NHS
South West
Clinical Senate

South West Clinical Senate Council, 19th June 2014, Taunton Rugby Club

The question

'What criteria should be used to determine suitability for discharge from acute units to community settings?'

The Senate Council agreed the scope of the question and advice should focus on adults over 65.

The Advice

Summary Advice to CCGs: An 11 point plan for improving the acute to community interface in the South West

The South West Clinical Senate is aware of commissioning activity in all CCGs around the primary-secondary care interface. The Senate was encouraged to address this area by several CCGs but variation in commissioning of community services across all 11 CCGs in the South West is such that some elements of the advice will already have been addressed by some CCGs.

1. The Senate view is that all CCGs should assess the services they commission against the recommendations in the NHS document Safe Compassionate Care for Frail Older People using an integrated Care Pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders. Consideration should be given to incorporating the recommendations into CQUINS for 2015/16.

Some elements of the following advice are included in the 'Safe Compassionate Care for Frail Older People' document but were felt to be of sufficient importance to recommend separately.

2. The availability of a 'Care Navigator' for all patients being discharged from acute trusts was identified by the Senate as being a top priority to enable patients with additional needs following discharge to access intended services. Care Navigators would act in an advocacy role and as a single point of contact for patients requiring complex care packages. It is recognised that some of the co-ordination function of the Care Navigator role could in time be provided by fully integrated IM&T systems. In the meantime, it is envisaged that Care Navigators will be identified from within existing multi-disciplinary teams (they could be non-clinical or clinical as appropriate) and would support individual episodes of care.

3. Consideration should also be given to developing 'Health Visitors for the Elderly' with responsibility for case finding linked to existing risk stratification work. This was addressed by NHS England in the Health Visitor Implementation Plan 2011–15- A Call to Action (February 2011) and draws attention to Health Visitors being "public health nurses trained to work at community, family and individual level and to promote community capacity building to enable communities to build on their strengths to develop new ways for providing services as part of the Big Society."

- It is recommended that a job description and competency framework for the Health Visitor for the Elderly role be developed in consultation with Health Education South West. These individuals (in addition to the Care Navigators) will need a thorough understanding of local services and systems across acute, mental health and community services.

4. It is recommended that acute providers be encouraged to move towards a policy of 'discharge to assess', in preference to prolonged in-patient stays to facilitate comprehensive assessment of a patient's ongoing health and social care needs in their own place of residence on the same day that they are discharged. The Sheffield 'discharge to assess' model and its benefits is described here

5. Comprehensive Geriatric Assessments (defined in the literature as 'interdisciplinary diagnostic processes') should be performed on admission to hospital on all patients with moderate or severe frailty to help determine (or modify existing) treatment plans, including plans for discharge and long term care. These assessments should include measures to improve medicines optimisation.

6. In order to support longer-term integration, it is recommended that commissioners and providers (health and local authority) should set the same standards for their clinical IM&T systems to encourage interoperability and compatibility across the system. South West CCGs should work together to develop a CQUIN as an enabler for this as a manageable step towards integration of health and social care information systems.

7. The Senate noted the evidenced links between isolation and increased healthcare needs in the elderly population and recommends the following actions in order to build community resilience;

- Statutory commissioners and providers should consider formalising relationships with 3rd sector organisations e.g. Age Concern. (See www.campaigntoendloneliness.org/ and www.nesta.org.uk)

- Evaluation of the Devon Neighbourhood Healthwatch initiative should be monitored and adapted in all areas where appropriate.

8. It is recommended that early assessment by Mental Health Liaison (MHL) workers should be undertaken in all patients with complex mental health needs and those with dementia who have significant behavioural or psychological symptoms. It is suggested that MHL referrals should be given the same priority as other urgent referrals with patients being assessed in hospital within 4 working hours of referral 7 days a week.

9. The Senate recommends that all NHS and County Council funded health and social care providers use the trusted assessor model, to ensure consistency of approach for their patients and avoid multiple assessments.

10. It is recommended that Acute trusts discharging patients to community teams/facilities should align their discharge protocols with all such facilities. Commissioners should agree minimum standards for community provision including inpatient and diagnostic capability jointly with both sets of providers.

11. It is recommended that South Western Ambulance Trust (SWAST) lead a system wide discussion between providers and commissioners to consolidate and improve their already excellent non-conveyance rates by exploring further opportunities for treating patients at their normal place of residence in line with agreed protocols and advanced directives e.g. Treatment Escalation Plan.

A patient safety alert has been issued by NHS England as part of its work to improve the quality and timeliness of communication with primary and social care when patients are discharged from hospital.