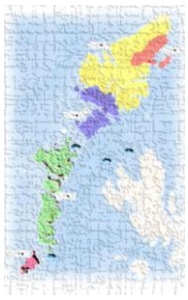

CÙRAM IS SLÀINTE NAN EILEAN SIAR

WESTERN ISLES HEALTH AND SOCIAL CARE PARTNERSHIP

ADMISSION AND DISCHARGE POLICY

PURPOSE OF REPORT

1. This report considers our ongoing work to improve our delayed discharge performance.

COMPETENCE

2. The content of the report is purely operational. There are no legal or financial impediments to the implementation of the policy and action plan.

SUMMARY

3. Over the last few years, the Western Isles has been a consistent outlier in terms of national performance on delayed discharge. Although a temporary improvement in performance was recorded as we expanded our overall long-term care home provision by nine beds, the summer period saw us revert to previous levels of delay.

4. In response, we have sought to better understand our delayed discharge problem in respect of demographic and epidemiological drivers; cost and spend information; assessment and flow; and service design. This in turn has led to a number of proposals to ensure that we maintain focus on improving our performance. These include:

    - Implementing the measures set out in the strategic plan, which were intended to reduce delays;
    - The development of an operational policy, which sets out to staff and stakeholders our clear expectations around admission and discharge;
    - The development of an operational action plan, which will oversee operational reforms in line with best practice

5. The operational policy was agreed by the Integrated CMT in September and we now want to ensure that our action plan is delivered. Members will be kept apprised of developments.

RECOMMENDATIONS

6. It is recommended that:

    a) The IJB notes the operational policy on delayed discharge, which was agreed by the Integrated CMT in September; and
    b) Note progress against the action plan.

Ron Culley
Chief Officer
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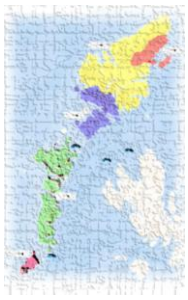

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WESTERN ISLES HEALTH AND SOCIAL CARE PARTNERSHIP

ADMISSION AND DISCHARGE POLICY

Introduction

1. This Policy has been produced by the Western Isles Health and Social Care Partnership. The Partnership recognises the importance of a jointly agreed Policy for Admission and Discharge to and from hospital. This Policy is to be followed for all patients. The aim is to provide a consistent co-ordinated approach with multi-disciplinary and multi-agency input whilst maintaining the individual's interests as central to the admission and discharge planning process.

Values

2. The policy is grounded on a set of values based on the human rights of the people who use our services, including:

- Respect for the inherent dignity and worth of all individuals
- Promotion of individual autonomy including the freedom and support to make one's own choices
- Support to ensure full and effective participation and inclusion in society
- Respect for difference and a desire to respond to individual needs
- Equal access to resources, services, information and opportunity

3. We will strive to ensure that the admission and discharge process is focused on improving personal independence. Our role is to make best use of personal capabilities, assets, family, and community.

Preventing Unnecessary Hospital Admission

4. In the event that a person presents with an issue which requires a medical intervention, our priority will be to avoid unnecessary hospital admission. We will support health and social care practitioners to appropriately care for people at home, where this can be done safely and effectively.

5. Effective use will be made of Anticipatory Care Plans, and where these are not in place for individual patients, local professionals should consider whether a person's care would be improved by the development of an ACP.

6. Where an individual can be supported medically without hospital admission, but needs additional support to maintain or recover independence, social care support, intensive reablement or bed-based intermediate care will be considered where that is available.

7. If a patient cannot be managed safely at home, or intermediate options are not available, they should be transported to A&E for further assessment and treatment. Ambulatory care will be provided to avoid hospital admission.

8. If, after medical assessment, a patient is not deemed fit to return to their place of residence, hospital admission may be necessary. An estimated date of discharge will be provided upon admission.

Assessment and Care Planning

9. It is recognised in national guidance that assessment in an acute setting can often lead to an inaccurate understanding of a person's capabilities. In view of this, the Multi-disciplinary team will seek to discharge to assess, either to a step-down facility where that is available or to a person's place of residence.

Hospital Discharge Policy

10. Our priority will be to support people to return to their previous living arrangements, whether that is their own home or a care home, with minimal risk of re-admission.

11. All patients who are eligible will receive early supported discharge from hospital, within 72 hours of being medically fit to return home. This process will be supported by intensive reablement at home or through step-down care in an intermediate care facility. This service will be targeted at people who have experienced a reduction in functional skills following hospital admission, who have the potential to return to previous level of function and independence within six weeks, and who do not have a severe cognitive impairment.

12. Patients with more complex care needs, who do not qualify for early supported discharge, will be supported and informed about their options if they are unable to return home. This will include supporting patients and their family to consider the choices they have in respect of residential care and other supported accommodation.

13. The whole system flow is described by way of an algorithm (as set out in Appendix 1).

14. A local Travel Policy has been created to support the discharge process. This should be followed at all times (see Appendix 2).

15. Ongoing care and support in hospital will not be considered unless all other options have been exhausted.

16. In support of this policy, a discharge action plan will be produced on an annual basis (see Appendix 3).

Delayed Discharge Recording and Reporting

17. In order to improve the overall performance of our discharge process, we have accurate and up-to-date management information. This should bring together metrics from existing inter-connected programmes including Unscheduled Care, Winter Planning, Delayed Discharge national reporting, Patient Flow (6 Essential Actions) and Social Care reporting. We therefore aspire to ensure that data collection meets national reporting requirements. Within a Western Isles context, data capture and reporting will be channelled through the TOPAS electronic system.

Monitoring

18. The Integration Joint Board and the Health Board will receive regular performance reports on delayed discharge, bed days lost, and a number of other indicators which will allow us to measure performance improvement.

19. As services and practices develop, this policy will be reviewed to improve or add to ways of working and to accommodate new service developments.

20. This Policy will be reviewed and reported bi-annually and monitored by the Partnership by way of a multi-agency working group.

Policy Context

21. The Partnership will deliver the 9 National Outcomes for Health and Well-Being through the implementation of the Strategic Plan, fulfilling the duties of the Public Bodies (Scotland) Act 2014. In doing so, we will have regard to:-

- The Scottish Office circular "Community Care Needs of Frail Older People: Integrating Professional Assessments and Care Arrangements SWSG 10/98" recommended that Partnerships and housing authorities should agree a local policy that enables discharge from hospital when the patient's assessment and/or treatment is concluded.
- The Partnership will apply the principles of the Health Care Quality Strategy of Safe, Effective and Person centred care.
- In 2002, the Delayed Discharges in Scotland Report was published which included a commitment to develop, implement and audit joint discharge policies and protocols.
- This was followed in 2013 by further guidance "Guidance on Choosing a Care Home on Discharge from Hospital", CEL 32/2013, which outlines the Partnership actively manage choice of care homes for people moving from hospital, in a way which is consistent and fair and minimises delays. The appeals part of this document in relation to discharge has been superseded by Hospital based Complex Clinical Care DL (2015)11.
- In 2007, the Scottish Government published 'The Planned Care Improvement Programme; Patient Flow in Planned Care; Admission, Discharge, Length of Stay and Follow-up'. This highlighted that planning for discharge should start as early as possible and that failure to plan properly can lead to protracted stays in hospital or people ending up in the wrong place without proper care or treatment.
- The Partnership will comply with the Caring Together: The Carers Strategy for Scotland 2010-2015, and the Carers (Scotland) Act 2016.
- The Partnership applies local Eligibility Criteria for Social Work and Social Care services based on the national guidance. This sits within a legislative context which seeks to deliver maximum choice and control to service users through the Social Work (Self-directed Support) Scotland Act 2013.
- The Partnership has a Joint Policy for the Provision of Community Equipment.
- The Partnership will follow the good guidance for practice on Adults with Incapacity (AWI)
- There is a local Patient Travel policy which will be followed.
- People, who are homeless at the point of admission to hospital, either on a planned or emergency basis, should not be discharged from hospital without referral to appropriate services in the community, on the basis of the person's consent. The 'Prevention of Homelessness Guidance – June 2009', produced by the Scottish Government and COSLA establishes the policy framework around how this should be managed locally.

Appendix 2 – Discharge Transport Policy

1. The cost of transferring patients from one hospital to another, or to a clinic or nursing home whilst their treatment remains the responsibility of an NHS hospital clinician, should be regarded as part of treatment costs; as should the travel costs of patients who are sent home either as part of their treatment or to meet a hospital's convenience. Patients who take leave from hospital at their own request cannot be helped with their travel costs.

2. At the point of discharge from hospital, it will normally be the responsibility of the individual or their family to arrange and absorb the costs of travel back to the place of residence.

3. In circumstances where a person's discharge is complicated by frailty or disability, and in the absence of family support, then NHS Western Isles will work with the Scottish Ambulance Service to transport a person back to their place of residence. Where Scottish Ambulance cannot provide a service, NHS Western Isles will work with third sector partners to support the discharge process.

4. The transport of a person who has been discharged to a place of residence outside of the Western Isles will be considered on a case by case basis. It should not be assumed that the cost of transport will be met by NHS Western Isles.

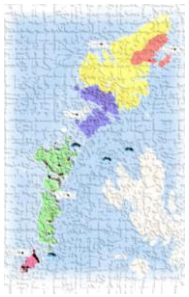
5. Upon discharge, appropriate transport arrangements should be made and all pertinent information regarding the person's condition should be given to the transporting service (e.g. Do Not Resuscitate status, infections, issues regarding transferring and in respect to manual handling). When arranging transport for discharge, it is vital that the discharge address is confirmed and checked as correct, as it may differ to the person's home address. It is equally important to check that the patient can access their destination address (e.g. do they have a key, can they manage any steps at the property).

6. Transport should only be provided for discharge when there are no family or friends to transport. Transport can be booked 24/7 and all staff should access this system to book according to the person's needs and mobility status.

7. The receiving care home or primary care team (if the person is returning home) should be notified of any known infection and the current infection control practices in place (e.g. antibiotic therapy, dressing regime, barrier nursing).

8. The person should have the necessary medication, dressings and relevant information about post discharge care.

9. All arrangements and referrals in relation to discharge planning should be clearly documented, signed and dated within the discharge planning documentation



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WESTERN ISLES HEALTH AND SOCIAL CARE PARTNERSHIP

Appendix 3 – Discharge Action Plan

	Ambition	Action	Lead	Timescale	RAG Status
Leadership	To ensure that delayed discharge is understood to be a central priority of the health and social care partnership	Monthly reports to Integrated Corporate Management Team, Co-chaired by the two Chief Executives	Emma Macsween	Monthly	
		Executive Lead for Delayed Discharge identified to lead management of system and report on performance	Emma Macsween	Achieved	
		Effective succession planning to ensure that discharge planning manager is secured in post	Chris Anne Campbell	September 2016	
Communication	To ensure that we are engaging effectively with carers and families to support discharge processes	Strengthen public information about care options	Emma Macsween	October 2016	
		Build up support offer to unpaid carers in response to Carers Act	Emma Macsween	March 2017	

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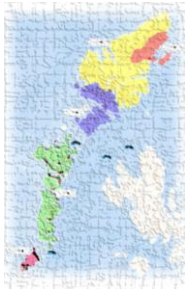

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	Ambition	Action	Lead	Timescale	RAG Status
Analysis and Prevention Tools	To improve our overall understanding of our local system To use management information more effectively to drive service improvement	**Development and dissemination of management information on**:- Patient Flow metrics Unscheduled care (6EAT) metrics, Anticipatory care/avoidable hospitalisations Winter Planning metrics Delayed Discharge metrics Social Care metrics	Mags Mackin	Initial collation – August 2016 Updated monthly thereafter	
	We prevent people being admitted to hospital where they can be supported in community settings	Ensure that SPARRA (Scottish Patients At Risk of Readmission and Admission) data is disseminated via dashboards and used by all primary care teams Anticipatory Care Plans become more widely used, especially for people with Long Term Conditions or who have palliative care needs	/HI Team Dr Kirsty Brightwell Kathleen McCulloch/ Dr Kirsty Brightwell	October 2016 March 2017	

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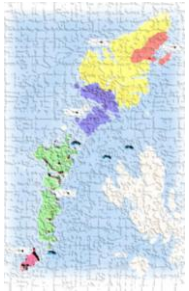

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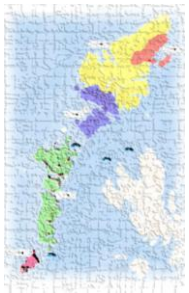
WESTERN ISLES HEALTH AND SOCIAL CARE PARTNERSHIP

	Ambition	Action	Lead	Timescale	RAG Status
Front Door	To ensure that hospital receiving services are well-equipped and well-informed in the provision of ambulatory care	Ensure that A&E and assessment staff have up to date information about care options, support and transport, including rapid response and Out of Hours options	Kirsty Street	October 2016, then regular updates	
		Work with nursing and medical staff on a policy of 'decide to admit' rather than 'admit to decide'	Dr Kirsty Brightwell	March 2017	
Admission	All patients are given an Estimated Date of Discharge and Ready for Discharge date	The use of Estimated Date of Discharge is applied against objective criteria	Hospital Manager Dr Kirsty Brightwell	December 2016	
		Training needs of clinicians are addressed in respect of estimating discharge date	Dr Kirsty Brightwell	December 2016	
Assessment	People's long-term care needs are only assessed at a point where they have had an opportunity to regain a level of independence	A presumption in favour of assessment at home will be implemented, linking with wider reforms around early supported discharge	Michael Stewart/ Sonja Smit	December 2016	
		Light-touch early assessment by MDT devised to support discharge planning, with defined timelines	Michael Stewart/ Sonja Smit	December 2016	
		Plans will be put in place to optimise the activity of patients in the hospital, to ensure physical independence is maintained	Jimmy Myles/ Angus Maclennan/ Mairi Campbell	October 2016	



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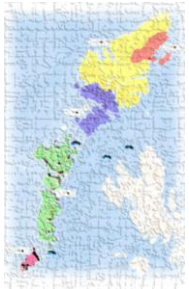
WESTERN ISLES HEALTH AND SOCIAL CARE PARTNERSHIP

	Ambition	Action	Lead	Timescale	RAG Status
Assessment	People's long-term care needs are only assessed at a point where they have had an opportunity to regain a level of independence	Pre-existing care packages are kept open until such times as a full assessment has been done, subsequent to reablement process	Paul Dundas/ Michael Stewart	December 2016	
Discharge	Patients are discharged safely and as quickly as possible back to their place of residence	Arrangements are put in place to increase the number of weekend discharges	Paul Dundas/ Jimmy Myles/ Michael Stewart	October 2016	
		Criteria-led discharge to continue to be developed	Jimmy Myles	March 2017	
		Transportation options are clearly understood by all staff involved in the discharge process	Jimmy Myles/ Angus Maclennan/ Mairi Campbell	October 2016	



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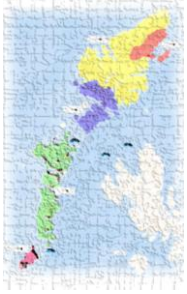
	Ambition	Action	Lead	Timescale	RAG Status
Service Redesign	The over-arching reforms set out in the strategic plan to develop intensive reablement services and step-up / step-down intermediate care is delivered	The early supported discharge team is augmented with home care coordination and assessment and care management capacity to deliver a multi-disciplinary approach	Paul Dundas/ Emma Macsween/ Jimmy Myles	October 2016	
		A blue print is developed for bed based intermediate care in Stornoway	Paul Dundas/ Emma Macsween/ Chris Anne Campbell	December 2016	
	Community capacity is developed by looking at innovative ways to support more care at home packages	Flexible recruitment of homecare workers and healthcare assistants for deployment in different settings	Paul Dundas/ Kathleen McCulloch	October 2016	



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