ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
HDR1
Scheme name
Hospital Discharge - *Joint working to facilitate Hospital discharges from Peterborough and UHL Hospitals*
What is the strategic objective of this scheme?
The service is required to facilitate discharges to the patients home or Step Down provisions to reduce the length of stay for people in the acute setting and reduce the number of delayed discharges from acute hospital settings. This needs to become a seven day per week service.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The scheme requires a hospital based social care worker at Peterborough Hospital and a Link Nurse based within Rutland Memorial Hospital and the REACH team to identify patients within Peterborough Hospital at an early stage and 'pull' patients from the acute setting to a step down facility. This work helps to co-ordinate discharges from UHL and other Out of County hospitals where Rutland residents may be admitted to ensure the optimum use of the available beds at Rutland Memorial Hospital and other local step down facilities.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Peterborough Hospital has been actively involved in identifying patients who will require social care and ongoing health care support following their acute hospital episode. Rutland County Council has identified additional resources required within existing Adult Social Care Service to ensure it can respond to pressure points. The service links closely with the in –house Reablement service (REACH). Rutland Memorial Hospital has identified a link nurse to help facilitate the hospital discharges. Links with UHL pathways work is taking place to align services with the discharge models being established for Leicester and Leicestershire. The Scheme needs to develop step down options and evaluate what model meets the needs and provides the best outcomes for any investment in line with the work being undertaken by the Better Care Together, Urgent Care Workstream. Possible options are to re-model the use of the beds available at Rutland Memorial Hospital; using an existing 'block bed' in a residential home to be used as a step down option with in-reach from health and social care rehabilitation/Reablement services; development of an extra-care resource in one of the local sheltered housing facilities.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Reduce permanent admissions to residential care –
Evidence shows that people who remain in an acute hospital bed for over 10 days have poorer long-term outcomes and are more likely to be admitted to residential care.

Reduce of length of Stay and the number of delayed transfers of care –
A trial of this service over the winter of 2013/14 has demonstrated that the number of delayed discharges were significantly reduced due to the introduction of this service.

Increase the number of people over 65 years still living at home after 91 days –
Evidence shows that people who remain in acute hospitals for more than 10 days have poorer outcomes in terms of their functional recovery. This scheme will therefore enable people to move out of the acute setting in a more timely way thus improving their rehabilitation/Reablement potential and likely hood of them remaining living at home for much longer.

Improved patient/service user experience –
When patients can be moved from an acute hospital to home or a more local setting it improves their emotional wellbeing and can make it easier for their friends and family to be able to visit etc. which can all assist with their experience and outcomes.

Further evidence is available from;
Kings Fund – Making our Health and Care systems fit for an ageing population (2014)

This approach fits with national and local strategies to shift resources into the community and develop the role of primary care and to develop integrated working between health and social care.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Impact	Scheme Assumption
No. of over 65's living at home after 91 days	Scheme will look to track re admission figures
Reduce number of delayed transfers of care	Proactively supports patients to leave hospital without delay
Improved patient/service user	Looks to put in place a tracker to track people who

experience.	have left hospital to see what each patients outcomes are
Length of stay	The scheme will reduce the length of stay through supporting individuals through assessments to ensure quick release from hospital
Cost avoidance	The Local Authority will avoid charges associated with delayed discharges

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Baseline information has been collected relating to patients admitted to Peterborough Hospital through a report commissioned by the Health and Wellbeing Board in 2014. This will assist and inform the evaluation of this scheme.

What are the key success factors for implementation of this scheme?

Factor	Explanation
Partner engagement	The success of the scheme is dependent on appropriately communicating with partners, service users and carers. The team manager within the Adult Social Care team needs to work closely with Partners to ensure pathways are clear and all options for discharge are being explored.
Assessment criteria and tools	The success of the project depends upon successfully identifying Rutland patients within Acute settings and being able to respond with suitable assessment that correctly identify Reablement potential and risk assessment tools. Established criteria and discharge pathways are needed to identify suitable step down facilities.
Monitoring & KPI tools	In order to evaluate the progress of the individual and the success of the project, there must be realistic, measureable and agreed KPIs.
Governance & escalation	Governance is a challenge in any partnership programme. The governance of this programme should enable clear and transparent assessment and escalation of risks. This can be achieved through: Agreement on the KPIs of the programme; Clear routes for issues escalation and resolution; Clear and transparent progress reports; Senior sponsorship from relevant partners; Consistent governance across districts/ areas – the service works within the council and across partners to ensure that lines of responsibility are clear.
Support System & tools	In order for the team to be as successful as possible, there must be appropriate supporting systems and processes in place. Part of the role entails advice and signposting of available community assets. The available pathways to access these services will be a key enabler to this aspect of the role and adequate staffing levels to ensure a seven day service.