AGENDA ITEM No.9

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

Meeting of East Renfrewshire Health and Social Care Partnership	Integration Joint Board
Held on	30 March 2016
Agenda Item	9
Title	Safe and Supported

Summary

This report provides an update on the approach taken by the HSCP to invest new delayed discharge funding to ensure East Renfrewshire residents are helped to remain at home and to be safely discharged from hospital when appropriate.

Presented by	Frank White, Head of Health & Community Care

Action Required

The Integration Joint Board is asked to note the contents of this report

Implications checklist – check box if applicable and include detail in report

☒ Financial	☐ Policy	☐ Legal	☐ Equalities
☐ Efficient Government	☒ Staffing	☐ Property	☐ IT

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

30 March 2016

Report by Julie Murray, Chief Officer

SAFE AND SUPPORTED

PURPOSE OF REPORT

1. This report updates the IJB on the HSCP's plans to invest the Delayed Discharge funding from the Scottish Government to ensure that residents of East Renfrewshire are helped to remain at home or are discharged from hospital with appropriate support.

RECOMMENDATION

2. The IJB is asked to note the contents of this report

BACKGROUND

3. The Scottish Government has made reducing delated discharge from hospital a key priority. All the evidence supports the view that if older people no longer need hospital treatment, they do better being at home than spending unnecessary time in hospital. The Government will change its current delayed discharge target in April, reducing its definition of a delay from 14 days to 72 hours. As part of its preparation for this change, and to support its broader approach to reducing delayed discharges it has provided all HSCPs with additional funding. The East Renfrewshire HSCP share is:-
   - 2015-16 £429,000
   - 2016-17 £500,500
   - 2017-18 £500,500

REPORT

4. When we were made aware of the new funding earlier in 2016, we took the opportunity to review how we were currently managing discharges from hospital. We decided to take a broader view of discharge, looking at it as a process, beginning when people were still at home, rather than a single discharge event. We have called this area of work Safe and Supported rather than delayed discharge to emphasise this wider approach.

5. Staff and third sector colleagues met for a planning event and agreed to establish 4 workstreams:-
   1. Prevention/Anticipatory
   2. At point of possible admission
   3. Admission
   4. Discharge

6. Each group has been developing ideas to build on current good practice and planning new approaches. What has been crucial has been the connections between each of the workstreams and the approach that focusses on prevention where possible to avoid potential delays for our residents.

Outcomes

7. During 2015-16 we have continued our use of staff based in the Victoria initially, then the Queen Elizabeth University Hospital when it opened, to liaise with medical staff to improve discharge processes. We have invested in step down beds and have used them in appropriate circumstances where further time was required to design support around individuals in the community.

8. By involving staff, GPs and third sector colleagues, in our planning for the future we are confident that we have begun to develop ways of working that will prevent unnecessary admissions and create a more coordinated response to people being discharged.

9. During April we will shortly finalise our plans for the next two years which will include:-
   - New Hospital Connector posts, embedding our staff in the Acute Recovery Unit at the QEUH to quickly identify East Renfrewshire residents who could be supported to go home.
   - Community connector posts who will intervene both before admission and after discharge to help residents access a wider range of community and HSCP supports, linking with appropriate HSCP staff.
   - Increased pharmacy input to ensure medication is available and regularly reviewed when people are discharged.
   - Appropriate use of step up/step down beds where individuals need more focussed, short term inputs out of a hospital setting before returning home.
   - Further development of community provision coordinated by colleagues in Voluntary Action East Renfrewshire (VAER) in partnership with the HSCP
   - Review of how quickly homecare can be accessed with better out of hours provision.

FINANCE AND EFFICIENCY

10. Funding is available from Scottish Government for these new initiatives.

CONSULTATION

11. GP, VAER, Scottish Care and community groups have been involved in developing this work.

PARTNERSHIP WORKING

12. HSCP has worked with partners from VAER and Scottish Care to develop the proposal.

IMPLICATIONS OF THE PROPOSALS

Staffing

13. New posts will be created to deliver this work.

CONCLUSIONS

14. We understand the importance of meeting the new 72 hour target for delayed discharge. We have however taken the view that the additional funding gives us the opportunity to review how we currently manage discharge and has allowed us to work with our partners to design more effective ways of working. During April, we will finalise our plans to use the additional funding to build on current good practice and add new approaches that will prevent unnecessary admissions. When people are admitted to hospital this will help to get home more quickly and with appropriate support.

RECOMMENDATIONS

15. The IJB is asked to note the contents of this report

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9 March 2016

BACKGROUND PAPERS

None

KEY WORDS

Safe and supported; delayed discharge; hospital discharge; discharge; admission; prevention

A report outlining plans to invest Scottish Government delayed discharge funding to ensure that residents are helped to remain at home or are discharged from hospital with appropriate support.