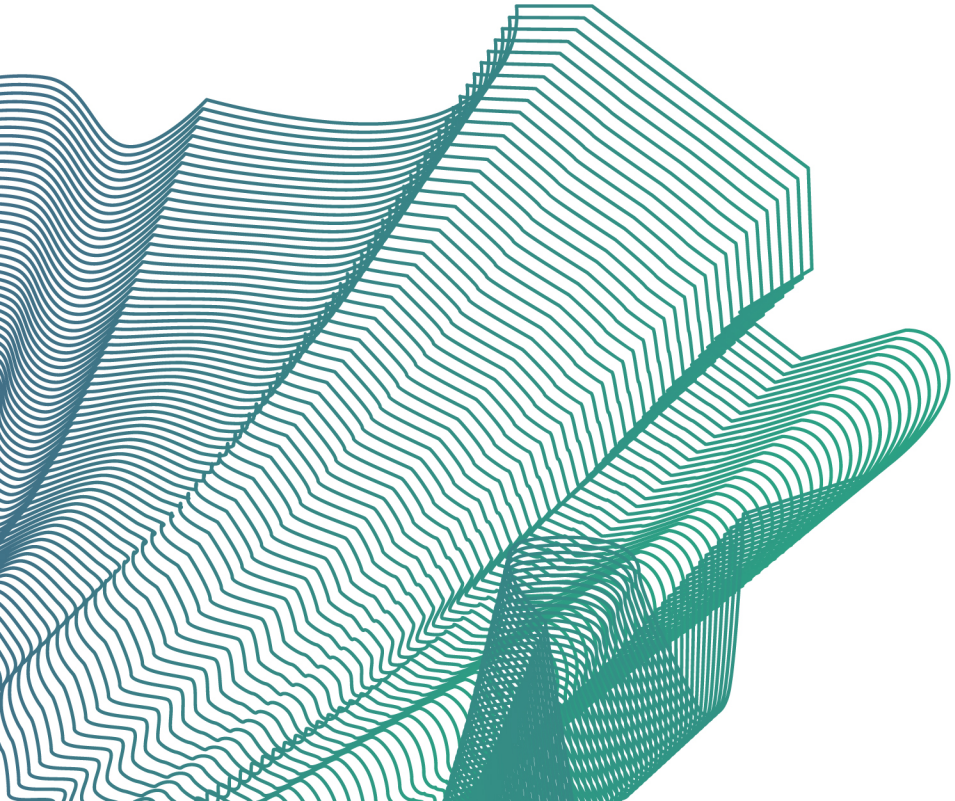
ROTHERHAM

INTEGRATED CARE PARTNERSHIP | HEALTH AND SOCIAL CARE

Place Response – Discharge Planning
February 2022



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Discharge Guidance

- 7 day discharge service based
- Based on home first principles
- With the aim of discharging people within 2 hours/same day of being declared medically optimised (and therefore no longer having right to reside R2R) ensuring safe discharge
- Daily morning board rounds to establish Right to Reside (R2R)
- Transfer to dedicated discharge area
- Period of support in the community to enable people to return to pre-admission levels of independence
- Continuing health and social care needs assessments to be conducted in community settings
- Scheme 2: National discharge fund to March 2022 to support same day discharge and reductions in length of stay
- National data performance reporting

Discharge to Assess Pathways

Pathway 0: c 50% of people

Simple discharge, no formal input from health or social care needed once home

Discharge activities carried out by wards

Pathway 1: c 45% of people

Support to recover at home; able to return home with support from health and/or social care.

Pathway 2: 4% of people

Rehabilitation or short-term care in a 24-hour bed-based setting.

Pathway 3: 1% of people

Require ongoing 24-hour nursing care, often in a bedded setting. Long-term care is likely to be required for these individuals

Pathways 1-3 assessments to be carried out in the community (other than establishing appropriate pathway, safeguarding where required)

What's Working Well?

Place Partnerships

- Robust Place Governance
  - ICP – Urgent and Community Transformation workstream
  - Escalation process including meetings (Monday/Wednesday). Based on daily escalation these meetings can be stepped up.
    - Executive meetings when Place is significantly challenged
- Flexible and Responsive partnerships at Place
- Place transformation leads through IBCF that are joint posts.
- Joint Commissioning Senior leadership
- Implementation of new guidance – Place led approach

Respond to Demands e.g.

- Additional Brokerage on Saturdays
- Additional Social Work resource into IDT
- Flexibility to increase bed base through RMBC community beds to meet fluctuating demand/surge
- Collaborative procurement (i.e. winter beds/designated beds)
- Increased Home Care through Dynamic Purchasing Framework
- 7 Day Equipment Service pilot to February 2022
- Additional Transport (extended hours) to 31st March 22

What's Working Well?

Acute Discharge Focus

- One of 6 Priorities in Trust Operational Plan – Deliver Step change in improvement in flow
- Executive lead for work programme
- Task and finish group – divisional involvement at ward level
- Improvement work including divisional workshops and process mapping TTOs,
- Board Rounds – held daily, patient flow matron providing support/mentorship to wards
- Discharge Co-ordinators – ward based working closely with IDT
- New discharge lounge – increased capacity
- Change of language within Operational Meetings – Right to Reside starting to really embed
- R2R is part of EPR and digital visibility supports targeted approach
- Long Length of Stay (LLOS) - Escalation Meetings, follow up actions
- Weekend Discharge including Medical Support to discharge

What impact has this had?

- The majority of Acute Non-Elective discharges are Pathways 0 (89%), roughly in line with national audit outcomes.
- IDT support 10% of the non elective discharges from the Acute which equates to c 57 per week on average.
- The majority of referral are for patients aged 70+
- As IDT see the most complex discharges within the Acute a higher proportion are discharged with support therefore;
    - **Approximately 50% (28) patients are discharged from IDT home with either no formal support, a care package or reablement**
    - **The remaining c.50% (28) are discharged into one of our commissioned bed bases which include both residential and nursing rehabilitation beds and Discharge to Assess for Continuing Health Care**
- Rotherham's community bed base provision is roughly 28 commissioned beds per 100k weighted population compared to 21 national average.
    - Outcomes from Intermediate Care in Jan 22 are as follows 19 discharges – c90% went home with family support/reablement or home care, 5% were readmitted and 5%went into long term care.
- Spot purchase beds are also used in addition to this on average of 27 beds. This relates to the use of Discharge funding which is ending in March 22

What Are We Worried About?

- Covid 19 increasing community transmission and impact on staff sickness – potential for further variants emerging
- Pressure on social care provision to support Discharge and Admission Avoidance
- Workforce challenges across Place Unable to recruit to key capacity, particularly services to support people at home.
- Multiple outbreaks of flu and/or covid-19 in community i.e Care Homes, guidance reduced to 14 days, but Care Homes are seeing multiple positive results on retesting.
- Requirement to reduce the number of people with a R2R in Trust through increased discharges – concern over not meeting our Local target
- Discharge Fund (Scheme 2) funding ends March 22 – planning for mitigating risks now

June 2021

Questions?

June 2021