ITEM No …14……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 30 AUGUST 2016**

REPORT ON: **DUNDEE DISCHARGE MANAGEMENT IMPROVEMENT PLAN AND USE OF FUNDING**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB40-2016**

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 Approves the Dundee Discharge Management Improvement Plan (attached as Appendix 1).

2.2 Notes progress in relation to spend against Discharge Monies.

3.0 FINANCIAL IMPLICATIONS

3.1 The cost of the initiatives outlined in this report will be funded from additional resources allocated by the Scottish Government to Health and Social Care Partnerships.

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, Chief Operating Officer 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 DELAYED DISCHARGE FUNDING

5.1 Delayed Discharge Funding Usage

5.1.1 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.

5.1.2 The Delayed Discharge funding has been used as demonstrated in the chart below. All projects reflect the aims, objectives and proposals contained within the Dundee Discharge Management Improvement Plan.

DELAYED DISCHARGE FUNDING		Actual Spend £k	Projected Spend £k	Planned Spend £k	Planned Spend £k	Planned Spend £k	Planned Spend £k
Project		**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Increased Home Care - DCC	Improved flow from Enablemement Services to longer term care	160	160	160	160	160	160
Additional Care Home Placements - 5 placements	Funding ring fenced to identified placements	120	104	104	104	104	104
Community Nursing Backfill	Increased early MDT membership at early assessment point	0	40	40	40	40	40
	MAINSTREAMED FROM 2016/17		304	304	304	304	304
Step Down Housing (Magdalan Yard Road)	Test of change - to address housing delays	6	8	10	10	10	10
Extend COPD Pilot	Improved follow up and self care support following discharge	81	90	100	100	100	100
Increased Nursing input to extend / increase DDT	Increased and quicker assessment across NWH and RVH	39	40	45	45	45	45
Step Down Housing (Gourdie Place) - MOVE FROM ICF from 16/17	Test of change - to address housing delays		9	11	11	11	11
Increased SW OT resource to support community discharge - equipment / adaptations - 1FT OT	18 month post (to 31/3/17)	22	44				
Increase MHO Availability - 1 FT MHO	18 month post (to 31/3/17) - successfully tested through Change Fund	22	44				
AHP Input to work with DDT to in reach into RVH	Increased and quicker assessment	16	35				
Resource Matching Unit - for shifts to identify support packages quicker	Quicker identification of resources for people awaiting discharge. Optimising capacity - fixed term posts (to 31/3/17)	62	115				
Earn Crescent - upgrade current resource (Step Down Housing) - (one off expenditure)	Capital investment to upgrade technology in flat	30					
Increased Home Care - External (Moved to alternative mainstream funding from 16/17)	Improved flow from Enablemement Services to longer term care	140					
Home Care (moved to alternative mainstream funding from 16/17)	Funding top up for 3 year commissioned service	250					
Learning Disabilities - OT equipment - access to specialised equipment and agree a pathway (one off expenditure)	Refresh and testing of new pathway and specialist equipment	10					
	PROJECT FUNDING / TESTS OF CHANGE	677	385	166	166	166	166
Total Delayed Discharge planned spend		957	689	470	470	470	470
Share Tayside-wide Power of Attorney Campaign costs		3	6				
Contribution to NHST winter plan		114					
Share of Acute Frailty Team expenditure			35				
Provision - seasonal pressures			200	200	200	200	200
Unallocated - Future Test of Change				**260**	**260**	**260**	**260**
Total Projected Spend		**1,074**	**930**	**930**	**930**	**930**	**930**
Scottish Government Funding							
2014/15 Delayed Discharge brought forward		115	0	0	0	0	0
2014/15 Winter Resilience brought forward		29	0	0	0	0	0
Delayed Discharge Fund		930	930	930	930	930	930
		1,074	**930**	**930**	**930**	**930**	**930**

5.2 Achievements through Use of the Delayed Discharge Funding

5.2.1 The Discharge Monies have supported the Dundee Partnership to further develop a number of initiatives 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 each of the projects is below.

5.2.2 Care at Home Service, Home Care and Resource Matching Unit: - The Resource Matching Unit is now established and along with the increase resource provision has increased capacity and efficiency of the care at home service. This has contributed to the reduction in number of delays due to patients awaiting a care package.

5.2.3 Additional Care Home Placements: - The Discharge Monies funded an additional five Care Home placements which generated additional capacity within the service.

5.2.4 Dundee Smart Flat and Step Down Housing Service: - The Discharge Monies enabled upgrade of a demonstration flat into a step down and rehabilitation resource which was launched in June 2016. In addition to this, step down housing resources have been developed as a partnership with Housing Associations. Already the step down resource has contributed to people being discharged when they are ready and contributes to our strategic intention to increase availability of step down resources.

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 coordinate 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 3rd 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.

5.2.6 Increased Social Work Occupational Therapy Service and Equipment - A single shared pathway across Health for accessing equipment and adaptations was implemented during 2015. This has greatly reduced duplication, reduced delays due to awaiting equipment/ adaptations and with the increased Social Work Occupational Therapy resource, has meant that discharge assessments are completed within 24 hours of request. Equipment is then delivered within 24 hours of an equipment prescription.

5.2.7 Increased MHO Availability – The additional hours to the 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 waiting time for an MHO.

5.2.8 Community Nursing Backfill – The additional funding to the Community Nursing Service has increased capacity of the service to improve communication and person centered care at point of discharge where Patients require ongoing support from the service.

6 HOME AND HOSPITAL TRANSITION IMPROVEMENT PLAN

6.1 Home and Hospital Transition Improvement Plan

6.1.1 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.

6.1.2 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.

6.1.3 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 has been developed.

6.1.4 The plan sets out a number of actions which are designed to contribute to the following National Health and Wellbeing Indicators:

- **National Indicator 1**: % of adults able to look after their health very well or quite well
- **National Indicator 5:** % of adults receiving any care or support who rate it as excellent or good
- **National Indicator 8:** % of carers who feel supported to continue in their caring role
- **National Indicator 12**: Emergency Admission Rate (per 100,000 people aged 18+)
- **National Indicator 13**: Rate of emergency bed days for adults
- **National Indicator 14**: readmission to hospital within 28 days
- **National Indicator 15**: Proportion of last 6 months of life spent at home or in a community setting
- **National Indicator 16**: Falls rate per 1,000 population in over 65's
- **National Indicator 18**: % of adults with intensive care needs receiving care at home
- **National Indicator 19:** Number of days people spend in hospital when they are ready to be discharged
- **National Indicator 20**: % of health and care resources spent on hospital stays where the patient was admitted in an emergency
- **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 hours of being ready

6.1.5 Progress against the Plan will be reviewed on a regular basis through the Home and Hospital Transition Group. This will then support feedback to the IJB on effectiveness of the Plan.

7.0 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.

8.0 CONSULTATIONS

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

9.0 BACKGROUND PAPERS

None.

David W Lynch
Chief Officer

DATE: 3 August 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
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)
		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)
		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)
		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)
		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)
		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)
		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)

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
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 hours of being ready	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)
		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)
		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)
		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)
		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)
		Redesign services to ensure rapid access to palliative services (NI 15, 18, 19, Dundee Health & Social Care Partnership Strategic Plan)
		Review access to end of life services so that people are supported in their place of choice. (NI 15, 18, 19)

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
		Review patient pathways between Carseview Hospital and the community. (NI 18, 19, 21, 22, Dundee Health & Social Care Partnership Strategic Plan)
		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)
		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)
		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)
		Review and remodel care at home services to provide more flexible responses. (NI 15, 18, 19, 21, 22)
		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)
		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)

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
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)
		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)
		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)
		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)
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)
		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)
		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.
		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

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
		Health and Social Care Partnership Strategic Plan)
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)
		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)
		Further develop local fall pathway initiatives to reduce risk of falls. (NI 16)
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)
		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)
		Establish integrated systems and processes which support information sharing and improved communication. (All Indicators)
		Review the systems and mechanisms for reporting around discharge management. (All Indicators)