joint improvement team
creativity, collaboration and continuous improvement

Home First

Ten Actions to Transform Discharge

JIT is a strategic improvement partnership between the Scottish Government, NHS Scotland, CoSLA, the Third Sector, the Independent Sector and the Housing Sector

Ten Actions to Transform Discharge

1	Use Data to Know How You are Doing • EDISON • Self Assessment
2	Scale up coordinated and anticipatory care • ACP and Key Information Summary • Integrated community support
3	Develop Intermediate Care • Hospital at Home • Step up and step down beds
4	Screen and assess for frailty • Frailty triage and pathway through acute care • Rapid access frailty clinics / enhanced community support
5	Integrate discharge planning • Discharge hubs • Equipment and Adaptations
6	Build capacity for care and support at home • Generic support worker • Third sector contribution
7	Assertive management of risk • Telehealth and Telecare • Assess at Home
8	Support people moving on to long term care • Policy on Interim placements • Assuring quality of care
9	Understand Adults with Incapacity Issues • Identifying AWI • Power of Attorney
10	Joint Commissioning and Resourcing • Advice note • Productive opportunity

A MEASURE OF QUALITY

Reliably achieving safe, timely and person centred discharge from hospital to home is an important indicator of quality and a measure of effective and integrated care.

Improving the pathway from hospital to home is at the heart of our 2020 Vision.

Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting.

We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self management.

When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm.

Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions.

There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

Hospitals provide valued and essential assessment, treatment and care whenever that can't be provided safely and effectively at home or in the community. However a prolonged stay in hospital is rarely associated with a good outcome.

Being in hospital disconnects people from their family, friends and social network and can result in a sense of isolation, loss of confidence and depression. Visiting hospital for a long period may heighten an already stressful situation for family carers. Older people experience functional decline as early as 72 hours after admission and are more likely to have an episode of delirium or infection. The risk of a poor outcome increases every time a frail patient is moved from ward to ward.

Every unnecessary day in hospital increases the risk of an adverse outcome for the individual, drives up the demand for institutional care and reduces the level of investment that is available for community support.

Expert Group

In 2010, the Delayed Discharge Expert Group recommended that discharge home from hospital should routinely take place in days not weeks.

When a patient no longer requires to remain in an acute hospital, they should be discharged home and their post hospital rehabilitation, care and support needs met by the community health and care team. If return home is not possible in the short term, they should transfer to a step down bed in the community for a period of Intermediate care and rehabilitation.

The Report of the Expert Group identified key success factors in reducing delays:

- Strong leadership and ownership of the agenda at all levels across all of the partner organisations with accountability by a senior executive who is in a strong position to challenge performance and practice

- Estimated Date of Discharge (EDD) routinely set and discharge planned from the point of admission (or before) with the norm being discharge within hours and days of readiness rather than weeks.

- A personal outcomes approach that tackles every delay, every day and uses data to examine performance and challenge causes of variation.

- A 'whole system approach' that offers appropriate community alternatives to hospital admission, frailty screening to prompt early specialist geriatric assessment and assertive management of risk by senior decision makers who 'decide to admit' rather than 'admit to decide'.

- Active participation by patients and their carers ensuring that they understand and are able to contribute as appropriate to care delivery and discharge planning, including use and sharing of Anticipatory Care Plans

- Staff work within an integrated multi-disciplinary and multi-agency framework and use joint Admission, Transfer and Discharge Protocols that clearly set out local processes for assessment, discharge and provision of community services.

- A named person with responsibility for co-ordinating all stages of discharge planning throughout the 'patient journey' including engagement with housing.

- Effective use of transitional and intermediate care services including step down beds and community hospitals so that acute hospital capacity is used appropriately and individuals achieve their optimal outcome.

- Acute hospital is not the optimum setting for assessing an individual's need for long term care and support so, unless unavoidable, no-one should move directly from an acute bed to a long-term care home placement

- Adoption and communication of a culture of 'Home First' as a default position - wherever possible and safe, patients return to the home they were admitted from and only explore alternatives if this is not possible.

Supporting Improvement

Building on these success factors, we have identified 10 actions you can take to transform discharge. Each action has links to tools that can support improvement.

1. Use Data to Know How You are Doing

Local improvement starts with intelligent use and feedback of information.

Electronic Discharge Information System ON-Line

EDISON is a real-time national information system that records and shares information on patients delayed, the care setting in which they are delayed and the main reason for the delay. ISD generates monthly management reports and publishes quarterly reports for all Partnerships. These reports state the total number of hospital bed days associated with all delays, including delays recorded as 'code 9' where it is recognised that discharge is out with the immediate control of the NHS or local authority. Code 9 includes patients awaiting a highly specialist facility and where an interim option is not appropriate, patients for whom an interim move is deemed unreasonable, and delays as a result of adults with incapacity legislation.

Review your real time delayed discharge data to understand emerging trends and target local actions to reduce delays.

Comparative health and social care data prepared by ASD may help you understand the impact of wider health and care resources in your partnership

Self Assessment Framework

JIT developed a performance improvement tool to help Partnerships identify their strengths, challenges and specific improvement actions to reduce their delays.

The Delayed Discharge self assessment can be found on the JIT website

Partnerships are asked to self assess their status in five domains:

.

- **Leadership and Performance Improvement**
- **Engagement and Accountability**
- **Improving Practice**
- **Demand and Capacity**
- **Patient and family experience**

The tool uses a "traffic lights" approach. If a response is red or amber, the partnership should agree remedial actions, leads and timescales.

Complete the self assessment as a whole system team.
Repeat the exercise if delayed discharge performance begins to dip.

2. Scale up coordinated and anticipatory care

Anticipatory care planning (ACP) encourages people to 'think ahead' and to have greater control and choice by recording their wishes and care preferences in the event of a future deterioration, or a sudden change in circumstances for their carer.
ACP can increase personal and carer resilience, reduce dependence on statutory services, reduce emergency attendances or admissions to hospital, and improve the way we support flow across the whole system.

JIT and QuEST developed an ACP 'route map' and PowerPoint slides to help primary care teams make best use of the new component in the GP contract. Case studies and digital stories describe the ACP process from the perspectives of the patient, carer and the professional. The *Improving Lives* DVD describes the powerful impact of a range of interventions that are prompted through ACP conversations.

http://www.qihub.scot.nhs.uk/quality-and-efficiency/outpatient-primary-and-community-care/primary-and-community-care-.aspx

Raise awareness of professionals, patients, carers and the public about the benefits of having an ACP – link this with your *Know Who To Turn To* work

Increase month on month the numbers of ACPs developed and use the GP contract to add value to the ACPs developed by other professionals

Sharing Key Information

The Key Information Summary (KIS) is a tool to create and share (with patient consent) a summary of the ACP so that other health and care providers are aware of the care plan and preferences. The KIS uses the Emergency Care Summary (ECS) infrastructure and includes data on medication and allergies. Information is updated every two hours to ensure KIS information is always up to date.

NHS24, SAS, A&E, Out of Hours and acute admission areas should already have access to KIS. Access by other departments will depend on Board PMS systems and clinical portal developments. This short video by Dr Dan Becket in Forth Valley describes how access to the KIS helps emergency care clinicians make the right decisions for and with patients.

Work with ehealth to increase the sites and services that access KIS. Increase month on month the numbers of KIS that are accessed – and feedback that data to clinicians to drive improvement.

For the latest update on KIS and patient information, go to www.keyinformationsummary.org.uk

Coordinated care management

The virtual ward, community ward or integrated community support team improves communication and coordination of care for people with chronic complex or frequently changing needs. They use risk stratification tools and professional judgement to identify individuals who are vulnerable and are at high risk of future emergency admission. The primary care and community team, with specialist advice if required, coordinate care in an anticipatory and holistic manner to help the person stay well and remain at home. This may require frequent and intensive clinical support as their condition changes over weeks / months.

Many partnerships can now demonstrate positive outcomes from these services. Emergency admissions can be reduced with prompt access to more intensive care at home in times of crisis.

Ayrshire and Arran Community Wards
Three community wards managing high risk patients with COPD, falls, heart failure and diabetes achieved high satisfaction scores, 49% fewer emergency admissions and 36% less bed days in the first 6 months for the caseload. The model offers:

- Unique point of patient-centred integration between independent contractors (GPs), primary and secondary care and Local Authority services
- Sufficient time for proactive intensive medical support and problem solving to develop and implement enhanced Anticipatory Care Planning
- Targeting help to the most resource intensive SPARRA patients
- Use of GPs with Special Interests and Advanced Practitioners

South Lanarkshire Integrated Community Support Team
This integrated team of nurses, AHPs, social workers and home care workers support people with complex needs to prevent emergency admission and support timely return home from hospital. Medical care is provided by the person's own GP who links, when needed, with hospital consultants. 90% of referrals to the team are able to remain at home at 30 days.

Dumfries and Galloway Integrated Hub
Dumfries and Galloway developed a Single Point of Access to community health and social cares services, STARS (*Short Term Augmented Response Service*) and Third Sector for people registered with two of the GP practices in Dumfries. Referrals are screened by Health and Social Services leads, discussed at a daily multi-agency meeting and the care provided is co-ordinated between the teams. Results show

- Reduction of up to 15 days in referral time from GP to care input
- Quicker inter-service handovers with increased capacity
- Greatly improved communication, staff morale and team working
- Increase in team knowledge of Third Sector support and services
- Greater understanding of what each discipline offers across the care pathway

Case studies and digital stories can be viewed at the Intermediate Care Community of Practice

Use your Change Fund and LUCAP to spread these care models

3. Develop Intermediate Care

"Maximising Recovery, Promoting Independence" describes a continuum of integrated services to prevent unnecessary admission to acute hospital or long-term residential care, promote faster recovery from illness, support timely discharge from hospital and optimise return to independent living. Partnerships with comprehensive Intermediate Care services are making the most progress in reducing rates of emergency bed days for older people.

Use your Change Fund and LUCAP to provide urgent 7 day access to safe and effective alternatives to admission, and support and care to return home from hospital, or closer to home, without delay.

Supported discharge or rapid response at home by a community team is an important element of Intermediate Care but, delivered without consultant or specialist involvement, is not generally a direct substitute for acute care.

Hospital at Home

Hospital at Home is an episode of specialist care delivered at home as a direct alternative to acute hospital care and where the care is overseen by a consultant / equivalent specialist (eg GPsWI) for a period of days not weeks.

Sasha Shepperd et al published a systematic review of H@H that obtained data from 844 patients in five randomised controlled trials. *CMAJ 2009;180(2):175-82.*

For selected patients, provision of hospital care at home yielded similar outcomes to inpatient care, at a similar or lower cost.

North Lanarkshire ASSET (Age Specialist Service Emergency Team) assess, diagnose, treat and support frail older people within their own home as a rapid specialist alternative to emergency admission to Monklands Hospital. The team take referrals from GPs, Emergency Response Centre (ERC), Emergency Department, Emergency Receiving Unit (ERU) and SAS paramedics.

The service has around 100 new referrals per month and a daily caseload of 10 – 32. Of over 2150 patients managed by ASSET, 76% have been maintained at home **at a cost of £689 per admission avoided**. Mortality is lower than for inpatients.

''I think just being in your own surroundings makes you feel happier and more confident and able to cope''. 'I mean who would want to go to hospital, when they could be treated just as well if not better at home…''

H@H teams are also in place in Fife and West Lothian. More information and case study examples are available on the Hospital at home section of the Intermediate Care Community of Practice.

Design a H@H model to suit your geography and workforce capability.

Step Up / Step Down Beds

A ***Home First*** default promotes Intermediate Care at home whenever it is safe and appropriate. However some people, particularly those who require alternative housing arrangements or adaptations, may benefit from a period of residential / bed based Intermediate Care. This can provide critical time and the right environment to recover confidence and independence, and avoid making premature life changing decisions about future long term care.

All partnerships have housing with care, care homes and community hospitals that may provide local step up / step down Intermediate Care. The required number of beds, location, provider(s) and support for each locality may vary and should be agreed through Joint Strategic Commissioning.

The critical path for making step up / step down beds work well involves:

- Care staff who promote a reablement approach
- GP support for providing General Medical Services
- In reach by specialist practitioners for rapid assessment and diagnosis
- In reach by community nursing, pharmacy and home care team to ensure effective communication, discharge management, anticipatory care planning and medicines reconciliation
- Single Point of Access to improve flow through the beds (eg emergency referral centre for step up) and discharge Hub for step down)
- 'Pull' system to enable people who require continued inpatient rehabilitation or are unlikely to be able to return home within two weeks of being clinically ready for discharge to move to a community bed

Some partnerships have redesigned local authority care home provision to provide short term Intermediate Care assessment beds. For example, Borders published a report on their Intermediate Care beds in Waverley Care Home. North Lanarkshire has commissioned a formative evaluation of their experience in changing two of their residential units to provide short stay assessment and intermediate care beds.

Stirling and Clackmannanshire have redesigned their pathway home from hospital so that no one enters long term care without a period of enablement in step down beds and the opportunity to consider their potential for return home.

Other areas such as Dundee and Edinburgh are working with the independent sector to commission intermediate care beds with certain local providers.

Insights and examples of step up / step down beds were shared in an Intermediate Care learning event in December 2013. These and other case study materials are available on the Intermediate Care Community of Practice.

Do a Day of Care Audit to understand your potential caseload for Intermediate Care and step down beds
Use step down beds to help you deliver no delays over 2 weeks.

4. Screen and Assess for Frailty

Frail individuals have physical, cognitive and functional impairments and are often admitted to hospital with falls, immobility and confusion. They are at high risk of healthcare associated infection, delirium, under-nutrition, poor tissue viability, have longer stays, higher mortality, higher rates of readmission and institutional outcomes.

Comprehensive Geriatric Assessment (CGA) is a coordinated multi-professional intervention for frailty that improves survival and functional outcomes, reduces dependency and delays the need for long term institutional care. **For every 6 frail older people managed in a specialist geriatric ward in contrast to a general ward, there would be 1 less death or care home outcome.** Ellis et al Cochrane review

	Death or institutionalization at up to 6 months	Significance
"Needs" Wards	OR 0.49 (95% CI 0.32 – 0.73)	p=0.0005
"Age Only" Wards	OR 0.83 (95% CI 0.72 – 0.96)	p=0.009
"Needs" Teams	OR 1.41 (95% CI 0.75 – 2.63)	p=0.29
"Age Only" Teams	OR 1.07 (95% CI 0.65 – 1.76)	p=0.8
Overall CGA	OR 0.81 (95% CI 0.71 – 0.91)	p=0.0005

Healthcare Improvement Scotland's: Older People in Acute Care (OPAC) Improvement programme has a specific focus on frailty. Board teams are testing use of a 'Think Frailty' screening tool in order to increase early access to CGA. The next phase will test the concept of ensuring CGA includes a 'frailty five': eg an ACP / DNA CPR conversation; medicines review; falls and fracture prevention; prevention and management of delirium – including zero boarding; and discharge planned and coordinated by a lead professional.

Apply the Think Frailty tool and develop a pathway to access CGA

Lanarkshire g.ellis@nhs.net

ACE nurses identify frail older people and streamline to early inpatient CGA or discharge to Hospital at Home or community services. This has contributed to a 20% reduction in rate of emergency bed days for over 75s from 09/10 – 12/13.

Lothian andrew.coull@nhslothian.scot.nhs.uk

The Elderly Care Assessment Team use a frailty tool to identify and assess frail older people across the hospital and coordinate their pathways through acute care. An ICT application is being tested for systematic identification from PMS data. Rate of 75+ emergency bed days has reduced by 10% from 09/10 -12/13.

Grampian roy.soiza@nhs.net

Frail Older People are identified using the 'Think Frailty' tool and, if they require admission, are transferred for CGA (generally within 4 hours). Audit data suggests only 1 older patient every third day is potentially inappropriately placed on a General Medical Ward. Benefits are due to early MDT intervention, individualised person-centred care, and a focus from day 1 on treatment goals and discharge planning. Compared to the previous pathway:

- Substantial reduction in mean length of stay (7.9 days vs 22.5 days, $p<0.001$).
- 17% of patients discharged within 24 hours and 36% within 48 hours compared to 3% and 9% respectively
- Transfer from hospital to care home fell from 13% to 9%

Ayrshire & Arran Rowan.Wallace@aaaht.scot.nhs.uk

Introduced a Frail Elderly Pathway and MDT assessment for over 65s attending the ED at Crosshouse hospital. 44 of 119 people over 65 years who attended the ED during the initial test of change week were identified as frail and had CGA. 26 of the 44 were discharged directly from the ED, increasing availability of beds in medical receiving unit and improving ED journey times and boarding rates. In the first 30 days of the pilot there were only 2 readmissions.

Community CGA

The benefits of CGA can also be achieved in the community for older people at risk of escalating dependency and future emergency admission. This is an earlier intervention than CGA delivered during an acute crisis by Hospital at Home.
Community CGA should include a similar 'frailty five': an ACP and Power of Attorney conversation; medicines review; assessment for falls risk and for telecare; assessment for carer support; and care coordinated by lead professional.
Some examples of community CGA are

Tayside Enhanced Support at Home and Early Intervention Pilot

A winter pilot of a community MDT (pharmacy, AHP, Nursing, Voluntary Sector, Social Care, GP and Medicine for the Elderly) to provide CGA and coordinated care and support for those identified as at risk achieved:
12% reduction in admissions against 4% increase for non participating areas
26% reduction in mean LOS using 19 less beds per night compared to previous year

Edinburgh's COMPASS (COMPrehensive ASSessment) team

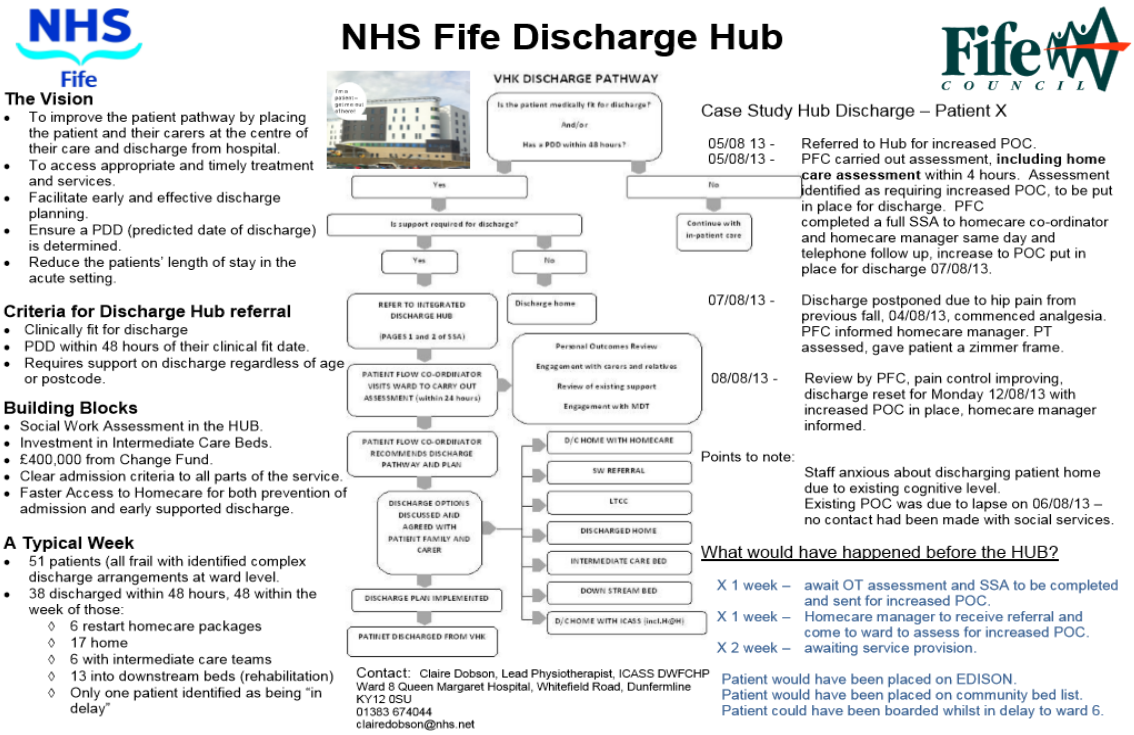
COMPASS identifies frail older people with escalating dependency or at risk of hospital admission and provides more integrated care and better outcomes through:

- a point of contact to discuss with a Medicine of the Elderly (MoE) consultant
- comprehensive assessment in domiciliary, outpatient, Day Hospital settings
- improved communication between community and hospital teams
- facilitating discharge and preventing readmission of patients

Develop comprehensive geriatric assessment in community settings

5. Integrate Discharge Planning

At a learning event in December 2013 NHS Forth Valley and NHS Lanarkshire shared their experience of developing Discharge Hubs as a single point of contact for communication, advice and education to streamline patient flow and discharge from hospital. Fife has also developed a successful Integrated Discharge Hub.



NHS Fife Discharge Hub

NHS Fife

The Vision

- To improve the patient pathway by placing the patient and their carers at the centre of their care and discharge from hospital.
- To access appropriate and timely treatment and services.
- Facilitate early and effective discharge planning.
- Ensure a PDD (predicted date of discharge) is determined.
- Reduce the patients' length of stay in the acute setting.

Criteria for Discharge Hub referral

- Clinically fit for discharge
- PDD within 48 hours of their clinical fit date.
- Requires support on discharge regardless of age or postcode.

Building Blocks

- Social Work Assessment in the HUB.
- Investment in Intermediate Care Beds.
- £400,000 from Change Fund.
- Clear admission criteria to all parts of the service.
- Faster Access to Homecare for both prevention of admission and early supported discharge.

A Typical Week

- 51 patients (all frail with identified complex discharge arrangements at ward level.
- 38 discharged within 48 hours, 48 within the week of those:
  - 6 restart homecare packages
  - 17 home
  - 6 with intermediate care teams
  - 13 into downstream beds (rehabilitation)
  - Only one patient identified as being "in delay"

VHK DISCHARGE PATHWAY

Is the patient medically fit for discharge?
And/or
Has a PDD within 48 hours?
Yes
No
Is support required for discharge?
Continue with in-patient care
Yes
No
REFER TO INTEGRATED DISCHARGE HUB (PAGES 1 and 2 of SSA)
Discharge home
Personal Outcomes Review
Engagement with carers and relatives
Review of existing support
Engagement with MDT
PATIENT FLOW CO-ORDINATOR VISITS WARD TO CARRY OUT ASSESSMENT (within 24 hours)
PATIENT FLOW CO-ORDINATOR RECOMMENDS DISCHARGE PATHWAY AND PLAN
D/C HOME WITH HOMECARE
SW REFERRAL
LTCC
DISCHARGED HOME
INTERMEDIATE CARE BED
DOWN STREAM BED
D/C HOME WITH ICASS (incl.H@H)
DISCHARGE OPTIONS DISCUSSED AND AGREED WITH PATIENT FAMILY AND CARER
DISCHARGE PLAN IMPLEMENTED
PATIENT DISCHARGED FROM VHK

Contact: Claire Dobson, Lead Physiotherapist, ICASS DWFCHP
Ward 8 Queen Margaret Hospital, Whitefield Road, Dunfermline
KY12 0SU
01383 674044
clairedobson@nhs.net

Fife Council

Case Study Hub Discharge – Patient X

05/08 13 - Referred to Hub for increased POC.
05/08/13 - PFC carried out assessment, **including home care assessment** within 4 hours. Assessment identified as requiring increased POC, to be put in place for discharge. PFC completed a full SSA to homecare co-ordinator and homecare manager same day and telephone follow up, increase to POC put in place for discharge 07/08/13.

07/08/13 - Discharge postponed due to hip pain from previous fall, 04/08/13, commenced analgesia. PFC informed homecare manager. PT assessed, gave patient a zimmer frame.

08/08/13 - Review by PFC, pain control improving, discharge reset for Monday 12/08/13 with increased POC in place, homecare manager informed.

Points to note:
Staff anxious about discharging patient home due to existing cognitive level.
Existing POC was due to lapse on 06/08/13 – no contact had been made with social services.

What would have happened before the HUB?

X 1 week – await OT assessment and SSA to be completed and sent for increased POC.
X 1 week – Homecare manager to receive referral and come to ward to assess for increased POC.
X 2 week – awaiting service provision.

Patient would have been placed on EDISON.
Patient would have been placed on community bed list.
Patient could have been boarded whilst in delay to ward 6.

Participants in the workshop described the 'blueprint' for an effective Discharge Hub.

Fully aligned with other health and care services across system
7 day and flexible working times
Co-located multi-disciplinary, multi-agency team with right skill mix and admin
Clear roles, responsibilities and joint policy and protocols
No boarding policy and practice
Electronic sharing of Information and assured data
Modern facilities with good IT – SmartBoard / Laptops/ ipads for staff in Hub
Capacity to access homecare and Third sector support
Immediate access to equipment and telecare
Real time "Laterooms" system for allocating community beds
Proactive management of choice and Adults with Incapacity issues
Case manager and escalation meetings for delays and 'frequent flyers'
Named lead for education of all staff including staff in care homes
Public awareness about quality and safety – and risks of remaining in hospital

A report, digital stories and presentations are available on the Community of Practice

Improve flow through creating a Hub for integrated discharge planning and assessment

Equipment and Adaptations

Quick access to equipment and adaptations is particularly important for timely discharge from hospital. Investing in and creating the infrastructure to deliver effective community equipment and adaptation services is essential to ensure people of all ages can access these when and where they need them. Assistive technology increases choice, improves quality of life, reduces pressure on carers and can reduce demand for other health and social care services, such as home care.

Good Practice Guides

Following publication of the Guidance on the Provision of Equipment and Adaptations in 2009 the Scottish Government and the JIT have developed two good practice guides and self-evaluation tools, covering equipment and adaptations.

Key themes in the guides include:

- governance, finance; and partnership arrangements;
- protocols for integrated assessment and provision across agencies, and
- Store service structure.

- Equipment good practice guide and self-evaluation tool
- Adaptations good practice guide and self-evaluation tool

Joint protocols and policies

Delays in provision of equipment or adaptations often occur due to confusion or disagreement between agencies. By creating joint protocols, partners can clearly define the roles and responsibilities of staff across different services, preventing duplication and delays. For many partnerships the process of developing the protocol has helped breakdown unhelpful historical boundaries that restricted access to equipment (for example enabling a nurse to assess for and directly order equipment that was traditionally the responsibility of a Physio or OT).

The joint protocol has allowed partnerships to:

- expand the range of staff that can directly assess equipment needs.
- expand the type of equipment that different staff can directly access;

Increase the skill base

To deliver effective pathways for community equipment services a wide range of staff across health and social care professions need to develop their competency in the assessment and provision of equipment. A national training pack has been developed by the Scottish group of the National Association of Equipment Providers (NAEP), in partnership with the JIT. The pack includes guidance on the provision of trainers, presentation materials and evaluation. It was issued in 2012 with the aim of improving the integrity and standard of training and quality assurance.

Agree a joint protocol, pathway, and funding for assessment and provision of equipment to strip out waste and delays

6. Build Capacity for care and support at home

Many partnerships are experiencing difficulties in sourcing sufficient capacity to provide care and support at home. Contributing factors include:

- Job seekers attracted to other sectors, particularly if buoyant local economy;
- Pay, training and support in the care sector including zero hours contracts;
- Design of care at home services reducing continuity and job satisfaction;
- Limited use of technology to increase workforce efficiency;
- Lack of investment in developing local Third sector support and volunteers;
- Suboptimal use of the assets of individuals, family and communities

Care Academies and Modern Apprenticeships, in partnership with Skills Development Scotland and local HEIs, may help recruit to the care sector.

Local community groups and Third sector providers, for example, British Red Cross, Royal Voluntary Service, Marie Curie and Macmillan services, can be commissioned to provide practical home from hospital support including:

- Transport home and follow up visits on return home from hospital
- Collection, delivery and return of medicines and equipment

Case study examples can be found at Community Capacity Building JIT website and at Royal voluntary service.org: home-from-hospital

Scottish Federation of Housing Association's Spotlight magazine: highlights examples of integrated housing with care services that are delivered by housing support assistants based in local sheltered housing units. These models make more efficient use of staff who already have trusting relationships with their tenants.

Understand demand for care at home and use assets of all sectors

Releasing Time to Care in the Community (RTCC)

JIT and QuEST are testing use of the Productive Integrated Team tools to support community services to improve efficiency and maximise capacity. These tools may be useful for maximising capacity of care at home services.

Support for Carers

From *2012-13 onwards, at least 20 per cent of the Change Fund is dedicated to supporting carers.* JIT hosted a learning event with Carers Policy Team and national Carer organisations to support partnerships to develop direct and indirect supports for carers - eg carer identification, information, advice and advocacy; emotional support and counselling to prevent carer breakdown and readmission.

Information can be accessed from the carer section on JIT website.

Reablement

A reablement approach to care at home leads to improved health and wellbeing, high client satisfaction and reduced expenditure on ongoing support. The evidence base is well documented in key publications from the Department of Health, Care Services Efficiency Delivery Programme, De Montfort University, University of York, University of Kent and the Edinburgh evaluation commissioned by the JIT.

Reablement is now central to the delivery of home care in most partnerships and continues to evolve rapidly. Services differ across Scotland, depending on the context, but the core features are:

- targeted towards individuals erred for home care support
- delivered by home care staff in the home
- an outcome-focused and time limited intervention
- explicit intention of reducing home care support
- continuous multi-disciplinary assessment for ongoing home care packages
- philosophy of 'helping people do; not do to or for'.

JITs work on Reablement has a focus on Performance – cost; financial tracking; outcome measures and benchmarking - and promoting best practice. Evidence and case studies can be found in the 2013 Report of a survey of Reablement in Scotland.

Rural generic support worker

Communities, social care and health service planners in remote, rural and Island areas are particularly challenged to make best use of their smaller workforce pools and resources to continue to deliver high quality care that meets the changing needs of their local communities. A joint NES and the Scottish Social Services Council (SSSC) report highlighted a growing demand and clear benefits for developing local health and social care support workers.

Remote and Rural Health Alliance (RRHEAL) mapped competency statements and education provision for health and care workers in island settings and compared and contrasted these with a draft job description of a Rural Generic Support Worker (RGSW). The resulting capability framework will interest partnerships aiming to deliver efficient high quality care and meet personalised outcomes.

JIT, RRHEAL and SSSC recently hosted a VC learning event on the contribution of RGSW to delivering local integrated care, creating flexibility within the support workforce and increasing service responsiveness.

The report and additional content is available on the *RRHEAL* education platform

Embed a reablement approach in care and support at home
Work with your OD and workforce leads to explore integrated support worker models to build capacity and resilience in care at home.

7. Assertive management of risk

There is evidence that a prolonged stay in hospital can cause harm through:

- A sense of disconnection from family, friends and usual social network leading to boredom, loneliness, confusion and depression.
- Increased susceptibility to hospital associated infection
- Higher risk of delirium, malnutrition, pressure sores, muscle wastage and falls.
- Loss of confidence and ability to cope at home leading to a premature decision to move to long term residential care
- Distress to the patient, family carer or proxy as they are unable to plan ahead for discharge and may face regular, frequent visits to the hospital.

Older people experience functional decline as early as 72 hours after admission and risk increases every time a frail patient is moved from ward to ward. Each day in hospital increases the risk of an adverse outcome, drives up demand for institutional care and reduces the level of investment that is available for community support.

Home First

A *Home First* ethos promotes early discharge planning, systematic use of Estimated Date of Discharge and reduced time awaiting assessment by a social worker or care manager. All professionals in the multi-agency team are ddiscouraged from making a life changing decision about future care while the individual has still to regain confidence and function. All adopt an assertive approach to managing risk through assessment at home or in a in a more enabling step down setting.

South Glasgow partners developed a pathway to identify individuals who could be discharged home while completing their community care assessment and supported by a flexible range of care including a rapid responder service linked with telecare, assistance with medication regimes, an overnight visiting service, carer support and third sector befriending services. More recent developments in Glasgow include social work practitioner information and resource meetings to streamline processes for assessment at home and the introduction of step down Intermediate Care placements to facilitate post discharge social care assessment

Preventing Falls

Perceived risk of a fall at home influences assessment and is implicated in up to 40% of care home admissions. Yet the highest reports of incident falls is in hospital or care homes. The *Up and About* Pathway (2010) aims to embed a systematic, effective and sustainable approach to the prevention of *recurrent* falls amongst older people in the community. Every health and social care partnership should have a local integrated falls and fragility fracture pathway *in operation* by the end of 2014.
Case studies and tools are available at Knowledge.scot.nhs.uk/falls and bone health

Work with your local falls lead to spread evidence based falls prevention, assessment and response services to reduce risk

Using Technology

A key aim of the *National Delivery Plan for Telehealth and Telecare to 2015* is for Telehealth and telecare to enable choice and control in health, care and wellbeing services for an additional 300,000 people. From analysis of Change Plans, partnerships acknowledge the important role that Telehealthcare can, and does, play in keeping people safe at home, but most are uncertain about how to scale it up.

The JIT, QuEST and the Scottish Centre for Telehealth and Telecare are developing a new improvement programme for 2014/15 to support partnerships to increase the pace of adoption of telehealth and telecare – to understand what to do next; how best to do it; what resources and infrastructure are needed; how to track and measure benefits, share knowledge and promote adoption of improvements.

At March 2013, 114,079 people in Scotland received a telecare – around 80% of those who receive support at home. Remote monitoring is of particular value for people affected by dementia and those who are at risk of falls. Seven partnerships are engaged in the European SMARTCARE project that aims to improve health, care and wellbeing by focusing on the role that ICT can play in the delivery of integrated care. Scotland will include 6,000 >50 people and 2,000 carers in the project with a focus on improving the pathway for people who have had a fall.

United4Health

This 3-year programme for people with heart failure, COPD and diabetes in Ayrshire & Arran, Lanarkshire, East Renfrewshire and Renfrewshire partnerships is the first large-scale phased roll-out of home health monitoring in Scotland. It uses technology to support self-management and for earlier detection of worsening health and early treatment that helps avoid hospitalisation and/or enable early discharge from hospital for patients who can be monitored at home during recovery.

Evaluation from 75 patients involved in the Ayrshire pilot showed:

- *70% reduction in emergency admission* with a cost savings of £29,000
- *26% reduction* in GP appointments
- *86% reduction in ADOC contacts*
- *Respiratory Out Patient contacts almost halved*
- *£25000 saving in associated respiratory health related costs*

Lessons from the Veterans Association in this report from 2020 highlight economies of scale and reduction in hospital utilisation by home monitoring and preventative approaches. These are being developed in Scotland through the Living it Up programme and the 'Light Touch Telehealth' monitoring approach in Lothian. More information is available at: www.sctt.scot.nhs.uk; https://portal.livingitup.org.uk/; http://www.jitscotland.org.uk/action-area/telehealth-and-telecare/ www.knowledge.scot.nhs.uk/telehealthcare.aspx

Embed telehealth and telecare solutions within your discharge pathway to improve safety and reduce risk of readmission

8. Support people moving on to long term care

Moving to a care home is a life changing decision for a person and their family. The potential for recovery and reablement should **always** be fully explored before making a decision on future long term care. If planning is rushed, the process is unlikely to be successful, may have a negative impact on the patient's health and wellbeing and result in inappropriate use of resources. It is also vital that 'choice' of care home is addressed at an early stage and in an effective and sensitive manner.

CEL 32 (2013) Guidance on Choosing a Care Home on Discharge from Hospital provides updated guidance for staff involved in the discharge of patients clinically fit for discharge, and, after all other options have been explored, are assessed as requiring long term care in a care home. The decision to discharge an individual is based on clinical need and must not be influenced by a person's choice of care home or resolution of financial issues.

Local authorities have a duty to arrange placement in a care home of choice, if:

- The accommodation is suitable to meet the person's eligible needs, as assessed by the local authority.
- It will not cost the authority more than it would usually expect to pay.
- The person in charge of the accommodation is willing to provide the accommodation, subject to the authority's usual terms and conditions.
- The accommodation will be available within a reasonable period

Cabinet Secretary for Health and Wellbeing has made it clear that a patient does not have a right to stay in hospital if this is against best clinical practice.

Where the preferred choice(s) of care home is not immediately available, the person will be required to make an interim move to a home with a suitable vacancy while they remain on the waiting list for their first choice. In fact most people opt to stay on in the interim place as they settle when they get to know their surroundings, staff and other residents.

Delays in discharge associated with choice may occur where:

- patient, family or proxy are unwilling to start or engage with the process
- patient, family or proxy dispute the hospital discharge
- patient, family or proxy have chosen a care home that does not have a suitable vacancy and have not identified an interim care home
- patient, family or proxy refuse to move to (or in the case of self-funders refuse to pay for) an interim care home

The Choice guidance provides advice on how to deal with these situations. Guidance should be embedded in a local admission, transfer and discharge protocol and robustly and consistently implemented by all staff. Sample protocols and resources for staff implementing the Choice Guidance can be found at JIT Scotland: delayed discharge area

Build confidence of all staff to consistently apply the updated Choice guidance to support people to move on from hospital without delay.

Assuring Quality in Residential Care

At the most recent Scottish care home census there were 916 care homes for older people in Scotland providing 38,465 places to 33,636 residents (97% in long stay). The introduction of the National Care Home Contract, national care standards and a strong and effective regulatory regime, along with a payment for quality to reward the best performing care homes, has improved the overall quality of care provided.

In its 2012-13 annual report, the Care Inspectorate reported that almost 75% of care homes received a grade of 4 or 5 out of 6 in the Quality of Care and Support. However around 5% of the market operate at grades 1 or 2. Despite some adoption of innovations in care such as myhomelife.org.uk, a collaborative movement focused on personalising practice within care homes for older people, there is much to be done to embed personalisation in the sector.

The Task Force on Residential Care for Older People was commissioned by Scottish Ministers and COSLA's political leadership to set out ideas and recommendations for delivery of high-quality, sustainable and personalised care and support in residential settings over the next twenty years. The report, published in March 2014, envisions three types of accommodation at the heart of the future residential sector:

- an evolution and expansion of extra-care housing;
- a residential sector focused on step-down / step-up care and rehabilitation
- a smaller, more specialised sector delivering high quality 24-hour care for people with substantial care needs.

The broad remit of the Task Force included recommending specific actions to:

- Agree a compulsory risk register, to provide an early warning system for care providers experiencing challenges to the continuity of care – and an associated ladder of intervention to target support from the partnership to work with the provider and to coproduce solutions for improvement and redesign of struggling services;
- Future-proof workforce skill mix and staffing numbers across the care home workforce and develop skills in managing frailty and long term conditions; dementia; intermediate care; self-management; use of technology; palliative and end of life care

Joint Strategic Plans should be a vehicle to bring a commissioning perspective to the care home market and a joint approach to modelling workforce capacity in order to support older people, including those who are resident in care homes, to remain cared for in a homely setting for as long as possible.

Good links must be established across community care and primary, community and acute care and mental health services to maximise the available support and expertise to care home residents and to the people who care for them in the home.

Liaise with local providers and the Care Inspectorate when embargoes to admission are applied - and work constructively together to make the required improvements without delay

9. Understand Adults with Incapacity (AWI) Issues

Current estimates are that up to 25% of general hospital beds are occupied by individuals with dementia. We know that people with dementia:

- are more likely to be admitted to hospital unnecessarily;
- have longer lengths of stay and more complications from the care provided and;
- are more likely to be discharged to care homes rather than return home.

An independent evaluation of a Rapid Assessment Interface and Discharge (RAID) psychiatric liaison service in Birmingham showed a reduction in bed occupancy valued at £3.55 million/ year and in social care costs of around £60,000 per week.

Improving care for older people in hospital

The Promoting Excellence educational framework aims to ensure the workforce has the right skills to work with people who have dementia. Healthcare Improvement Scotland is leading a programme to improve coordinated care for frail older people and people with cognitive impairment in acute hospitals.

This work supports staff to apply screening tools to detect and manage people with dementia or delirium. It is raising awareness of the Adults with Incapacity (Scotland) Act 2000. This provides a range of ways to allow others to act or make decisions for an adult who lacks the capacity to make some or all decisions for themselves.

Early consideration of the individual's capacity to make informed decisions about their future care can avoid unnecessary delays in discharge. JIT has updated the Good Practice Guide for discharging people who lack capacity.

Use your dementia improvement work to help you streamline the discharge pathway for people who lack capacity

CEL 32 (2013) Guidance on Choosing a Care Home on Discharge from Hospital updates guidance for staff on assessing capacity and describes the responsibilities of a proxy decision maker or welfare attorney to ensure:

- Any action or decision taken **must benefit the adult** and only be taken when that benefit cannot reasonably be achieved without it.
- Any action or decision taken should be the minimum necessary to achieve the purpose and the option **that restricts freedom as little as possible**.

In the context of discharge from hospital, assessment of benefit and restrictions must consider the risk of harm and negative outcomes that are associated with delays.

Power of Attorney

One way another person can act for an adult with incapacity is where the adult has granted a power of attorney (PoA). This allows an individual, whilst he or she has capacity, to grant someone they trust the powers to act as continuing financial and/or

welfare attorney, in the event that he or she loses capacity at some point in future. http://www.publicguardian- scotland.gov.uk/forms/power_of_attorney.asp
The process for granting power of attorney is cheaper and quicker than the process for guardianship. Legal aid is available and people over 60 and on benefits can have wills, PoA and Advance Directives competed for free, or at a subsidised cost. Many organisations, such as Alzheimer's Scotland and Age Scotland acknowledge the benefit of appointing a PoA and have advice and factsheets on their websites and signposting through their social media sites and newsletters.

Glasgow City partnership and linked organisations shared PoA information with staff and negotiated a fixed rate fee with a number of solicitors in the Glasgow area:

- £310 per person - this includes VAT of £40 and registration of POA of £70.
- £500 per couple - this includes VAT of £60 and registration of POA of £140

They ran a PoA advertising campaign on STV in December 2013 supported by a Twitter account, Facebook page and website start the Conversation

Start the conversation about PoA in your partnership with staff, patients and carer groups and through Anticipatory Care Planning

Section 13ZA

The *Social Work (Scotland) Act 1968* ("1968 Act") was amended in 2007 to include powers, under Section13ZA, that make it explicit that a local authority, where they have assessed the adult's needs and concluded that they require a community care service but are not capable of making decisions about the service, may take any steps they consider necessary to help the adult benefit from the service.

Build confidence of staff in using section 13ZA appropriately to support people to move on and reduce delays

Guardianship

In most cases, although the adult lacks capacity to take decisions about their own welfare, all interested parties agree with care intervention proposed and it appears that the adult is unlikely to indicate an unwillingness to remain in the proposed care arrangements– such as moving to a care home. In these cases the adult's lack of capacity should not delay them moving on from hospital and an application for guardianship may not be necessary.

In some cases, it may be necessary to seek a court Guardianship Order to provide legal authority for the guardian to make decisions and act on behalf of a person with impaired capacity, in order to safeguard and promote their interests over a period of time (as opposed to intervention orders, which are for one-off decisions). An application can be for a financial and/or welfare order.

- *Guardianship and Intervention Orders* - Making an Application: A Guide for Carers
- *The Adults with Incapacity (Scotland) Act 2000:* A Short Guide to the Act
- Office of the Public Guardian

10. Joint Commissioning and Resourcing

The Delayed Discharge Expert Group considered that recording and managing reductions in the level of bed days lost to delayed discharge is a more accurate whole system measure than number of people delayed at a point in time.

The methodology used attributes bed days to the month(s) when they occurred - the number of bed days occurring in a particular month may then be divided by the number of days in the month to calculate the average number of beds occupied that month by patients whose discharge was delayed. The number of bed days associated with delays includes all code 9 delays and delays less then 72 hours.

At the January 2014 census, two thirds of people delayed were in a community hospital or other community setting. The proportion of delays that are in a community setting is even higher for those who are delayed more than 2 weeks.

Costs of Delays

JIT and ISD developed a tool that estimates for each partnership the average direct costs in each quarter that can be attributed to bed days associated with delayed discharges (Average Direct Cost per Day 2011/12 Costs Book).

- Costs for Standard Delays @ £176 per day
- Costs for Code 9 Delays @ £194 per day

The method used follows the principles of detailed, developmental patient level costing methodology ("PLICS"). The selected direct cost pools medical, nursing, pharmacy, AHP and other direct care. The occupied bed days from the 2011/12 Costs Book SFR5.3 (Inpatients) return were aggregated by specialty/line number across all hospitals in Scotland and the cost per bed day per specialty/line number derived from the resulting totals. A weighted average cost per day was calculated using the proportion of delayed discharges in each specialty as weights.

The proportion of delayed discharge patients by specialty was calculated by taking an average of the number of patients in each specialty across four census points (January, April, July and October 2012) as gathered by ISD's quarterly Delayed Discharge census. This will take into consideration seasonal variation.

There is still some debate on which costs should be included and excluded for a "delayed discharge" cost per day. The Expert group considered it most appropriate to quote the 'gross' cost to the NHS of bed days lost and costed this, in 2011, at £246 per day. That would estimate the gross cost across Scotland for bed days lost in 2013 at £125 million.

The Costs Book team is currently investigating the proportion of total allocated costs that relate to catering, cleaning, etc at a hospital level with a view to potentially applying an appropriate overhead percentage to the calculated direct costs.

Understand where your delays are - and the estimated direct costs associated with these delays

Joint Strategic Commissioning

JIT produced an Advice Note on Joint Strategic Commissioning (JSC), defined as

"all the activities involved in assessing and forecasting needs, linking investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place."

It describes actions for Integration Authorities during their transitional year during which they will have to migrate from current JSC Plans for Older People (and other care groups), to Strategic Plans that incorporate a Financial Plan, relating to all integrated resources by April 2015.

NHS ISD is developing a platform to inform intelligent local commissioning, support decision making on investment and disinvestment, and enable service redesign to support preventative and anticipatory care. ISD will link health and social care data at an individual level to build an understanding of how people use services. This will enable partnerships to understand the drivers behind local variation in patterns of service use, and to plan for more effective use of resources in future.

Improvement Support

JIT is delivering an integration and strategic commissioning development programme supported by a number of tools that include:

- Joint Strategic Commissioning Learning Development Framework
- Success Factors for Integration: Readiness Checklist
- Partnership Outcomes Performance Improvement Tool.

Other supports available from the Scottish Government and partners are:

- Workforce development;
- Financial advice on joint planning and arrangements.

Guidance on the scope of the integrated budget will be finalised by end of 2014. It is anticipated that this will set out the minimum scope of the functions and resources that are to be delegated.

Many partnerships will already use IRF data relating to Health Board and local authority programme budgets for the major care groups. Partnerships can go to www.isdscotland.org/Products-and-Services/Health-and-Social-Care-Integration/ to access the local data profile for their area.

Detailed local authority information that provides the basis for their annual LFR3 return should be readily available and provides a more informative picture of local activity than the annual return itself.

As you develop your JSC Plan, consider the direct costs associated with bed days occupied by delays - and the potential to reinvest this resource in community based healthcare and support.