provision of medical interventions in the community (for example, as has been provided by Medihome); a falls service; and access to intermediate care type services that can offer therapy and enabling support particularly to older people with cognitive problems as well as those who are physically frail. Currently, service development in each of these areas is planned, limited or inadequate – but not yet in place. Intermediate care in particular is poorly developed in terms of the range of the service repertoire, its capacity and its degree of systemic integration. I return to this again later in the report.
Recommendation: Commissioning and Provision

The Rapid Response initiative is one element of system change in community and intermediate care provision - albeit an important one. An aspect of this wider system change has to be an evaluation and review of the role that Radiate will play in the context of diversion further upstream in the community.

It will be critical that evaluation of the impact of Rapid Response should include its specific function vis a vis Radiate and its impact on the traffic and characteristics of patients dealt with by Radiate. This requires a co-ordinated approach to planning and service development at both commissioning and provider levels.

4. WARD ADMISSION

4.1 Risk Factors in Prolonged Acute Stay

There are several distinct groups of patients for whom the nature of the illness/condition precipitating admission or subsequent illness events contributes to prolonged acute stay.

Firstly, there are those for whom the particular mix of factors contributing to lengthy stay are either outside the control of the hospital or relate to heightened risk particularly for those in advanced older age with physical co morbidity. For example:

- Patients who suffer a severe, disabling stroke or brain injury that in addition to intensive, inpatient rehabilitation also requires neuro-rehabilitation within a specialist centre. Whilst the numbers involved at any one time are small (typically two to three), their overall length of stay may be 100+ days, that includes around a two month wait for a specialist neuro-rehabilitation centre from acceptance to admission.

- Patients for whom investigations of symptoms reveal a malignancy, or who have further illness events (MI, CVA).

- Patients who experience post-operative complications – CVA, MI, respiratory difficulties – for which advanced age and/or co-morbidity heighten risk.

Secondly, there are those where although frailty heightens risk, hospital practice is a contributory factor – particularly such infections as MRSA and C.difficile (although some patients also tested positive for such infections on admission). For patients in this sample, six acquired a C.difficile infection, contributing to ‘unwellness’ and a further four contracted MRSA.

Thirdly, there are those with complex multi-dimensional needs where critical to the move from acute care is timely assessment, a concerted and co-ordinated approach to discharge planning and service capacity to facilitate acute discharge. For example:

- Combined physical and mental health problems;
- Deterioration of physical or mental health requiring a move from residential to nursing care;
- Combined physical and social problems (chaotic lifestyle, neglect, poor physical environment).
There is general agreement at policy, strategic and operational level that from the perspective of efficient use of acute beds, patient experience and outcomes, length of in-patient stay should be as short as possible and necessary. Major policy initiatives and investment at national level, such as intermediate care and reimbursement in England have been directed toward this objective. Before working through the patient journey, I take a slight diversion to examine reimbursement and the approach to implementation in Richmond and Hounslow as expressed in the Joint Protocol for Delayed Transfers of Care agreed between WMUH, the local authorities and PCTs in Richmond and Hounslow (2003).

5 THE CONTEXT OF REIMBURSEMENT

For ease of reference I have summarised the main provisions of the reimbursement process as set out in the Community Care (Delayed Discharges) Act of 2003 (Box 2). Key features are the imposition of statutory duties around what is expected of different parties in the hospital discharge process (i.e. minimum timescales for completing assessments). It also broadens out the decision making on fitness and safety for discharge beyond medical personnel to include the wider multidisciplinary team. This provides the backdrop for examining the approach taken in Richmond and Hounslow boroughs with health partners to the legislation and subsequent practice guidance and which is enshrined in the Joint Protocol.

Box 2 - Summary of the Reimbursement Process

- NHS bodies have a statutory duty to notify social services of a patient’s likely need for community care services (referred to as an ‘assessment notification’ or Section 2 notification). Section 2 notifications should only be made after patients’ eligibility for continuing NHS care has been assessed. Where possible, assessment notifications should include an estimated date of discharge.

- There is a defined timescale – a minimum interval of two days for social services to complete the individual assessment and provide appropriate social care services.

- A second notification (Discharge Notification or Section 5 notification) follows completion of a multi-disciplinary assessment and gives notice of the proposed day on which discharge will take place (minimum 24 hours notice).

- A reimbursement charge is paid by social services to the acute trust if the fact of social services not having met their obligations – that is to assess the patient (and carer if appropriate) and provide social care services within the set time – is the sole reason for the delay in discharge from hospital. If any element of the delay is related to NHS areas of responsibility then reimbursement does not apply.

NHS bodies have to make both notifications to social services if a claim for reimbursement is to be triggered. The charge applies from 11am on the day after the proposed discharge date identified by the NHS in the discharge notification, or three days after social services have been given an assessment notification of a patient’s likely need for community care services, which ever is later. If services are not in place after 11am, the full daily charge will apply from that day onward.
The principles underpinning the partnership approach set out in the Joint Protocol were: joint agreement on prioritising expenditure; transparency of finance and resources in the system; and investment of all new monies including the Delayed Discharge Grant in enhancing capacity. Investment was focused particularly on the expansion of Radiate, and the establishment of the Notifications Team with the dual remit: to monitor assessment and discharge planning for patients on a Section 2; and provide an assessment and discharge planning role in respect of patients in acute trusts outside the borough boundary. The team manager also acted as a single point of access for all notifications and for negotiating and agreeing delayed transfer of care returns. The rationale underpinning this approach was that investment in service development would both reduce reimbursable delays and be called off against any fines incurred.

From a local authority perspective, the strategy has meant substantial investment in services within/at the boundary of the acute hospital, resulting in minimal reimbursable delays – a pattern that is reflected with varying levels of success nationally. From the perspective of the acute trust, with its focus on increasing throughput and reducing length of stay, the emphasis is wider than a reduction in reimbursable delays and includes a broader interest in lengthy in-patient episodes. The broadening out of the weekly multi-disciplinary forum at WMUH in autumn 2005 from consideration of patients whose discharge was delayed to include all patients with lengthy acute episodes (defined as stays of more than 20 days) was a response to identifying and managing this.

Whilst some of the operational details have changed over time – for example the notifications team no longer exists – the Joint Protocol continues to provide the framework for managing the discharge process.

Pertinent to a critical review of the protocol and how it is operating in practice is the research evidence relating to reimbursement. Firstly, whilst there has been a significant reduction in reportable delays and particularly reimbursable delays, both the Department of Health commissioned research which I and colleagues carried out where Hounslow was one of the sites (Godfrey et al 2008) and that conducted by others (McCoy et al, 2007), point to the continued challenge of patients experiencing very long delays.

Second, very little money has changed hands as most health and social care economies have prioritised joint action to enhance capacity over fines.

Third, and with reference to the notification system, the findings from our research inform my view namely:

- A helpful facet of reimbursement is the Section 2 or notification of need for assessment and provision of support on discharge that it allows for proper identification of the patients needs and multi-disciplinary input to facilitate safe discharge – although the formal timescales are generally agreed as unworkable in respect of the more complex discharges that increasingly are the purview of most hospital social work teams;

- The Section 5 in contrast is a potent source of tensions between operational staff, and since it gives rise to ‘gaming’ and ongoing low level negativity that is inimical to joint working is not effective in reducing delays.
From fieldwork in Hounslow during 2006/07 we found that: “…Section 5s are only issued where the multi-disciplinary team agrees that this should occur and the social worker is perceived as dragging his/her feet. Where the process is underway to achieve discharge, for example, a plan of action has been negotiated and agreed with the patients/relative and a decision is awaited from the multi-agency panel to whom all requests for intensive care packages or long term care must be made, Section 5s tend not to be issued… a Section 5 was issued for an average of 6% of all Section 2 notifications – with the bulk of these being sent by hospitals outside of the borough.” (Godfrey et al, op.cit. p56).

The Executive Summary is attached as an Appendix for information.

Based on this research and the case paper analysis, there is no evidence to suggest a change in practice in the use of the Section 5. More important is a fundamental review of the process of multi-disciplinary assessment and decision-making around discharge planning for patients with complex needs. Specific issues that need to be addressed in respect of such a review are set out in the pages that follow.

**Recommendation: Protocol and Procedures**

The Joint Protocol on Delayed Transfers of Care between WMUH and health and social care agencies in Richmond and Hounslow continues to provide a useful framework for managing, notifying and clarifying responsibilities around delays.

Extending the focus beyond delays to include lengthy in patient episodes has been important in addressing problems and blockages at the level of individual patients.

There is a need to cast organisational gaze on patient pathways more broadly. Specifically, this requires a root and branch review of multi-disciplinary working to respond to the acute on chronic and multi-faceted needs experienced particularly in advanced older age and for those with complex health problems.

### 6 PLANNING FOR DISCHARGE

#### 6.1. The Planning Process

Under reimbursement, as noted above, the trigger for a community care assessment to plan for discharge is a Section 2 notice. Whilst formally a Section 2 provides a minimum of three working days for the completion of a social care assessment and the mobilisation of services to meet identified needs, the guidance suggests that good practice will include an early alert of the likelihood that someone may need support. The Joint Protocol also places emphasis on early assessment.
Thus:

- “Joint assessment should commence at the earliest possible opportunity where there are indications that community care services will be required to enable safe transfer from acute health services;
- Assessment will be joint between social services staff and health services, following the principles laid out in the Single Assessment Process and will agree the support needs which have to be addressed to ensure safe transfer; and
- Consideration will always be given to the benefits that both intermediate and transitional care services have to offer people.
- Full involvement of patients and their carers in both assessment and care planning is central to discharge planning”.

Further, drawing on the “Discharge from Hospital - pathways, process and practice” handbook (Department of Health, 2003), the protocol identifies that building on good practice, partners in Hounslow will:

- Agree, operate and performance manage a joint discharge policy;
- Focus on early identification of individuals who have additional needs;
- Identify and train a co-coordinator at ward level in each acute hospital;
- Develop an integrated assessment and discharge team;
- Underpin all of the above with strong managerial and clinical leadership, effective communication and an ongoing commitment to inter-agency training;

Information collected for the delayed discharge research in Hounslow found that Section 2s were issued within days of admission in respect of patients who were deemed likely to require multi-disciplinary support to facilitate discharge. This was based on data collected between the autumn of 2006 and late summer of 2007. In essence, this provided the justification for social work involvement. Moreover, the practice of early notification is based on recognition of the complexity of need that requires time to achieve a user-centred response. From the case papers examined here practise appears to have changed. Although different arguments have been put forward as to why this has occurred, including pressure on social workers and on ward staff, it contributes at least in part to the length of inpatient stay for patients with particular types of problems, trajectories and needs. But it is also reflective of what I describe later as a stage approach to treatment and action planning that militates against a multi-dimensional response to the often complex and multifaceted needs of older people in acute care.

**Recommendations:**

**Assessment and Discharge Planning Process and Procedures**

Early notification of need for social care input is essential to good discharge planning. For people with complex needs, the involvement of social workers in exploring options and choices with patients and their relatives at an early stage is not only good practice; it is key to achieving a timely and co-ordinated path through acute care. The use of the Section 2 early in the acute episode as a means of alerting the social work teams to the likely need for social care support should be implemented.
6.2. **Risk Factors for a Multi-disciplinary Assessment**

There are specific circumstances that should routinely trigger a Section 2 notification early in the acute episode: where the patient has been receiving a package of care prior to admission; where there is a marked decline in functional ability; or where the reason for admission is an acute onset condition with long term disabling impact as for example, with a stroke. Additionally, there emerged from the case paper analysis a number of triggers or risk factors that pose the need for a multi-disciplinary assessment including social care early in the acute episode.

**a) Deterioration in Physical and Mental Health over Acute Episodes**

There were patients - typically in advanced older age (80+), living alone, without formal social care support - who had a number of short in-patient episodes within 6 to 12 months prior to their lengthy episode or several A&E admissions over a similar period. The pattern of the trajectory over time suggested an overall picture of decline. This could take the form of increasing frailty, self-neglect and/or a shift from some short-term memory loss to increased confusion which was undiagnosed. Unless the patient had previous involvement with in-patient therapy services or information on A&E admission was detailed in the case notes, each admission tended to be treated as a unique event and the pattern of decline over time not noted early on. If such patients could be identified at admission and a medical, functional and social assessment undertaken early in the acute episode, planning for discharge could begin earlier. The current sequencing of treatment and assessment – medical and functional, then activities of daily living, then social services assessment – militates against a joint strategy to direct rehabilitation and social care provision to optimise independence and facilitate discharge.

**b) Poor Recovery following Fractures and Orthopaedic Surgery**

There were a number of patients who experienced slow recovery following orthopaedic surgery, particularly fractured neck of femur. This could relate to low mood, loss of hope of recovery especially when the person might have experienced previous falls and injuries, or co-morbid cognitive problems. There were two distinct scenarios here – both which resulted in a narrowing or closing down of discharge options.

Firstly, there were those in advanced older age (85+), who were managing independently, albeit precariously; but whose relatives now expressed concern about their continued ability to remain at home and began to set in train a process of negotiation with the older person about accepting long term care. By the time recovery began to pick up, psychological acceptance of long term care by patients and relatives had established a dynamic that could not be easily reversed. It is important to note that in this scenario, it was relatives and not medical or ward staff that initiated the process. Even so, organisational factors and different professional perspectives on risk contributed to it. Whilst early multi-disciplinary intervention is critical to keeping options open, concerted multi-dimensional intervention is also crucial and I return to this below in considering the process of assessment and discharge planning.
Secondly, there were those with cognitive problems whose ability to participate in physiotherapy was viewed as impaired, for example, they were unable to follow instructions. Whilst some such patients were referred to the liaison mental health nurse, the point at which this occurred was relatively late in the acute episode, which meant that they could only play a very limited role in action toward discharge.

Among the case paper sample, nearly half the patients (22) were identified as having some kind of mental health problem of varying acuteness and severity of whom ten only were known to/involved with specialist psychiatric services. Nine of these 22 patients were referred to liaison mental health workers to carry out an assessment of mental health and/or of the patient’s decision making capacity to return home. In most cases, the request for a mental health/capacity assessment not only occurred late in the acute episode but was prompted by disagreements between patients and relatives about the discharge option. This is illustrated in the case example in Box 4 relating to Mr Andrews.

The process of assessment of mental health need appeared very protracted – particularly in respect of Hounslow patients. The timeline (Box 3) has been constructed from the pattern found in a number of cases where the patient was not previously known to specialist mental health services but presented with intermittent confusion and reported increased memory loss over a prolonged period.

<table>
<thead>
<tr>
<th>Box 3</th>
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<tbody>
<tr>
<td>T1 Day 0: MDT decision to request a psychiatric review.</td>
</tr>
<tr>
<td>T2 Day 6: Assessment commenced. To report back following discussion with colleagues.</td>
</tr>
<tr>
<td>T3 Day 15: Conclusion: patient does not have capacity to make decision on discharge</td>
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There are two issues posed here that are pertinent to the wider review of the mental health liaison model. First, is the apparently limited use of mental health expertise by general ward staff shaped by their experience of practise or does it reflect a limited conception of what such expertise can offer? It seemed to be a combination of both. Whilst typically most referrals to mental health specialists (at least from the case papers examined) concerned an assessment of mental health or capacity, there were a couple of examples relating to Richmond patients where the liaison role encompassed psychological support and medication review over a number of sessions, thereby contributing directly to the overall plan for discharge.

c) **High Level of Care provided by Families/Relatives**

The provision of a high level of informal care by families prior to acute admission should trigger an early Section 2 assessment. This acknowledges that firstly, the circumstances surrounding admission may disturb an already fragile informal care situation; secondly, that families may be ambivalent about continuing to provide support which is not expressed until the point of discharge is immanent. Two exemplars with different outcomes although with similar impact on lengthening the acute episode, are illustrative (Box 4).
Box 4

Mr Radcliffe (73) was admitted from home with a general weakness – unable to get out of bed for several days and was doubly incontinent. He had multiple physical problems (diabetes, CVA, osteoarthritis, partially sighted and moderate/severe Alzheimer’s. His wife provided all care. Within 8 days of admission, he was mobilising with assistance. The ward contacted the family to indicate Mr Radcliffe was ready to be discharged within the next couple of days. Mrs Radcliffe expressed the view that she could no longer care for her husband; that he had deteriorated over the previous months and she had found it increasingly difficult to manage prior to this current admission. She was also unwell herself. This then provided the trigger for the ward to issue a Section 2 notification. Two months later Mr Radcliffe was discharged to an EMI nursing home, following a Continuing Care Assessment, agreement on funding and placement secured. The main factor contributing to the length of episode was Mrs Radcliffe’s ambivalence as to whether she wanted her husband home or in long term care.

Mr Andrews (77) has advanced Parkinson’s and was admitted with marked swelling of the abdomen and vomiting via ambulance. He lives alone although a sister who lives locally keeps an eye out for him and he has been getting home care twice daily for a couple of months since a previous acute admission. His neighbour reported that he had become increasingly confused over recent months. He subsequently had surgery and a stoma fitted. In the first week post surgery, he made good progress with mobility, plans were in hand around options for stoma management, he was eager to return home and the social worker was involved in getting the views of Mr Andrews and his family about need for support. Mr Andrews’ nephew – the relative in contact with the hospital - continued to express concern about Mr Andrews’ ability to manage at home and his level of confusion and indicated he was planning to move Mr Andrews and his sister nearer to where he lived. For Mr. Andrews this would mean a move into long term care. Medical and therapy staff considered that with further therapy and work on stoma management, he had a good chance of being able to go home. Over the next two weeks, Mr Andrews exhibited marked and fluctuating confusion; was frequently tearful about not going home although he also demonstrated recall of practical stoma skills. His relatives refused access to his house considering staff were not taking his confusion seriously. A psychiatric assessment concluded he had capacity to make a decision about his discharge. A meeting with the family resulted in home access; Mr Andrews despite fluctuating confusion was oriented in his own home. He was eventually discharged home with a care package. There were no further acute admissions in the following six months.
Drawing on these illustrative examples as well as similar cases, there are different types of contextual factors, often working together which contribute to these different destination outcomes.

a) Caregiving context: the level and intensity of informal care provided and therefore the possibility of substituting formal for informal care;

b) Patient context: determination of the patient to return home, and that they are assessed as having the capacity to make the decision;

c) Organisational and professional context: early focus on the discharge objective; involvement of the multi-professional team; clear, consistent leadership provided by those with authority and expertise to find solutions to overcome the obstacles posed by the health condition and/or its management;

d) Resources: to provide appropriate support to facilitate returning home.

In summary, the engagement of the whole multi-disciplinary team, including social workers early on in the acute episode is a key factor not only in keeping options option to facilitate a return home if possible but to identify and respond to known risk factors that contribute to lengthy in-patient episodes. 

**Recommendation: Assessment and Response to Mental Health Need**

Assessment, identification and support in respect of mental health need is critical for people with co-morbid physical and mental health problems – a significant group among those with complex needs.

A review should be carried out to examine which model of liaison mental health would be most effective in providing appropriate input to the process of treatment and discharge planning. Such a review needs to engage the wider multi-disciplinary team.

**Recommendations: Assessment and Discharge Planning Process and Procedures**

As part of a wider review of multi-disciplinary assessment and discharge planning processes, there is a need for negotiation between ward staff and the social work teams to review the process and timing for social work involvement in planning. A specific aspect of this could usefully include joint development of common set of risk factors known to contribute to lengthy stays and proactive strategies to manage them.

I now turn to consider organisational and cultural factors in multi-disciplinary action planning – key to managing effective discharge.
6.3. Concerted Multi-disciplinary Action

**Rehabilitation ethos**

There exists a strong rehabilitation ethos within the hospital. This has two facets: physiotherapy input in particular is provided as a routine part of daily treatment; and decision making on ‘fitness for discharge’ includes an assessment of functional fitness (related to where the person is being discharged). Occupational therapy input routinely occurs when active discharge planning is set in train and it is intended that the patient will return home. Typically, this involves a home visit to assess the environment and need for assistive devices/alterations etc. This sequencing assumes a linear and upward trajectory of recovery and consensus between professionals, relatives and patient about future destination. Both assumptions are problematic in respect of these long-stay patients as I have illustrated above. Box 5 provides further illustration.

**Box 5**

Mr. Davis, 73 was admitted to hospital via ambulance, having fallen and suffered a fractured neck of femur. He has a long term alcohol problem and when drinking neglects himself. He also has diabetes. He lives alone in sheltered accommodation.

Recovery from surgery was slow; he appeared agitated and confused, had a UTI infection and was in pain. Two weeks following surgery it was noted that he had made no functional gains post-surgery. A referral was made to occupational therapy, the result was a request to re-refer when progress occurred. 19 days after surgery, a Section 2 was sent and acknowledged as received by Social Services. A further nine days after this, the social worker met with Mr. Davis to discuss options. In the intervening period, there was little change in his ability to mobilize; he continued to refuse regular physiotherapy; appeared to have given up, expressing the fear that he would be unable to walk again.

From the ward round seven days later, there was a note that a continuing care assessment might be needed if it was considered that Mr. Davis had no rehabilitation potential. Five days following the ward round, the therapy team indicated that he would be considered for the rehabilitation ward if he began to participate in rehabilitation – this to be reviewed within a further week. Over the following four weeks, Mr. Davis was described as unwell, confused and frequently drowsy during the day. A network meeting held at this point concluded that a continuing care assessment should proceed: Mr. Davis did not express a view on his preferred option.

Subsequently, Mr. Davis made some functional gains, a capacity assessment was carried out and concluded that he had capacity to make a decision about going home. He agreed to a home visit with the OT and the conclusion was that he could manage at home with aids and a package of care.
Whilst I have described the time sequencing above, I am not suggesting that during this period Mr. Davis was ‘fit for discharge’: he was “medically unwell”: Crucially, however, the sequencing of action and decision-making around future planning reveals important issues about the organisation and process of assessment, treatment and planning. First, medical and physiotherapy treatment generally proceeds on a day to day basis – the focus being clinical and functional ‘fitness’. Second, although referrals are made to other professionals, it is in the context of identifying their specific role within the planning sequence. There is little evidence (from the documentation at least) of concerted action as a multi-disciplinary team to review together the factors that might be militating against progress with a plan of action to tackle them together and respective roles and responsibilities established. What emerges is a sense of drift – as each professional works within his/her own sphere of expertise.

Another feature of this exemplar and relevant to the use of the rehabilitation ward is the emphasis on engagement as a key criterion for eligibility. For older people particularly with multiple problems, there is an iterative relationship between confidence, hope and securing functional improvement. An enabling, rehabilitative environment within a specific rehabilitation facility may provide the pre-conditions for engagement in therapy intervention. Taking risks to open out eligibility to those patients who are more difficult to engage may affect success rates. However, testing out the boundaries of what is possible and achievable and evaluating the outcomes for patients with different types of need has the potential to expand the role of the rehabilitation ward in reducing lengthy stays.

It is important to note that some of the patient journeys examined included people who had previous in-patient episodes where they had spent time on the rehabilitation ward. These included patients who were very old (85+), with multiple problems including some confusion who had experienced serious fractures (for example fractured femur). The enabling and therapy support provided on the rehabilitation ward was critical to their successful return home. What distinguished them at the time from those above was their willingness from the outset to participate in therapy.

6.4 Negotiating Options and Formalising Decision-Making

There are inevitably different perceptions of risk and risk management between individual staff and across professionals and agencies that shape and constrain the discharge options for patients with multiple and complex needs. This applies particularly to those with cognitive problems. At the same time staff members are also operating within an environment where there is neither consensus between relatives and patients about valued discharge choices nor is there consistency in expressed views and wishes of patients and their relatives over the acute episode. For these long stay patients, however, organisational and cultural factors around the process of discharge planning operate as major constraints not only in narrowing down options at critical points in the patient journey but contribute to its length.
As stated in the introduction, the impression from the case notes and how they are recorded is of a rhythm of organisation life that assesses and measures change on a daily basis. This may be appropriate in the context of short, intensive interventions to manage acute medical problems. It is not conducive to responding to the complex, multi-dimensional needs of the patients that form the bulk of those with long-in patient episodes and for whom the assessment of ‘medical stability’ is subject to fluctuation and change.

What I have described above as the stage approach to discharge planning is inadequate to manage this complexity. Indeed, the concept of discharge planning does not fully encapsulate a process that requires concerted multi-disciplinary decision making and action from the outset geared to moving patients quickly through acute care. Whilst there is multi-disciplinary engagement, with some professionals being more or less involved at different stages of discharge, there also exists considerable variation between wards in the use of, and value attached to multi-disciplinary meetings. Moreover, action and decisions arrived at are not consistently recorded and acted upon.

**Recommendations: Organisational and Cultural Change**

Central to the development of smooth pathways through the hospital is commitment, process and action plan to take forward major organisational and cultural shift in the approach to multi-disciplinary working. The elements include: a consistent, explicit process of decision making from admission that identifies risks in moving people through the acute episode, sets in train action and strategies to manage these (including appropriate rehabilitation and psychiatric intervention), and provides clear leadership, backed with the authority to ensure responsibilities are allocated across professionals with a robust system for recording and tracking decisions. This can build upon good practise in elderly and specialist stroke care.

It is important to note the positive contribution of the weekly meetings established in autumn of 2005 to consider all patients with lengthy acute episodes. It placed the focus on identifying and addressing the problem of length of acute episode and not simply the issue of reimbursable delays. As it is primarily reactive, it does not in itself address the cultural and organisational changes indicated above although it should continue to play a role in identifying and unblocking problems relating to individual patients.
7. CONTINUING CARE ASSESSMENT AND SOCIAL CARE ASSESSMENT

A major area for confusion with existing procedures relates to the operation of Continuing Care and Delayed Discharge assessment processes.

Department of Health guidelines indicate that the NHS is required
“… to assess a patient’s needs for fully funded NHS continuing care against SHA eligibility criteria before an assessment notification (section 2 notice) is issued.

It is clear however that this process is intended to clarify the responsibilities of Social Services in respect of reimbursable delays. Thus the same document continues:
“If assessment at this point does not indicate the need for fully funded NHS continuing care, assessment notification and discharge planning can begin. If assessment at this point does indicate the need for fully funded NHS continuing care (or other NHS services, including intermediate care) an assessment notification should not be issued because social care will not be needed. Any delays in providing assessment or services for patients in this category are not subject to reimbursement because no assessment notification will have been issued.

If a patient asks for a review of the decision not to provide fully funded NHS continuing care this should take place within 14 days. During this period the patient remains the responsibility of the NHS and no delay accrues to social services. If the original decision not to provide fully funded NHS continuing care is upheld, assessment notification can be made (if necessary) and discharge planning resume”.

The process set out in the Joint Protocol between WMUH and Richmond and Hounslow introduces a variant to the national guidelines, namely that where an assessment of eligibility for fully funded nursing care is deemed necessary
“… it is considered prudent to issue Section 2 notices in such cases, to minimise the potential for confusion. Only where a Section 2 indicates that an assessment for continuing care is not needed should the reimbursement process begin. As in all cases, applications for continuing care should continue to be made through the Hounslow and Richmond long-term care panel systems”.

Whilst the protocol points to the desirability of issuing a Section 2 notice at the same time as eligibility for NHS continuing care is being assessed, it is aimed – like the national guidelines – at clarifying the process of reimbursement. For the long stay patients in both Richmond and Hounslow, the case paper analysis reveals confusion and lack of consistency at several different levels:

- The purpose of the Continuing Care assessment
- The process of assessment and its relationship to reimbursement
7.1 Purpose of the Continuing Care Assessment

17 of the case papers examined (5 Richmond and 12 Hounslow patients) involved a request for a Continuing Care Assessment. These related to patients who were being assessed for NHS Nursing Care, NHS Continuing Healthcare and in Hounslow for residential care and large packages of care at home as well. It included patients that were admitted from their own homes and from residential and nursing home care. Whilst the use of a common assessment framework has the value of simplicity, it also poses difficulties. First, the criteria for the varied care and funding streams are different so that the domains of need assessed and the value attached to them also varies. Second, it places a considerable burden on Continuing Care assessors responsible for co-ordinating, completing and managing the process. Third, it is an inefficient use of resources.

I understand that hospital policy has recently changed at the instigation of WMUH. In future, it is intended that the NHS Continuing Healthcare Checklist will be used in the first instance to identify those individuals who need a full assessment as to whether they have a primary health need and qualify for NHS Continuing Healthcare. This will mean also that partners will need to agree the kinds of assessments needed for residential and NHS nursing care.

The new policy should bring clarity to the CCA process as well as expedite the assessment.

7.2 Process of Continuing Care Assessment and Relationship to Reimbursement

There were other aspects of decision making around continuing care assessment identified from the case papers and also posed in the stakeholder interviews.

Where a multi-disciplinary meeting concluded that the patient required a continuing care assessment, this might not be acted upon for several weeks. In some cases, this was because the patient had expressed a wish to return home and a psychiatric assessment of their capacity to make decisions was sought before proceeding. In other situations, the CCA was started and there was a change in circumstances – the patient made further progress or there were differences between family members about the options to be pursued. In a small number of cases, it reflected the same phenomenon of drift I referred to above in respect of multi-disciplinary decision-making: there was no ownership of the decision and consequently no one to take responsibility for ensuring it was acted upon apart from plaintive notes in the medical and therapy records about staff needing to complete the relevant sections. But simultaneously with drift, there was also a closing down of any possibility of work toward home – no decision making in such cases made inevitable a move into long term care.

Although the joint protocol considers it “prudent” for the Section 2 to be issued at the same time as the need for an assessment of NHS Continuing Healthcare Funding is considered, practice varies considerably. For some patients reviewed – in both Richmond and Hounslow - there was no Section 2 sent, even when the assessment was for NHS Nursing Care; for others it was sent some time before the CCA request.
Use of the Continuing Care Checklist should clarify the relationship between the CCA and reimbursement. Thus in all cases where social care may be needed, including NHS nursing care the Section 2 should be sent. Following through the logic of the Joint Protocol would suggest that the Section 2 would also be sent when an assessment of eligibility for Continuing NHS Care is identified from use of the Checklist – although the patient continues to remain the responsibility of the NHS during this period.

Generally, once a decision is made about NHS Nursing Care, NHS Continuing Healthcare and residential care, a placement has already been identified and the person can move quickly. Recent access to a number of step-down beds within EMI units has also contributed to moving people on when an acute bed is no longer required. Even so, nearly a fifth of all delays in 2007/8, relate to the exercise of patient/family choice (10%) or self-funders (7%), (similar to their contribution to bed-days lost). Whilst sensitivity to the needs and wishes of patients and their families is paramount during what is a major point of transition, often involving difficult negotiations between irreconcilable interests, there are also issues of equity involved: between existing patients and potential patients; between those that pay for their care and those who do not.

Recommendations: Patient Choice

Involvement of the patient and family throughout the planning process, including in network/family meetings, working through options and choices at each stage should facilitate a more open and transparent approach to balancing equity and choice. Where a mutually agreed solution cannot be found, use of an interim bed, pending a resolution, should be resorted to and a dedicated budget for the purpose of spot purchasing such a resource explored.

8. RESOURCES TO FACILITATE TRANSITION FROM ACUTE CARE

8.1. Intermediate Care in Hounslow

A specific objective of the review was to assess the need for intermediate care in Hounslow. For staff interviewed across all agencies in the borough, there was a general consensus that Intermediate Care provision is inadequate in the range of the service repertoire to meet varied types of need, in the lack of capacity to meet particular levels of need and in its degree of co-ordination of services one with the other. I will examine each of these in turn but it seems useful at the outset to revisit the purpose and function of intermediate care provision to provide the backdrop to the discussion.
8.2. Intermediate Care: Purpose and Function

There is general agreement in the policy and research literature that intermediate care is best understood as a configuration or network of services with a distinct purpose and function – and not simply as a number of discrete services. Its purpose is to address twin objectives: the more effective use of acute care through avoidance of both inappropriate hospital admissions and bed occupancy; and enhancing independence (maximising abilities) and inter-dependence (participation and inclusion). In the context of re-shaping acute care to concentrate on the provision of specialist medical treatment that cannot be offered in other settings, intermediate care supports the transition between illness and the resumption of daily life routines. Intermediate care is a fundamental component within the spectrum of care for older people in particular: they are at greater risk of sudden onset conditions and trauma like hip fracture with impact on functional abilities, quality of life and mortality; the co-occurrence of different health problems in older age may complicate recovery from illness, even where high technology treatment in an acute ward is not required; the management of illness, especially in advanced old age, may be compromised by the depletion of resources – through loss of friends and intimates following bereavement or because of reduced vigour and stamina. It is this diversity of need in the transition between sectors and services and between illness and ‘recovery’ that dictates a multi-dimensional and multi-agency response embracing therapy; nursing; social, psychological, practical; enabling and environmental help (including aids and adaptations).

In pursuit of its purposes, the function of intermediate care – inherent in the name – is to integrate, link and provide a transition (or bridge) between locations (home/hospital and vice versa); between sectors (acute/primary/social care/housing); and between individual states (illness and recovery, or management of acquired or chronic disability). This integrative function operates at two levels. On the one hand, it operates internally across intermediate care services, to ensure a coherent and continuous pathway between illness, self-management and recovery that may involve the delivery of one or more services singly, consecutively, or in combination. On the other hand, it operates between sectors – to route people appropriately into it (eligibility criteria and referral processes) and to facilitate the smooth flow of people through and out of it. Its essence is that people are seen as a whole; not just in terms of cognitive and physical abilities but as individuals in a social setting. It is this that defines its multi-disciplinarity – albeit this may be expressed through either multi-disciplinary teams or new partnerships between services (e.g. enabling support with teams of therapists, for example). It is also part of the essence of intermediate care that it is time-limited.

Intermediate care then should demonstrate a shift from discrete and uncoordinated services to a set of services that are coordinated with one another. At an operational level, this requires clarity on the purpose, scope and content of each service and its specific role within the overall configuration; at commissioning level it means the forging of a strategy that addresses service development in the specific context of locally defined need.
8.3. Range and Capacity of the Intermediate Care Repertoire in Hounslow

There are striking similarities and significant differences in the intermediate care landscape now compared with the period between late 2002 and 2004 when I carried out fieldwork in Hounslow for a national study of intermediate care. Then, it was considered that the scope and coverage of services was limited and what did exist was fragmented. The vision as articulated had four components. First, it was to broaden the scope and capacity of residential based rehabilitation by developing a mix of residential and nursing beds to enable older people with a wide range of dependency needs to benefit. Second, it was to integrate enabling support (through Age Concern Home from Hospital and then HART) and therapy (through Radiate) to offer community based rehabilitation as an alternative to residential for those who could be assisted in their own home. Third, it was to develop a single point of access for all therapy and enabling services that would facilitate the routing of people into the service most appropriate for them. Fourth, it was to expand the capacity and role of the rapid response service at A&E (Radiate) to prevent inappropriate acute admissions.

Whilst the form and content of services did not take the shape envisaged, there has been an expansion of provision – so what are the issues now?

Residential Rehabilitation

There has been loss of capacity in residential based rehabilitation with the closure of the Heston and Eldridge CRUs. But there is also recognition that the Eldridge closure has not been experienced as a loss since the eligibility criteria employed excluded many younger people with rehabilitation needs. Eldridge could neither meet the needs of people requiring a specialist, tertiary rehabilitation facility nor of those who suffered a dense stroke – the primary need in respect of this particular group of patients. Lack of capacity in specialist rehabilitation is a significant source of all delays and the largest single contributory factor in bed days lost through delays. Data on delayed transfers of care for 2007/8 (Dobson 2008) indicates that 11% of all delays and 24% of days lost as a result of delays occurred as a result of waiting for assessment and provision of rehabilitation in a tertiary, specialist facility.

The establishment of the rehabilitation ward at WMUH (16 to 20 beds) and the commissioning of seven (now six beds) at Clayponds, has, it might be argued, picked up unmet need both in terms of nursing and therapy led rehabilitation and residential based rehabilitation. Data for Hounslow regarding delayed transfers of care suggests this is not the case. Waiting for admission to the rehabilitation ward – with bed occupancy of 96.8% over the 12 months from April 2007 – was responsible for 8% of all delayed transfers of care (and 5% of lost bed days); waiting for a bed at Clayponds was responsible for 9% of all delays and 12% of bed days lost. Further, although only a minority of Sandbanks referrals now come from the hospital – waiting time for the facility contributes 8% of all delayed transfers of care and 7% of bed days lost.

In summary, more than a third of all delayed transfers of care and nearly half all bed days lost in 2007/8 related to lack of capacity across all residential based rehabilitation facilities. And whilst the largest single capacity gap is for specialist rehabilitation, this is an issue for all of the residential facilities available to Hounslow patients.
Community Rehabilitation

There have been several significant changes to the community rehabilitation landscape: the separation of community therapy services from a base within WMUH, aligned with Radiate; the expansion of the Single Point of Access to provide a route into the district nursing service and community matrons; the creation of a single community therapy team, incorporating individual specialist teams such as neuro-rehabilitation and physiotherapy to provide a more effective response to the range of routine, specialist and complex needs; and the demise of HART albeit with some although not all of its functions assumed by the Social Services Assessment and Re-enablement Team (ART).

From activity statistics for the Community Rehabilitation Service (excluding the Community Rehabilitation Unit), there has been a year on year increase in the number of referrals. At the same time, the average number of contacts for the service as a whole has been broadly maintained (around four). Even so this also conceals considerable variation in the contacts with patients with particular types of need and over time. In 2007/8, for example, whereas the average number of contacts for the Neuro-Rehabilitation Team was ten; it was 2.6 for the Community Rehabilitation Team - a reduction in the number of contacts compared with the previous year.

Clearly, one needs to be very cautious about drawing conclusions from this data. As noted in the Community Rehabilitation Report (Community Rehabilitation Report Statistics 2007), direct contacts are only a crude measure of activity on account of the re-organisation of the service “with the flexible use of staff capacity across service areas and changing allocation of caseload”, and the introduction of “… initiatives to increase efficiency by use of phone contacts for screening, advice and follow-up”. (op.cit., p5).

In terms of expanding the repertoire of intermediate care provision, the question is posed as to whether the Community Rehabilitation Service could provide a time limited alternative to residential based rehabilitation for service users who do not need 24-hour care and who could, with additional practical and enabling support if required, be supported to ‘recovery’ in their own home. Currently, it appears that not only is the step between the need for 24-hour residential based rehabilitation and routine therapy support in the community too great, but that it could not be closed without new investment given the under-resourcing of this provision in comparison with similar elsewhere. Moreover, such support would also need aligning with enablement services.

In summary, there are individual components of intermediate care in Hounslow that work well. There are also new initiatives on stream which will not directly or immediately affect the long stay ‘problem’ but do have the potential to reduce demand in in-patient care (for example, Rapid Response and the Physiotherapy Pilot with elective orthopaedic procedures). Overall, there is both a lack of capacity in residential based rehabilitation as well as an over-reliance on such capacity to the exclusion of community based models.
Recommendations: Intermediate Care
A thoroughgoing review of intermediate care provision is required in Hounslow. This should include consideration of the overall service repertoire, the appropriate balance between services to prevent acute admission and facilitate timely discharge; and between residential and community based provision. Additionally, it should include how best to respond to the needs of older people who do not currently access intermediate care (for example those with cognitive problems); and the configuring of working relationships between agencies and services to ensure a multi-level response to diverse need.

9. CONCLUSION
The discussion and recommendations presented in this report relate to two broad themes both of which require fundamental change in service development and practice: establishing a consistent and robust approach to multi-disciplinary working and decision making; and creating a comprehensive and coherent intermediate care repertoire in the context of a new commissioning environment where competition will be as much a feature of inter-agency relationships as collaboration. Taking this agenda forward is both about process: how to engage all partners together; as well as content.
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Appendix 1: List of Information Received

Documents
A&E 4-Hours Action Plan.
Advice given to Patients.
Choice Procedure Updated March 2008
Discharge Charter Draft 1
Draft 3 Report: Comparative Study of IARDS Social Work Teams
IARDS Review Report, August 2006
Infection Control Procedures and Audits
Mental Health Liaison Business Case in A&E.
Urgent Care Programme Summary
WMUH Joint Protocol – Final.

Data
Alternative Performance Report.
A&E Frequent Attenders.
Community Rehabilitation Service Hounslow Activity 2006/07; 2007/8; 2008/9
Delayed Transfers of Care LB Hounslow 1 April 2007- end March 2008.
Delayed Transfers of Care, LB Richmond, Sept. 2007 – Sept. 2008
Notifications Accepted and Withdrawn, LB Hounslow, 2006/07; 2007/08.
WMUH Re-admission Rates: trends April 2002-March 2008