ITEM No …7……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 28 FEBRUARY 2017**

REPORT ON: **DUNDEE HOME AND HOSPITAL TRANSITION PLAN UPDATE**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB2-2017**

1.0 PURPOSE OF REPORT

1.1 To provide an update to the Health and Social Care Integration Joint Board of the outcome and progress of actions and arrangements put in place across the Partnership to respond to discharge management.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the content of the report and progress in relation to the Dundee Discharge Management Improvement Plan (attached as Appendix 1).

3.0 FINANCIAL IMPLICATIONS

3.1 The expenditure noted in this report is funded from Delayed Discharge Funds which form part of Dundee Health and Social Care Partnership's recurring budgeted resources.

4.0 MAIN TEXT

4.1 Background to Discharge Management

4.1.1 A delayed discharge is a hospital inpatient who is clinically ready for discharge from inpatient hospital care and who continues to occupy a hospital bed beyond the ready for discharge date. (ISD Delayed Discharges Definitions and Data Recording Manual).

4.1.2 The focus on effective discharge management is reflected through the National Health and Wellbeing Outcomes and their indicators. There are two indicators that relate directly to effective discharge management:

- National Indicator 19: Number of days people spend in hospital when they are ready to be discharged;
- National Indicator 22: Percentage of people who are discharged from hospital within 72 hours of being ready.

4.1.3 There are a number of other indicators which indirectly relate to discharge management and admission to hospital. These are percentage of people admitted to hospital from home during the year, who are discharged to a care home; percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency; readmission to hospital within 28 days; emergency admission rate and emergency bed day rate.

4.2 Governance and Monitoring Arrangements

4.2.1 Within Dundee a Home and Hospital Transitions Group, chaired by the Head of Service, Health and Community Care, oversees performance and improvement actions in relation to Discharge Management. The Group aims to ensure that citizens of Dundee are supported at home, but when people do have to go to hospital they are only there as long as they need to be.

4.2.2 On a weekly basis, an update is provided to the Chief Officer, Director of Acute Services and key Home and Hospital Transitions Group members on delay position. This information is used to maintain an ongoing focus on enabling patients to be discharged from hospital when they are ready as well as to inform improvements.

5.0 DISCHARGE MANAGEMENT IMPROVEMENT PLAN

5.1 Home and Hospital Transition Improvement Plan

5.1.1 The Home and Hospital Transitions Group, chaired by the Head of Service, Health and Community Care, aims to ensure that citizens of Dundee are supported at home, but when people do have to go to hospital they are only there as long as they need to be.

5.1.2 This ambition is reflective of the National Health and Wellbeing Outcomes and their Indicators and the strategic ambitions set out within Dundee Health and Social Care Partnership Strategic and Commissioning Plan. In particular it focuses on prevention of emergency admission and readmission to hospital, supporting people to live at home and be discharged when they are ready.

5.1.3 To support achievement of this ambition, contribute to the Dundee Health and Social Care Partnership Strategic and Commissioning Plan and evidence progress against National Health and Wellbeing Outcome Indicators, a Home and Hospital Transition Improvement Plan was developed and approved by the Integrated Joint Board on 24 August 2016.

5.2 Home and Hospital Transition Plan Project Progress

5.2.1 The Dundee Health and Social Care Partnership has invested in additional capacity in the Health, Social Care and third sector workforce through Change Fund, Integrated Care Fund and latterly the Delayed Discharge funding streams to support both the unnecessary admission to hospital and prevention of discharge delay.

5.2.2 The Discharge Monies have supported the Dundee Partnership to further develop a number of initiatives and build capacity within our workforce that have contributed to enabling citizens of Dundee to be supported at home, but when people do have to go to hospital they are only there as long as they need to be. Progress against key actions is below.

5.2.3 Care at Home Service, Home Care and Resource Matching Unit: - The Resource Matching Unit is now established and along with the increase resource provision from the discharge funding has increased capacity and efficiency of the care at home service. A further piece of improvement activity has been carried out to improve communication between the Discharge Hub and the Resource Matching Unit, in order to achieve our aim of achieving discharge on the planned date of discharge for all patients. It is planned that this work will contribute to a reduction in number of delays due to patients awaiting a care package.

5.2.4 Care Home Placements: - The Discharge Monies funded an additional five Care Home placements which generated additional capacity within the service. To support winter planning, a further additional five Care Home placements were future funded to enable service users to be able to leave hospital into a homely setting. We have put a number of resource in place to support assessment for 24 hour care to take place in a more homely setting as it is recognized that hospital is not an appropriate place to do this. Currently there are nine places available in care homes. Two further places will be developed over the next six months in housing with care and a social care service is being commissioned to allow intensive support for an assessment to be done at home.

5.2.5 Discharge Management Team and Integrated Discharge Hub – The increased AHP and Nursing input into the Discharge Team has increased its capacity to co-ordinate discharges and contribute to the development of an Integrated Health and Social Care Discharge Hub. An integrated Social Work and Health Discharge Hub was implemented on 3 December 2015. This Hub has established a single route for referrals, reduced duplication between social work and health teams and established a shared ethos on person centered discharge planning within a multi-disciplinary team approach. In line with the Home and Hospital Transition Plan, work is now underway to further develop this Hub into a fully integrated team to increase capacity of the service and enhance and further develop opportunity for discharge assessment for all patients at Ninewells.

5.2.6 Guardianship – The additional hours to the Mental Health Officer (MHO) Service has significantly increased capacity of the MHO Service to respond to requests for Guardianship reports. This has resulted in a timely completion of reports and reduction in bed days lost as a result of waiting for an MHO.

5.2.7 Power of Attorney Campaign – A further Power of Attorney campaign took place during the winter period and included provision of information about becoming a Power of Attorney on social media, newsletters, television advertising and a dedicated website. The funding through the discharge monies has supported this to happen. It is organized that this will be followed up by promotional events during 2017 and through further communication and campaign work. It is planned that by increasing the number of Power of Attorneys this will reduce number of bed days lost through people awaiting application for Guardianship.

5.2.8 Carers – A Strategic Plan for Supporting Carers has been drafted and formal consultation took place on the Plan between November 2016 and January 2017. Through the strategic plan, Dundee Health and Social Care Partnership aim to achieve a *caring Dundee in which all Carers feel listened to, valued and supported so that they feel well and are able to live a life alongside caring.* In relation to discharge management, work is underway to develop and implement a pathway for involving Carers in the discharge planning process, so that Carers feel listened to, valued and supported.

5.2.9 Prevention of Admission - To support our focus on prevention of admission, a review of information and data will be undertaken over the next three months to understand reasons for emergency admission, admission and readmission to hospital within 28 days of discharge so that this informs improvement activity in relation to these areas.

6.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment and Risk Management. There are no major issues.

7.0 CONSULTATIONS

The Chief Finance Officer and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

None.

David W Lynch
Chief Officer

DATE: 3 February 2016

National Health And Wellbeing Outcomes	Indicators which Demonstrate Improvement and Contribute To National Health And Wellbeing Outcomes.	Actions To Achieve Indicators and Outcomes Cross Referenced by National Health and Wellbeing Outcome Indicator.	Lead
National Outcome 1: Healthier Living **and** **National Outcome 5: Reduce Health Inequalities**	• **National Indicator 1**: % of adults able to look after their health very well or quite well • **National Indicator 12**: Emergency Admission Rate (per 100,000 people aged 18+) • **National Indicator 13**: Rate of emergency bed days for adults	Review reasons for emergency admission across hospital settings to establish a clear benchmark and then identify and agree improvement actions which will contribute to a reduction in emergency admission to hospital (NI 12,13)	Locality Manager
		Further develop use of technology enabled care as a means of enabling people to live independently and look after their own health. (NI 1, 12,13)	Locality Manager
		Further embed Enhanced Community Model for support for Older Adults and introduce the Community Model for Support with Adults as a means of reducing emergency admissions and enabling people to live independently and look after their health in their own home or homely setting. (NI 1, 12,13)	Locality Manager
		Further develop awareness and use of anticipatory care plans for all Adults where a plan would be of benefit to the Adult. (NI 1, 12,13)	Nurse Consultant
		Prioritise and invest in models of support that help to support life style changes which improve health through Care Group Strategic Planning Groups. (NI 1, Dundee Health and Social Care Partnership Strategic Plan)	SPG Leads
		Embed health checks as a means to engage people in the health and wellbeing agenda, to increase self-care, and avoid longer term ill health. (NI 1, 12, 13, Dundee Health and Social Care Partnership Strategic Plan)	SPG Leads
		Develop shared training programmes for frontline staff to support awareness and understanding of sensory impairment including signposting; sensory health checks and support. (NI 1, Dundee Health and Social Care Partnership Strategic Plan)	Locality Manager

National Health And Wellbeing Outcomes	Indicators which Demonstrate Improvement and Contribute To National Health And Wellbeing Outcomes.	Actions To Achieve Indicators and Outcomes Cross Referenced by National Health and Wellbeing Outcome Indicator.	Lead
National Outcome 2: Independent Living	• **National Indicator 18**: % of adults with intensive care needs receiving care at home • **National Indicator 15**: Proportion of last 6 months of life spent at home or in a community setting • **National Indicator 19:** Number of days people spend in hospital when they are ready to be discharged • **National Indicator 21**: % of people admitted to hospital from home during the year, who are discharged to a care home • **National Indicator 22**: % of people discharged from hospital within 72	Support more people to be assessed at home or a homely setting rather than in hospital by completing and evaluating the 'Moving Assessment into the Community' project for older people and resource the proposed change. (NI 19, 21, 22, Dundee Health & Social Care Partnership Strategic Plan).	Locality Manager
		Expand the 'Moving Assessment into the Community' project to specialist areas and test pathways. (NI 19, 21, 22, Dundee Health & Social Care Partnership Strategic Plan).	Locality Manager
		Increase our investment in intermediate forms of care such as step up/step down accommodation and support for all adults. (NI 19, 22, 21, Dundee Health & Social Care Partnership Strategic Plan).	Locality Manager
		Further develop discharge planning arrangements for adults with mental ill-health, physical disability and acquired brain injury. (NI 19, 22, Dundee Health & Social Care Partnership Strategic Plan).	Locality Manager
		Invest in resources which support assessment for 24 hour care taking place at home or home like settings (NI 18, 19, 21, 22, Dundee Health & Social Care Partnership Strategic Plan).	Locality Manager
		Redesign services to ensure rapid access to palliative services (NI 15, 18, 19, Dundee Health & Social Care Partnership Strategic Plan).	Locality Manager

National Health And Wellbeing Outcomes	Indicators which Demonstrate Improvement and Contribute To National Health And Wellbeing Outcomes.	Actions To Achieve Indicators and Outcomes Cross Referenced by National Health and Wellbeing Outcome Indicator.	Lead
	hours of being ready	Review access to end of life services so that people are supported in their place of choice (NI 15, 18, 19)	Locality Manager
		Review patient pathways between Carseview Hospital and the community. (NI 18, 19, 21, 22, Dundee Health & Social Care Partnership Strategic Plan)	Locality Manager
		Embed within care group strategic commissioning plans the development of a range of community resources and supports which facilitate community based assessment, enable people to remain in their own home and be discharged from hospital when they are ready. (NI 15, 18, 19, 21, 22)	SPG Leads
		Further develop earlier identification of requirement for measures under Adults With Incapacity (Scotland) Act 2016 so that people are not waiting for completion of formal measures within a hospital setting. (NI 19, 21, 22)	Localty Manager
		Promote Power of Attorney through local campaigns as a means of increasing number of Power of Attorneys so that Adults are not waiting in hospital settings for decisions about their care upon discharge. (NI 19, 21, 22)	Locality Manager
		Review and remodel care at home services to provide more flexible responses. (NI 15, 18, 19, 21, 22)	Locality Manager

National Health And Wellbeing Outcomes	Indicators which Demonstrate Improvement and Contribute To National Health And Wellbeing Outcomes.	Actions To Achieve Indicators and Outcomes Cross Referenced by National Health and Wellbeing Outcome Indicator.	Lead
		Lead a review, with partners, of the current Learning Disability acute liaison service and develop a future model (NI 5, Dundee Health and Social Care Partnership Strategic Plan)	Locality Manager
		Further develop models of Community Rehabilitation to support transitions between home and hospital (NI 15, 18, 19, 21, 22, Dundee Health and Social Care Strategic Plan)	Locality Manager
National Outcome 3: Positive Experiences and Outcomes	• **National Indicator 5**: % of adults receiving any care or support who rate it as excellent or good	Implement IRISS home from hospital research findings (NI 5)	Locality Manager
		Develop and implement discharge management procedures and guidance to promote consistency in practice in relation to discharge management and use of planned date of discharge. (All Indicators)	Locality Manager
		Establish and implement a Discharge Management Learning Framework and Learning Networks as a means of promoting and enabling consistency in practice and ensuring effective person centred communication during transition between hospital and home. (NI 5)	Locality Manager
		Develop an 'early indicator of deteriorating health and well-being tool', for use by front line social care staff to reduce the instances of hospital admissions, increase the use of preventative interventions, and assist people to look after their health and well-being (NI 1,5)	Locality Manager

National Health And Wellbeing Outcomes	Indicators which Demonstrate Improvement and Contribute To National Health And Wellbeing Outcomes.	Actions To Achieve Indicators and Outcomes Cross Referenced by National Health and Wellbeing Outcome Indicator.	Lead
National Outcome 6: Carers are Supported	• **National Indicator 8**: % of carers who feel supported to continue in their caring role	Implement a statement and pathway for involving Carers in discharge planning process in line with section 28 of the Carers (Scotland) Act 2016 in partnership with Carers and Carers Organisations (NI 8, Carers (Scotland) Act 2016, Dundee Health and Social Care Strategic Plan)	Locality Manager
		Embed the statement and pathway for involving Carers in discharge planning within discharge guidance, planned date of discharge guidance, multi-agency Carer's guidance and a learning and workforce development framework. (NI, Carers (Scotland) Act 2016, Dundee Health and Social Care Strategic Plan)	Locality Manager
		Embed Equal Partners in Care Learning Framework and Carers Learning Networks to enable the Health and Social Care Workforce to enable Carers to feel identified and supported.	Locality Manager
		Develop a Strategic Commissioning Statement for Carers with input/involvement from carers' groups and carer' partnerships and implement this. (NI 8, Carers (Scotland) Act 2016, Dundee Health and Social Care Partnership Strategic Plan)	Locality Manager
National Outcome 7: People are Safe	• **National Indicator 14**: readmission to hospital within 28 days • **National Indicator 16:** Falls rate per 1,000 population in over 65's	Further implement the planned date of discharge model so that patients , carers are involved in a well-planned discharge and have coordinated follow up care where required upon discharge (NI 21, 22, 14)	Locality Manager
		Further develop post discharge support to people with long term conditions in order to contribute to a reduction in emergency hospital admission and readmission to hospital. (NI 14)	Locality Manager

National Health And Wellbeing Outcomes	Indicators which Demonstrate Improvement and Contribute To National Health And Wellbeing Outcomes.	Actions To Achieve Indicators and Outcomes Cross Referenced by National Health and Wellbeing Outcome Indicator.	Lead
		Further develop local fall pathway initiatives to reduce risk of falls (NI 16)	Locality Manager
National Outcome 9: Resources are used Efficiently and Effectively	**National Indicator 20**: % of health and care resources spent on hospital stays where the patient was admitted in an emergency.	Extend the co- location of teams with common purpose and broaden the definition of integration to include all sectors (health, social work, third sector, independent sector). (NI 20, Dundee Health and Social Care Partnership Strategic Plan)	Locality Manager
		Implement a fully Integrated Discharge Management Team to increase capacity of the service and enhance and further develop opportunity for discharge assessment for all patients at Ninewells. (NI 20, Dundee Health and Social Care Partnership Strategic Plan)	Locality Manager
		Establish integrated systems and processes which support information sharing and improved communication (All Indicators)	Locality Manager
		Review the systems and mechanisms for reporting around discharge management (All Indicators)	Locality Manager