Safe Effective Discharge

Adult Social Care

&

The IOW NHS Trust

PAPER J

Working Together

- Delivering
  - Integrated Discharge Team
  - Regaining Independence Service
  - Working with system partners – Age UK
  - Seven day working
- Reviewing how we work together
  - Improving processes, procedures and communication

Integrated Complex Discharge Team

- Works alongside patient navigation team to identify those patients needing support from adult social care
- The ICDT attend all patient flow meetings in the hospital where there is agreement about which pathway the patient is on
- Detailed discharge plans are developed to ensure the safe transition from hospital to home or Nursing/Residential Home

Regaining Independence Service (RIS)

- RIS focuses returning patients to independence following an attendance at the hospital by
  - Providing a single point of access to the service upon discharge from the hospital
  - Focusing on patients with reablement goals.
- The Team consists of
  - Trust's rehabilitation services delivered in the community and all ASC reablement services.
- Activity
  - During a week in December there were 54 referrals from wards to the SPA of which 20 were accepted by the RIS.

Age UK

- Adult Social Care funds Age UK to deliver a free brokerage service for people who chose not to use ASC.
- The brokerage service works closely with the Single Point of Commissioning Team in ASC to identify and procure on behalf of people looking for and funding their own care.
- Age UK also support patients in hospital by providing a take home service ensuring people have heating, and basic provisions.

Seven Day Working

- ASC has a social worker, reablement lead and broker from SPOC based in the hospital all weekend and every bank holiday.

- The social worker and reablement lead are based in the operations room so that they can work with the hospital's weekend managers to focus on avoidance of hospital admission and working with the right patients to help discharge

- There is a MDT based in A&E (Medical, Nursing social worker, district nurse and therapist) who work together to avoid hospital admissions.

Review of Discharge Processes

- Multi-Agency Review of all Medically Fit Patients – 18 December 19
  - Social Services, CCG, Medics, Nursing, Management
- Purpose of the event to:-
  - Identify Delays and Support Effective Discharge Pre Christmas
  - Identify system wide blockages and propose streamline process
  - Provide a baseline for larger piece of work in January 2020.

Findings - Benefits

- Significant benefit of Multi Disciplinary team going to ward together
- Agreement and commitment to revisit how we work with each other and to improve communication
- Commitment to working as one team and work closer together
- Agreement to have more joint visits to ward and more combined events / Closer working

Findings – Comms and System

- Communication
  - People not aware of actions colleagues had taken, causing delay to the patients discharge
  - People not documenting actions they had taken and not communicating with colleagues
  - Ward Sisters not understanding what was happing with patients
  - Lack of clarity “what does Medically Fit Mean”
- Complicated System
  - People didn’t fully understand the system and completed incorrect forms or spoke to the wrong agencies
  - People misinterpreted the system and made assumptions, which then became fact!
  - Complexity and number of steps within the system causes delays

Findings – EDD and Surge

- Discharge Date
  - People weren't working to the Estimate Date of Discharge
  - People were making allowances in the EDD for external agencies, needlessly extending patients length of stay.
- Surge Management
  - Need to recognise when there is a surge in admissions this will impact Care Managers 5-7 days later.
  - Need to recognise that this will impact availability of POC and Care / Nursing home availability

Discharge Support

- Through winter funding from January Age UK will be supporting hospital wards around discharge planning and supporting patients and their families with discharge out of hospital
- Trusted Assessor processes have been agreed across Trust and partners to improve discharge.
- Trust is part of ‘Home First’ NHSi collaborative and focus of quality improvement is care homes
- Care Home Support scheme being developed through winter funding to improve support in care homes and improve discharge and reduce readmission.
- Single Point of Access being implemented for Rehabilitation and Reablement across the Trust and Adult Social Care.
- Community bed capacity being made visible on Hospital IT system to aid communication and improve discharge planning.

Safe Discharge – Hospital to complete

- How do we ensure that patients are safely discharged from hospital. What process do we have in place to ensure they have the correct medication (Red Bags?) and that patients know what they need to do when they get home.
- How do we make sure the patients have the correct equipment in their home for when they are discharged.
- How do we make sure that we co-ordinate with ASC so when patients are discharged they are not left alone with no POC to ensure their on going care
- How do we communicate with Nursing and Residential Homes to facilitate safe discharge