Telford & Wrekin Co-operative Council

Protect, care and invest to create a better borough

Integrated Care System
Shropshire, Telford and Wrekin

Hospital Discharge and Intermediate Care update

Presentation to Telford & Wrekin Health Scrutiny Committee – 01 March 2023

Michael Bennett – Service Delivery Manager: Hospital and Enablement, Telford and Wrekin Council

Sarah Bass – Place Based Commissioning and Procurement Lead, Telford and Wrekin Council

Gareth Robinson – Director of Delivery and Transformation, NHS Shropshire Telford and Wrekin

Sara Biffen – Chief Operating Officer, Shropshire and Telford Hospital NHS Trust

Angie Wallace – Chief Operating Officer, Shropshire Community Health NHS Trust

Purpose of session

The session will cover the following areas:

1. Better Care Fund (BCF) contribution to Shropshire, Telford & Wrekin programmes including discharge and intermediate care
2. Discharge from hospital processes
3. Drivers for increase demand
4. Planning for 2023/24

Better Care Fund (BCF) support local and system wide programmes (1)

Key delivery mechanisms and principles:

- Joined up approaches across place based programmes
- Local Care and Urgent Care programmes
- Strengths-based, person centred approach across all access points
- Personalised approaches as a fundamental principle
- Co-production
- BCF priority for 22/23 includes maximising discharge

BCF Priorities for 2022 / 23

- Improving health inequalities
- Proactive Prevention approaches
- Reducing avoidable admissions
- Improving discharge processes
- Maximising flow and reduce avoidable delays
- Integrated and joined up services

Better Care Fund (BCF) support local and system wide programmes (2)

The BCF programme for 2022 / 23 includes:

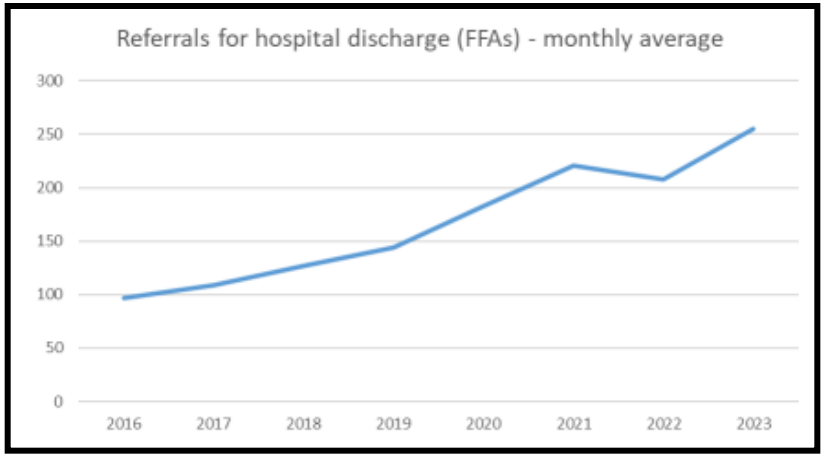
- Maximising potential for admission avoidance including virtual wards
- Enhancing integrated working with Community Teams
- Maximising proactive prevention approaches to reduce / delay use of statutory services (including development of Ageing Well Strategy)
- Integrated HICMs to Urgent Care Delivery
- Develop options for delivery of sustainable intermediate care functions
- Re-commission domiciliary care provision to maximise resources and meet increased demand.

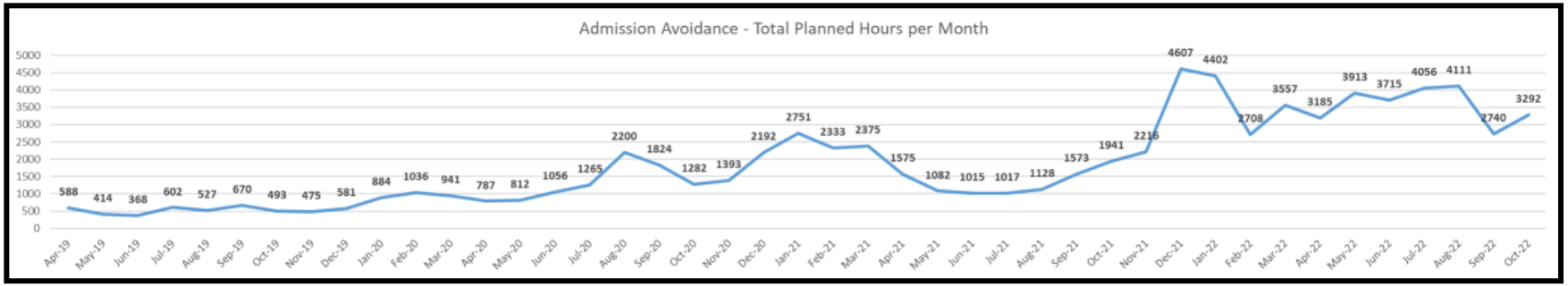
Discharge from hospital processes

- Hospital flow process and early discharge planning
- Telford Integrated Community Assessment Team (TICAT) in-reach to wards
- Inter-Disciplinary Team (IDT) facilitate discharges
- Daily check of community and domiciliary care capacity to match placements to identified need across each Pathway
- Multi-Agency Agency Discharge Events to identify and embed processes to improve discharge processes
- Daily operational calls and processes to track all discharge numbers
- System Discharge Alliance programme to maximise discharges across 7 days reporting the Urgent Care Priority programme

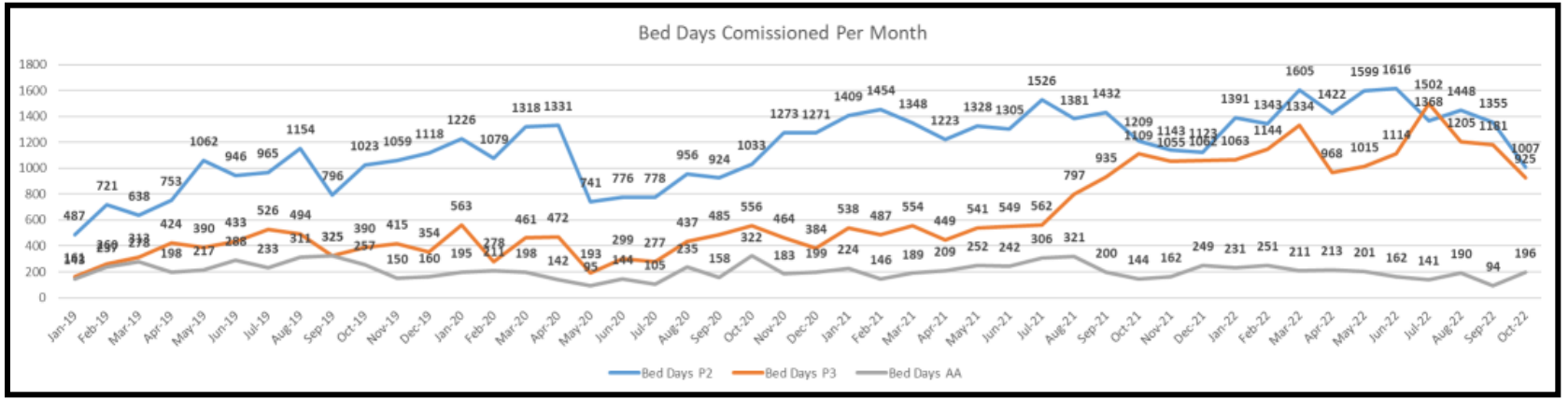
Increased Demand

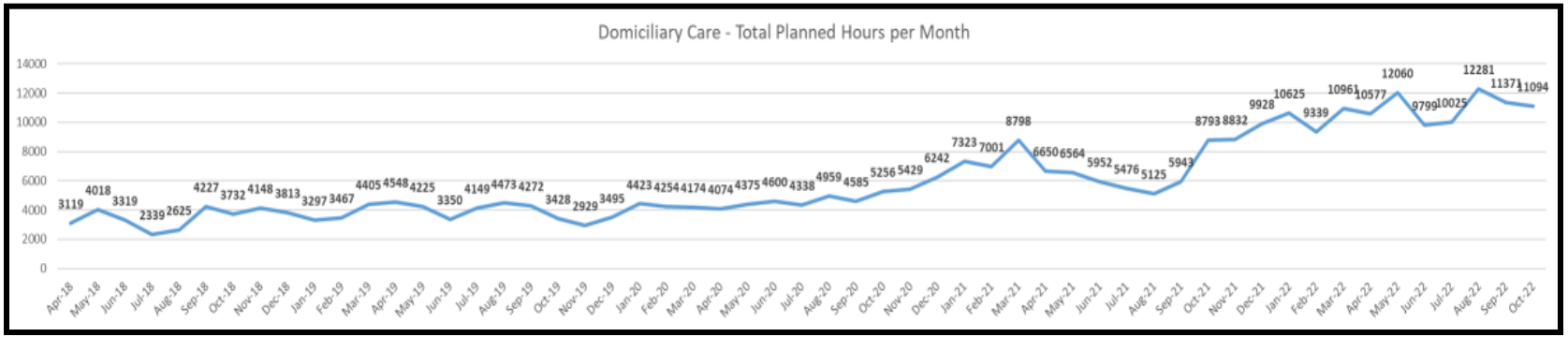
- Increase of referrals by 115% over last 6 years
- Bed utilisation increased by 90% over 4 years
- Domiciliary care utilisation increased by 200% over 5 years
- Increased admission avoidance
- Increased length of stay in beds
- Increased length of stay receiving domiciliary care





Increased Demand (2)





Drivers of the Increased Demand

- Ageing population
- Increased complexity of presentation
- Impacts of covid
- Therapy capacity below National Intermediate Care Audit averages
- Market bed capacity (95% of beds utilised locally hindering flow)
- Approaches to managing acute hospital demand which are increasing demand for community based care and support.
  - Alternatives to admission increased need for care, beds and intermediate care
  - Virtual ward
- Workforce capacity
- Cost increases due to increased demand, market capacity and cost of living. Utilising beds out of area and agency domiciliary care provider

Resident Stories (1)

Impact of limited therapy capacity

L is a 92 year old involved in the church and local choir. They have a gradual decline in mobility and are admitted to hospital on two occasions and treated for a urinary tract infection. On both occasions they needed to access an Intermediate Care bed.

Hospital admission 1:

- Admitted in May to a block bed.
- Received regular physio input.
- Improved mobilisation and ability to transfer;
- Returned home within 3-4 weeks and needed no further support.

Hospital admission 2:

- Admitted in September to a spot bed in Shrewsbury.
- Received no therapy assessment for 6 weeks and little mobilisation within the care setting.
- When physio input commenced, it helped improve mobilisation but they also needed an adapted home environment to support safer mobilisation at home

Resident Stories (2)

Managing the complexities of discharge

P is a 85 year old identified as Medically Fit after 14 days in hospital. TICAT and ward agreed the need for a Pathway 2 nursing bed.

P and their family agreed the location, which was sourced within 2 days. Covid testing for discharge showed P was covid+ve, although asymptomatic. P needed to wait for up to 10 days in hospital and have further tests from day 5 until testing showed P was covid clear.

This led to:

- increased risk of other infections and decompensation to P;
- frustration and boredom;
- further delays in hospital of three days whilst another bed was sourced (10 days+ delay in total)

Resident Stories (3)

Navigating differing family views

A is a 86 year old presenting with dementia. A does not have capacity and family members have different views about the discharge plan.

Options:

- home to A's familiar environment, or
- bed based intermediate care where she is more likely to need 1:1 care at least initially.

Capacity and Best Interest Assessments were completed and an Multi-Disciplinary Team Meeting (MDT) with the ward and family members was held to agree the plan. There was no Power of Attorney and A's Next of Kin (partner) was not sure about A's wishes.

The ultimate decision of a bed took 7 days, while A stayed in hospital and needed 1:1 observations

Resident Stories (4)

Options to reduce demand – Enablement grant

D is a 88 year old living in a rural area of Telford.

D needs three personal care calls daily following treatment for a urinary tract infection and D has reduced mobility and is at risk of falls.

D has a supportive family who visit daily. D's family agreed to receive a grant to provide the personal care rather than a care agency. This was initially agreed for two weeks, which enabled a same day discharge from hospital.

The grant was extended as it helped meet D's and his family's needs. This was converted into a Direct Payment as a long term arrangement.

Planning for 2023 / 24

- Seeking to manage demand, improve processes and further efficiencies of resources to reduce overall costs;
- Demand modelling and projections;
- Further development of admission avoidance and Virtual Ward to reduce acute hospital demand;
- Financial modelling and planning;
- Further improvement of flow processes and discharge planning;
- Intermediate Care delivery approach;
- Commissioning approaches; and
- Planning for 2024/25 to include Community bed review and agreeing future Intermediate Care bed approach.

Telford & Wrekin Co-operative Council

Protect, care and invest to create a better borough

Integrated Care System
Shropshire, Telford and Wrekin

Any Questions?