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The role of SCH in ensuring timely discharge from Hospital

We play an important role in ensuring timely discharge. We are also in a position to work as a system integrator and innovator. This affords us the ability to bring specialism in to the community, closer to patient's homes and work with our acute trusts to ensure only appropriate patients are admitted and lengths of stay are suitable.

Some of the initiatives we are undertaking are:

- Ensure that only people who require hospital interventions reach hospital. Part of the work we have done here includes leading a new project to bring Interface Geriatrics to Suffolk. We expect to have two consultant geriatricians in post in West Suffolk on 1/10/13 and one in East Suffolk 13/10/13. We are hosting a national recruitment event on 4/12/13 to attract more specialists to the region. We have also invested in a new gold standard system of medical cover across all of our community beds, using only local GP surgeries to care for these patients. This has resulted in an increase in the quality of care and reduction in the lengths of stay in our community hospitals.
- Once people have been admitted to hospital we provide a timely, responsive service to support the smooth process of discharge back to either place of residence or community bed.
- Our Modern Matrons have been tasked to deal with any and all referrals from the acute hospitals within one hour of receipt
- We had our first patient flow meeting with IHT on 18/9/13. Actions agreed include: 1) Identify patients in IHT earlier in their stay 2) Continue to develop the referral form 3) Suggest that non weight bearing patients can be accommodated on a case by case basis
- To tackle issues in a system wide manner our Senior Modern Matron (a recently created post to ensure coordination in this area) will shadow the IHT discharge
- team to better understand how our referrers processes work. In turn the new patient flow manger from IHT will visit our sites and meet our East Suffolk Modern Matrons.
- In West Suffolk we have identified a need and are looking to recruit a band 4 discharge planning coordinator for 6 months plus some additional OT hours

Key challenges in ensuring timely discharge

- The biggest challenge is that no single organisation holds the key – this must be a system wide approach.
- SCH is involved with both East and West CCGs in transformation and winter planning agendas. See below for a brief appendix of our involvement in these agendas (appendix one).
- In addition we meet regularly and have shared action plans with both acute trusts and Suffolk County Council.
- Developing the Community Intervention Service (CIS) to support both the prevention of inappropriate admissions to hospital and in 'pulling' patients from hospital where it is appropriate.
- We are developing processes in conjunction with our acute hospital colleagues to identify those patients who will require community services on discharge as early after admission as possible. This will allow us to plan community intervention either in the patients own home or in a community hospital much earlier.
- Working with our acute hospital colleagues and social care colleagues to establish a comprehensive geriatric assessment process that allows complex patients to be reviewed in any setting including hospital with supporting processes in place for early discharge back to their place of residence with supporting community and or social services.
- Work is underway in our **C**are **C**oordination **C**entre (CCC) to review whether social care input within the CCC would be beneficial. This will allow us to co-ordinate a health and social care response in a more timely way to facilitate discharge.
- Working with Age UK, Suffolk family carers and ACS to provide direct access for CIS staff and timely access to crisis social care support to prevent hospital admission.

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Appendix One

CCG	Transformation Bid	Status
West	2 FTE nurses for community IV therapy	Accepted
West	Patients flow increase nursing beds with cover on a 7 day roster	Accepted
West	2 FTE drivers on 7 days roster to reduce bottlenecks delivering equipment	Decision Pending
West	Double the capacity of the pulmonary rehab team to clear the inherited 300 patient backlog	Not funded
East and West	Telehealth monitoring of long term conditions to encourage self management and avoid admission	Not Funded
East and West	Early Supported Discharge (ESD) of patients using remote monitoring technology	Not Funded
East	Integrated winter pressure proposal – 25 beds with full cover	Not Funded