Scottish Borders Health & Social Care
Integration Joint Board

Meeting Date: 18 December 2017

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“DISCHARGE TO ASSESS” HOSPITAL TO HOME PILOT

Purpose of Report:	To introduce a new policy of discharging patients from hospital to undertake an assessment of need at home and provide a programme of re-ablement activities to lessen the need for on-going care.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) Agree the extension of the “Hospital to Home” pilot across the Hawick, and Central localities in addition to the Berwickshire locality.
Personnel:	Introduction of a new Hospital to Home Service to work alongside existing programmes.
Carers:	Introduction of a new Hospital to Home Service to work alongside existing programmes.
Equalities:	This policy will target those patients most likely to benefit from an assessment in a specialist discharge to assess facility. The overall policy direction of discharge to assess will apply equally where possible.
Financial:	Further funding bids will need to be considered by the IJB as the Health Board and the Local Authority progress their plans.
Legal:	This proposal is for a trial period over this winter. Depending on the outcome of this test, consultation would be more appropriate in the spring of 2018.
Risk Implications:	A risk assessment will be undertaken through the plans designed to implement the “Discharge to Assess” policy.

Background

1.1 On 8th November 2017, the Integration Joint Board approved papers proposing the issuing of a Direction to NHS Borders and Scottish Borders Council to introduce a policy of “Discharge to Assess.

1.2 As part of the work to meet this new Direction and to support the easing of pressures within secondary care, the IJB agreed to the opening of:

- 6 beds at Haylodge Community Hospital - as step down beds, where patients can be moved from Borders General Hospital (BGH) to await a package of care or a Care Home place.

- up to 15-beds at Craw Wood (Tweedbank) for Discharge to Assess (DTA), where patients capable of giving consent can be moved from BGH, again to await a package of care or a Care Home place.

1.3 The paper also agreed funding of £108k to support the appointment of staff to operate a “Hospital to Home” function to increase the capacity within home care.

1.4 Further work and preparation has been undertaken since this decision, and this paper is requesting the expansion beyond Berwickshire to Hawick and Central Localities. This will allow more patients to be supported, and as well as providing greater care capacity over the winter period, it will offer a more robust sample to test and evaluate the model.

1.5 This paper outlines in greater detail the estimated costs and recommendations to introduce a pilot for Hospital to Home facilities across Hawick, Berwickshire and Central Localities.

Proposal

2.1 The following proposal has been developed, by a dedicated short-life cross Partnership Project Team, for the implementation of discharge to assess facilities within Borders.

2.2 This work is identified as one of the recommendations within John Bolton’s work for the Borders Partnership and NICE guidance also states that; individuals should not be sent directly to a care home from an acute setting.

2.3 To comply with these recommendations and meet the pressures within the Borders hospitals, the partnership needs to reduce demand for care, to a level that existing capacity within home care provision, and the current number of care home beds can provide for.

2.4 The proposed activity will offer the opportunity for individuals delayed in hospital to go home where they will be provided with a “Re-ableing” programme of activities. These will be provided for by a Health Care Support Worker, under the guidance of a District Nurse and/or an Allied Health Professional. It is expected that one member of staff will cater for 2 or more clients.

2.5 These workers and the associated Nursing/AHP teams will support an assessment of the client's needs to determine their improvement and if there are any on-going needs beyond the initial 6 week duration of this work. Should there be a need for a Social Work assessment these will be undertaken by the START social work teams operating through the nearest Community Hospital. These assessments will greatly benefit from the fact they will be undertaken in the client's own familiar surroundings.

2.6 There will be a central management and administration of these teams for the allocation of cases, the coordination of rotas and the introduction of on-going care beyond the 6 weeks on the programme.

2.7 Whilst there will be central management and coordination, the workers will be professionally lead by District Nurse teams in partnership with AHPs. (A range of duties for these workers is outlined within Appendix 1.)

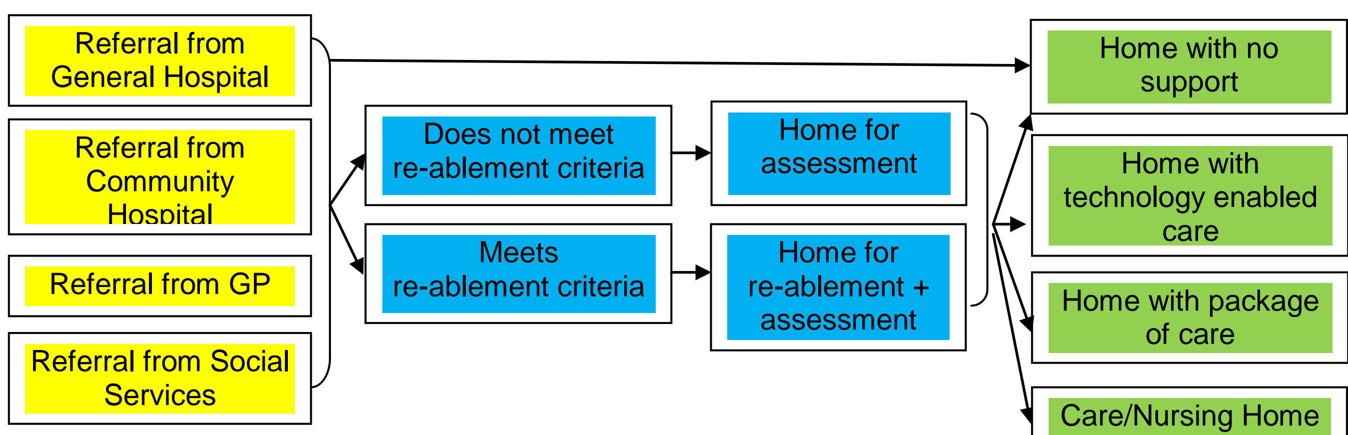
2.8 It is important that this new resource is properly targeted towards those individuals who will benefit from "re-ablement". Strict criteria need to be applied therefore at hospital discharge so only appropriate patients are referred. If such criteria are not adhered to there is a very real danger that patients will stay for long periods of time within programme, thus preventing flow and removing the opportunity for other patients to gain from the resource.

2.9 It is also important that the exit from this re-ablement service is undertaken as soon as the individual has improved within expectations. Whilst this work will ease demands on on-going care, there remains a dependency that such care will be readily available. To this end other work streams need to continue, to maintain the capacity of Care Homes and Home Care commissioned.

2.10 As yet there is little empirical evidence of the success of this type of work, however, experience from other partnerships across the UK demonstrate that we should expect reductions of between 40% and 50% in the size of packages of care required following this intervention. In many cases this work has also completely averted or substantially delayed the need of a care home place.

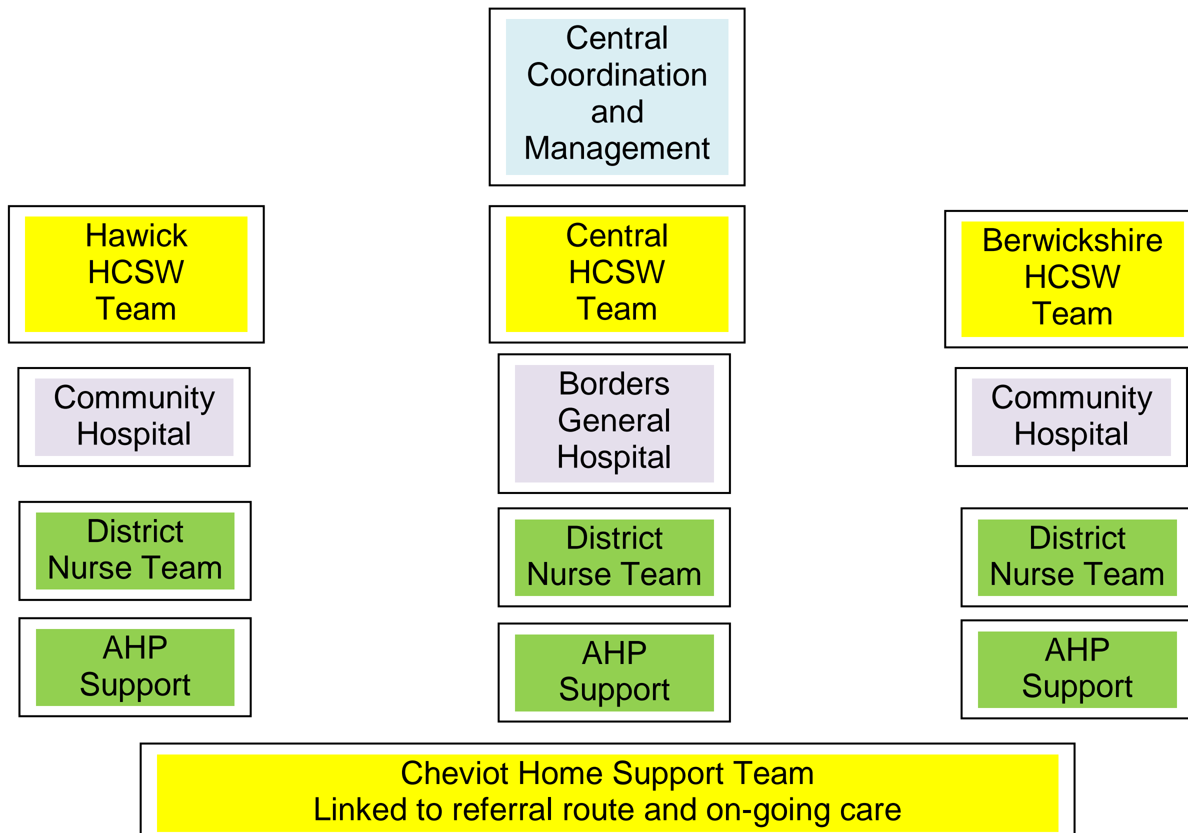
2.11 The evaluation of the re-ablement work will inform the predictions of the demand for care in future years and therefore support the commissioning plans of the partnership.

2.12 Proposed Model



2.13 The majority of individuals currently delayed within hospital are from Berwickshire, Hawick and the Central localities of the Borders. It would therefore be desirable that the pilot should target these areas. It is proposed that 15 Health Care Support Workers are appointed to these areas. Further work will be coordinated with the Cheviot Home Care provision which will be included within the referral routing from BGH and Community Hospitals.

2.14 Existing multi-agency work is being undertaken in the Cheviot Locality which will support the overall programme. The coordination of Hospital to Home will liaise with the Cheviot teams to ensure congruence of their activities.



Costs

3.1 The summarised costs of the options described above are detailed in the following table:

Number of staff	Est. Cost	Operational period
15 HSCW	£124,500	
16hrs/wk B6 Nurse	£5,427	
22.5 hrs/wk B7 Nurse	£9,150	
Supplies	£3,000	
Mobile	£1,500	
Transport	£18,300	1st Jan 2018 - 30th April 2018
Total	£161,877	

3.2 The total cost to implement all three areas, is estimated at £161,877.

3.3 The IJB agreed to support the Hospital to Home work at its meeting in November to the sum of £108,000. The request here is to expand this work across three localities, most challenged with delayed discharge from hospital. The additional funding for this expansion is therefore £53,877. The overall funding envelope already agreed by the IJB at the extraordinary meeting for “Discharge to Assess” actions was £850k. It is proposed that the additional costs of approximately £54k are found within this overall envelope as this work will lessen the needs for surge beds within community hospitals.

3.4 Expected throughput of patients leaving hospital and going through re-ablement is based on a minimum of 3 patients per HCSW every 6 weeks. Over the period of three months, this equates to offering capacity for 255 patients leaving hospital. The cost per patient would therefore be £698.

3.5 The implementation of discharge to assess facilities supports the aim of the Integration Joint Board (IJB) to ensure delayed discharge levels are reduced. The use of Integrated Care Funding (ICF) to pilot this new patient pathway is supported by the partnership Executive Management Team (EMT).

Appendix 1.

Health Care Support Worker

JOB DESCRIPTION

1. JOB IDENTIFICATION

Job Title:	Clinical Support Worker
Responsible to:	Hospital to Home co-ordinator
Accountable to:	Hospital to Home co-ordinator
Department(s):	
Job Reference:	
No of Job Holders:	
Last Update	

2. JOB PURPOSE

In partnership with the registered nurse/HtH co-ordinator, assesses and reviews the patient's personal goal plan, using the patient's individual care plan. Implement the plan of care to ensure delivery of a high standard. Works on a regular basis without direct supervision from a registered nurse.

As part of a multidisciplinary team, the post holder will carry out personal care duties for patients, in support of the registered nurse/HtH co-ordinator and other relevant professional practitioners, where appropriate.

3. DIMENSIONS

To enhance the current care at home services by providing care for medically fit patients, waiting in a hospital bed for a Package of Care and living in the Scottish Borders. This will reduce the patient's length of stay in hospital.

The post includes morning and evening shifts and weekend working. This post requires travelling between patients.

ORGANISATIONAL POSITION

Clinical Services Manager

Lead Nurse

Hospital to Home coordinator

This post

The post is employed within NHS Borders and there will be a requirement to work flexibly across Borders Community and Hospital based services to meet service demands.

5. ROLE OF DEPARTMENT

To provide high quality nursing care to patients with a variety of clinical needs in the community setting, meeting the identified physical and psychological needs. The post holder will, when required, assist the registered nurse/other health care professionals with the management of direct and in-direct patient care.

6. KEY RESULT AREAS

1. To carry out a range of clinical duties with minimal/no supervision, including for example, washing, dressing and getting patient up, preparing meals, prompting with medication, blood pressure monitoring, oxygen saturation levels, body temperature, pulse rate and respiration rate, glucose monitoring (BM Sticks), collection and testing of urine samples/faecal samples/sputum samples and wound/MRSA swabs ensuring delivery of high quality patient care at all times. NB: this list is not exhaustive and will vary depending on area of work.

2. To carry out/administers simple dressings using both sterile and non sterile techniques, as per Treatment Plan.

3. To work in partnership with the Community Allied Health Professionals to promote patient independence.

4. To reorganise/prioritise own workload according to patient need and service needs without direct supervision.

5. To co-operate with and maintain good working relationships with both the multidisciplinary team and other Healthcare and Social Care professionals. Have an empathetic approach to patients, carers and relatives, answering any queries, suggestions or concerns they may have where possible, referring them to the registered nurse/HtH coordinator where appropriate.

6. To maintain up to date written records, reporting and escalating as required, informing the registered nurse/HtH coordinator of any changes or outcomes of clinical interventions undertaken including any observed change in the patients condition. Recording any changes/treatments administered/action taken to comply with local, Professional and Health service standards. Maintain patient confidentiality at all times.

7. To be responsible for ensuring personal on-going training as required, ensuring skills/competencies are maintained.

8. To supervise, in partnership with the registered nurse, new clinical support workers and nursing students in direct patient care.

9. To work within defined standards, protocols, policies and procedures for the community, directorate and NHS Borders including the development of risk assessments to ensure delivery of the highest level of patient care at all times.

10. To monitor stock levels of all supplies, to support and maintain the running of the service in order to promote the effective and efficient use of resources.

11. To participate in clinical audit of services provided to ensure evidence based practice is identified and implemented.

7a. EQUIPMENT AND MACHINERY

The following are examples of equipment which will be used when undertaking the role:

Manual Handling equipment:
Stand-aid, full body hoist, bath hoist, glide sheets, pat slide, banana board

Communication aids :
Telephone, computers, scanners

Medical Equipment :
Glucometer, Blood pressure and temperature monitoring system, blood collection systems, bladder scanner, 12 Lead ECG recording

Other:
Various walking aids, raised toilet seats, electric bath, electrically controlled chairs, wheelchairs, weighing scales, height measurement tool, specialist mattresses, microwave.

This list is not exhaustive

Note: New equipment may be introduced as the organisation and technology develops, however training will be provided.

7b. SYSTEMS

The following are examples of system which will be used when undertaking the role:

TRAK - maintenance of patient records.

Pecos – for ordering stores and supplies

Risk assessments – DATIX

eLearning modules – personal development

Intranet and internet – access to policies

Note: New systems may be introduced as the organisation and technology develops, however training will be provided.

8. ASSIGNMENT AND REVIEW OF WORK

Workload is allocated by the Registered nurse/ HtH co-ordinator. The member of staff is expected to be responsible for planning own workload with minimum supervision/no supervision by the Registered

nurse.

The post holder will receive their work review and annual appraisal from the Registered Nurse.

9. DECISIONS AND JUDGEMENTS

Uses own initiative to assess patient condition, pertaining to both the emotional and physical needs, making recommendations to changes to care plan to the registered nurse, improve outcomes within the bounds of existing knowledge and skills.

Recognising abnormal readings when undertaking clinical observations of patients and escalating these to the registered nurse for advice/action.

10. MOST CHALLENGING/DIFFICULT PARTS OF THE JOB

Undertaking a physically, mentally and emotionally demanding job whilst at the same time taking care to safeguard their own health and safety as well as those of colleagues and patients.

Maintain high standards of patient care within defined resources.

Working with patients who may be distressed, anxious, or terminally ill or have cognitive impairment and communication problems.

Maintaining skills and knowledge level in clinical competencies and core skills.

Travelling between patients in all weather conditions.

11. COMMUNICATIONS AND RELATIONSHIPS

The post holder will communicate on a regular basis with the patient, their relatives, the multidisciplinary team, internal and external agencies involved with the provision of care using effective verbal, non-verbal and written communication

Will communicate proficiently with regards to planning, implementation and review of workload.

Requires to communicate effectively with patients who may be distressed/worried or anxious

Communicate with the registered nurse/ HtH co-ordinator regarding their personal development needs.

12. PHYSICAL, MENTAL, EMOTIONAL AND ENVIRONMENTAL DEMANDS OF THE JOB

Physical Skills

Venepuncture

PC skills

Manual handling skills

Physical Demands:

Manual handling on a daily basis including e.g. safely manoeuvre patients some of whom may be highly dependent, manoeuvring wheelchairs, hoists.

Activities include repeated bending, crouching, and kneeling in restricted areas as well as standing/walking for long periods during the shift.

May participate in resuscitation procedures at the direction of the registered nurse/ambulance staff.

Mental Demands:

Maintaining high levels of patient interaction on a daily basis and concentration required when observing patients conditions and undertaking clinical duties.

Maintaining high levels of concentration on a daily basis when checking documents/case notes and documentary observation whilst subject to interruptions from patients/relatives

Ability to deal flexibly with frequently changing situations and unpredictable events (e.g. falls, patient illness) prioritising demands of clinical and non-clinical workload.

Constant awareness of risk factors.

Emotional Demands:

Communicating with distressed, anxious, worried patients/relatives/carers and supporting relatives/carers following receipt of bad news

Caring for patients who are terminally ill or have a progressive illness

Supporting new staff and learners

Lone worker for the majority of the time when out in the community

Environmental:
Working in conditions, which involve daily exposure to bodily fluids including sputum, vomit, urine, faeces and occasionally wound exudates.

Patient's home environment including pets.

Potential exposure to episodes of verbal and physical aggression from patients/relatives/carers.

13. KNOWLEDGE, TRAINING AND EXPERIENCE REQUIRED TO DO THE JOB

Effective written and verbal communication skills.

Ability to work with people and as part of a multidisciplinary team.

Ability to show initiative, take responsibility and work without supervision on a daily basis.

Organisational and time management skills

14. JOB DESCRIPTION AGREEMENT

A separate job description will need to be signed off by each jobholder to whom the job description applies. Job Holder's Signature: Head of Department Signature:	Date: Date: