Regional Integration Fund - Two-page profile

Hospital Discharge Programme (PR008)

This profile shows the high-level details relates to the annual proposal, monitoring and evaluation, including indicators, performance measures, expenditure and the impact for service users.

Overview/summary of the programme

The programme aims to facilitate seamless transitions for older adults, individuals with dementia, and those with physical and sensory impairments from hospital to community care settings. Supported by core funding from the Local Authority and the RIF, it operates with support from a Team Manager alongside professionals like Principal Social Workers, social workers, and Care and Support Practitioners.

Key elements of the programme include a specialised hospital team providing tailored assessments and support for patients with complex care needs, preparing them for community reintegration. Additionally, a dedicated social work post assists individuals with less complex needs, ensuring comprehensive support across all discharge pathways. The team collaborates closely with hospital-based staff and community partners to coordinate discharge plans effectively.

Central to its operation is the Single Point of Access team, serving as the central hub for receiving and managing all hospital discharges. This ensures streamlined coordination and continuity of care. The programme prioritises patient involvement in discharge planning, aiming to minimise delays and optimise care transitions for improved patient outcomes and caregiver support in the community.

RIF deliverables:

Primary model of care:

Home from hospital

Enablers:

Promoting the social value sector

Integrated community hubs

Workforce development and integration

Priority population group:

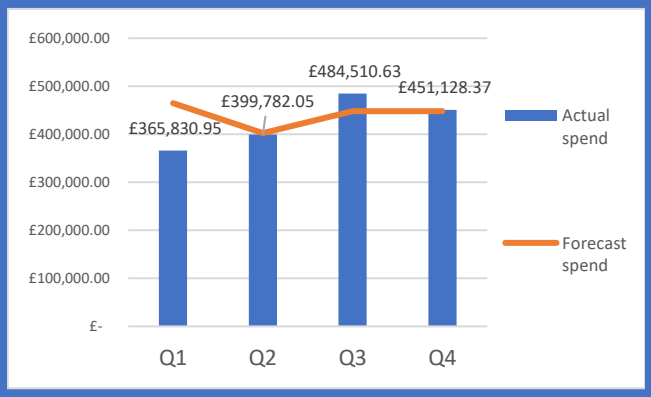
Older people

Regional approach:

The programme is delivered by multiple partners across the region, predominantly from the statutory sector. RIF contributes towards a much larger investment from statutory partners. It is an integrated programme that works closely with partners from across all sectors.

Priority (Linked to Area Plan)
Older people and people with dementia will enjoy good health and wellbeing and supported to live independently for longer.
Older people and people with dementia will receive the support they need to remain in their home for as long as possible, or to move back home as quick as possible following a hospital admission.
People with dementia and their families will have access to the information, advice and guidance that they need.

Project expenditure – £1,701,252 (2023/24 FY)



Projects/partners supporting delivery:

Local Health Board
Local authorities
Community health services
Third sector
Care providers

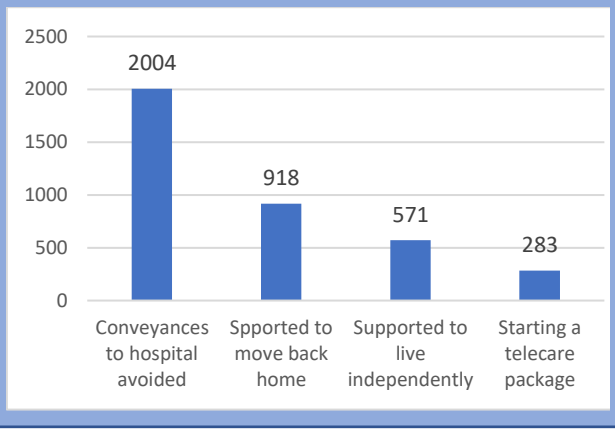
Summary of expenditure:

The funding received from RIF is a contribution towards the delivery of carers support across the region. The funding provided during 2023/24 was fully utilised during the year.

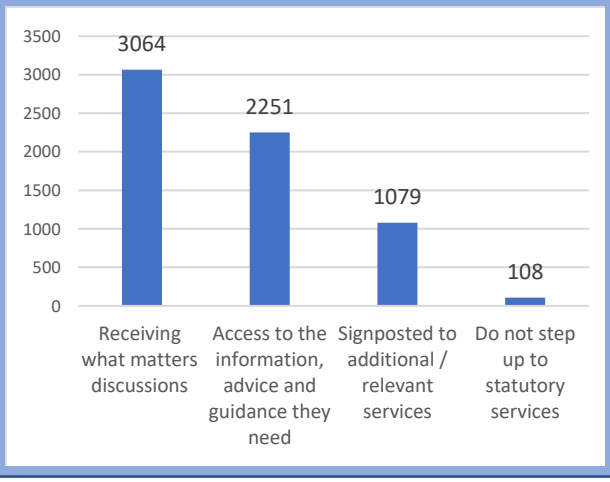
Programme outputs (annual figures):
(includes additional outcome measures)

No of referrals received	4150
No of discharges facilitated	2744
No accessing support / advice / services	2251
No of people supported to improve finances / access benefits	493
No of programmes completed	326
No of people admitted to hospital following a fall (prevention)	31

Programme outcomes: (primary measures)
(Numbers)



Programme outcomes: (primary measures)



Impact of the programme (qualitative):

1. **Empowerment and independence:** The programme has enabled more patients to return home and live independently, enhancing their quality of life. The focus on personalised care plans and early intervention has prevented unnecessary hospital readmissions and supported patients' long-term wellbeing.
2. **Patient and carer satisfaction:** Patients and their families have expressed high levels of satisfaction with the support and information provided.
3. **Improved communication:** Positive feedback from healthcare professionals and patients highlights significant improvements in communication, which have streamlined discharge processes and reduced confusion.
4. **Positive feedback:** Numerous testimonials highlight the programme's effectiveness. Patients and carers have also shared their appreciation for the support received.
5. **Collaboration:** The programme has strengthened multi-disciplinary teamwork, facilitating better understanding and cooperation between health and social care professionals.

Overall, the qualitative impact of the programme is evident in the improved patient experiences, enhanced professional relationships, and more effective discharge

Performance overview: (summary)

The Hospital Discharge Programme has improved patient care coordination and discharge. Key performance measures include 4,150 referrals, 2,744 hospital discharges facilitated, and 2,004 conveyances to hospital avoided. The programme has also successfully provided support and advice to 2,251 individuals, helped 493 people improve their finances/access benefits, and supported 918 people in moving back home.

The integration of the Electronic Transfer of Care Document (E-Toc) and E-Whiteboard has streamlined information sharing and real-time updates.

Positive feedback highlights improved communication and support, although staffing and recruitment challenges have impacted on-site coordination. Capacity constraints in the home care sector and dementia nursing placements caused delays, and cultural changes required for the D2RA process necessitate ongoing training.

The programme's future focus includes refining processes, leveraging technology, fostering teamwork, and continuous training to adapt to new procedures, ensuring improved patient outcomes and efficient health and social care delivery.

Recommendations:

The programme has demonstrated significant positive impacts on patient care and discharge efficiency, evidenced by both quantitative metrics and qualitative feedback. It has addressed critical issues such as reducing hospital conveyances, facilitating timely discharges, and supporting independent living, which are crucial for the overall healthcare system's functionality.

Some potential recommendations to consider:

- Continue to fund at current levels and consider how the programme can be reconfigured (if required) to support the new pathways.
- Consider ringfenced funding for comprehensive training programmes for staff, focusing on new procedures and pathways including D2RA and the use of integrated technology systems.
- Allocate dedicated funding for developing and implementing robust monitoring and evaluation frameworks to track programme performance, identify areas for improvement, and ensure accountability.