Committee(s)	Dated:
Health and Social Care Scrutiny – For information	30/10/2017
Subject: Hospital Discharge	**Public**
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Summary

There is a national focus on ensuring that people are prevented from being admitted to hospital needlessly and on making sure that discharge from hospital is timely and efficient. A number of measures are in place between adult social care and NHS colleagues to tackle this issue. The report and presentation illustrate the measures being taken. In addition the unplanned and planned care workstreams of integrated commissioning are developing action plans together. This report includes a presentation on the hospital discharge pathway.

Recommendation

Members are asked to:

- Note the report.

Main Report

Background

1. The emphasis nationally for the NHS and social care is on self-care and preventing the need for hospital admission. The adult social care team will assess people at home to help prevent falls and to provide equipment, adaptations, reablement (home care focussed on building people's independence) and longer term support. The adult team works closely with NHS colleagues in Hackney and neighbouring boroughs to ensure a smooth admission and discharge process. Homerton is the main hospital for Hackney residents although many City residents use the Royal London Hospital and UCLH – so liaison meetings are held with all of these hospitals.

Current Position

2. Measures are in place to ensure that a smooth and timely hospital discharges can occur. These are included in the presentation at Appendix One and are as follows:

    - City of London Corporation adult social care employs a care navigator – a role that works between the team and the hospitals used by City residents. The

navigator is notified of admissions and impending discharges and can arrange the support needed.

- The duty social worker can also arrange support packages for people returning home.
- The reablement team can provide a tailored programme of support for people returning home after a period of illness as well as equipment to assist them getting around the home.
- The City's domiciliary care provider can provide additional home care as needed.
- If there is a need for urgent discharge over the weekend we have services that can provide support as per the pathway for "Reablement plus".
- A "placement without prejudice" protocol is being developed to avoid people staying in hospital while health and social care decide who should be assessing and paying for long term support. This will mean that social care will provide and fund support in the interim but should the person be found eligible for nhs funded support, the payment would be re-imbursed to social care.

3. Through Better Care Fund funded projects and other services, the City of London Corporation aims to maintain its good performance on Delayed Transfers of Care (DTOCs) and contributes to a system wide approach to minimising the number of DTOCs. The City of London has a number of schemes which are key in helping people at the point of discharge, it has also developed a High Impact Change Model (HICM) Action plan based on national best practice.

Implications

4. The actions in the High Impact Change Model action plan are being developed.

5. People will receive a timely and effective discharge from hospital.

Appendices

- Appendix 1 – Presentation on high impact change model and hospital to home

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