Report to:	**Partnerships Scrutiny Committee**
Date of Meeting:	**4th September 2017**
Lead Member / Officer:	**Lead Member for Well-being and Independence/ Head of Community Support Services**
Report Author:	**Principal Manager, Community Support Services**
Title:	**Timely Hospital Discharge**

1. What is the report about?

To provide an update on the progress to date in developing community arrangements to support timely discharges from hospital

2. What is the reason for making this report?

To provide information regarding progress in achieving timely hospital discharge and the various initiatives which have been developed in relation to this in order for Members to comment on these.

3. What are the Recommendations?

That Members provide feedback on the partnership activities to support timely discharge.

4. Report details

4.1 Delayed Transfers of Care/Discharge Flow

During 2016-2017, the Single Point of Access (SPOA) in Denbighshire received 15,126 referrals for community services. 4512 (29.8%) were from acute and community hospitals and a further 60 were from the Emergency Quadrant. Partners continue to monitor and manage potential delays of care in regular partnership meetings as well as during the monthly formal audit, which is reported to Welsh Government (WG) and forms the basis of the statutory performance indicator. Within Denbighshire the delays validated for social care reasons have reduced since the development of the Step down Cluster in September 2016. In 2014-2015, there were 12; in 2015-2016 there were 25; in 2016-2017 there were 23; and in the first 4 months of 2017-2018, there has only been 1 such delay.

4.2 The Step down Cluster/Step Down Team

There has been a pincer approach to improving discharge in the last year with the creation of a Step down Team within the Betsi Cadwaladr University Health Board (BCUHB) and the Step Down Cluster in Community Support Services in Denbighshire County Council. The Step Down Team comprises of the existing Assessment Discharge and Transfer Team (ADT) and the Discharge Liaison Nurses, enhanced by the additional support of a Psychiatric Liaison Nurse. This Team is led by a senior Manager who is an Occupational Therapist by profession but who has also worked in Denbighshire Social Services for many years

Simultaneously, the Step-Down Cluster was formed in Community Support Services from some temporary additional funding from the Intermediate/Integrated Care Fund (ICF) until the end of September 2017 as well as transferring some staff from the Locality Teams. The Cluster continues to work closely with the Single Point of Access and the Reablement Service. Referrals are mainly received from the two acute hospitals, seven community hospitals as well as the Enhanced Care Service in both the North and South of the County.

Individual Step down Cluster caseloads at any one time are no more than 11 per member of staff as they are all actively managed and an individual case worker may have a case for up to 8-10 weeks depending on need.

The benefits to discharge flow include the ability to respond quickly and prioritise discharges; targeted knowledge around discharge process and options for expediting discharge to a safe and appropriate destination; a person centred approach that helps individuals articulate their needs and concerns around discharge; targeted knowledge around positive risk management; specialised knowledge regarding the Continuing Health Care process; the ability to evidence needs for high cost care packages to facilitate discharge and to find creative solutions for ongoing sustainable support in the community

Some of the success of the Step down cluster is attributed to the skills and knowledge of the manager who is also an Occupational Therapist by profession. She has a thorough understanding of hospital processes, social care and reablement criteria as well as a specialist knowledge of the bio/psycho/social needs of individuals and the resources to address them.

Discussions are currently taking place in relation to some integration between the Glan Clwyd Step Down Team, the Denbighshire Step Down Cluster and Conwy County Borough Council hospital-based social work service

4.3 Work with and to support Care Homes

In December 2016, Partners agreed it was important to support the Care Home Sector. Equipment to support safe moving and handling practice was purchased; an Advanced Nurse Practitioner post specifically to support care homes in South Denbighshire was appointed; and Treatment Escalation Plans were introduced in many Denbighshire care home for residents following the Intermediate Care funded pilot.

4.4 Current Community Activity to support timely discharge through prevention includes:

- District Nurses are now providing 24/7 service in Denbighshire
- A small Falls Prevention Team based in SPOA was appointed in July 2017. This includes activity within care homes to prevent admission due to falls.
- There is now an establishment of 9 Health and Social Care Support Workers (HSCSW) in Denbighshire and a large part of their role is to facilitate discharge as well as prevent admission where possible. They are accessible through SPOA via the Community Nursing Service at weekends. From April 2016 to August 2017 the HSCSW Service received 256 referrals, 67% of these were hospital discharges.
- Early preventative activity through the development of Talking Points and the role of Community Navigators is viewed as crucial. Talking Points helped 1464 citizens between July 2016 and June 2017, with information (84%), advice (83%) and assistance (7%). The Community Navigators measure well-being outcomes to

demonstrate their success and appear to be thought highly of by professional and citizens alike.

4.5 Future Plans/Pilots

There are developments both within the hospital and within the community planned. This includes the development/further development of:

- The Elderly multi-disciplinary unit to try and prevent admission to hospital and to wrap care around these people in their own homes instead. There will be a pilot for six weeks in September 2017 aiming to keep citizens fit and healthy in line with the Social Services and Well-being (Wales) Act. Community staff can refer anyone they believe would benefit from a multi-disciplinary assessment and intervention.
- The development of a Frailty Unit to have coordinated care for frail patients. There will be a pilot for 6 weeks in October 2017.
- Community Resource Teams. Opportunities for the co-location of community nursing, therapies and social care staff are being actively pursued and implemented and a major project is currently being scoped for integrated working to improve the coordination of care to citizens. The first Community Resource team has recently been co-located in the Royal Alexandra Hospital in Rhyl.
- The longer term development of the new hospital facility in Rhyl

4.6 Regular and improved communication:

- There are regular planned and one off partnership general discussions for both general partnership activity and specifically for unscheduled care and hospital discharge. During August, the discussion included the possibility of working in partnership to establish a 'home first' model and targeting those patients who would be appropriate. We also discussed practices to ensure that those people who already have packages of care (that are financially maintained for 2 weeks when someone goes in to hospital) do not stay in any longer than necessary when fit for discharge, risking inefficiency because of having to re-arrange support

- The District Nursing Service and Chronic Conditions Nurses are now notified of patients with catheters being admitted so that they can support that cohort of often vulnerable patients to return home in a timely way.

5. How does the decision contribute to the Corporate Priorities?

Supporting hospital discharge has a clear impact on the corporate priority to ensure that vulnerable people are protected and able to live as independently as possible.

6. What will it cost and how will it affect other services?

It is expected that work in this area and any proposals for the future will have a positive effect on service delivery. There will be no additional costs unless funded by grants such as the Intermediate Care Fund. Preventing inappropriate or avoidable admission and getting the discharge process right and at the right time is likely to reduce dependency on social care services

7. What are the main conclusions of the Well-being Impact Assessment?

The plans for timely hospital discharge largely affect older people and their need to access to good quality community health and social care services. The approach used by Denbighshire Social Services is in line with the Social Services and Well-being Act and aims at empowering communities to become more resilient and manage their own health and well-being. As shared plans develop, there will be a need for more thorough impact assessments. Having a robust workforce development plan is crucial. See appendix from January 17 Partnership Scrutiny Report (WBIA attached).

8. What consultations have been carried out with Scrutiny and others?

The contents of this report have been prepared in consultation with colleagues in BCU. The planning for most of the services referred to has been discussed in partnership fora such as Partnership Thursday, the Denbighshire Joint Locality Forum; the Central Area Integrated Services Board and various unscheduled care meetings and workshops.

9. Chief Finance Officer Statement

Not applicable.

10. What risks are there and is there anything we can do to reduce them?

The risks to the delivery of safe healthcare within North Wales are major, which is why CSS prioritise and work closely with colleagues in BCU on this subject. The lack of care workers is a risk to the safety of vulnerable people in Denbighshire. Actions for being effective includes the need for a major culture change within the organisations as well as managing the expectations of the general public.

11. Power to make the Decision

Section 7 of the Council's Constitution outlines Scrutiny's powers with respect to policy development and review and monitoring the Authority's performance in meeting policy objectives.

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