Appendix A – WINTER INTERVENTIONS

Summary of winter interventions to support discharge and achieve the following.

- people are supported to return home as soon as they no longer need an acute hospital bed and are supported to make decisions about their future long-term care needs and where they want to be.
- support people to stay at home and remain as independent as possible as long as possible through reablement and care.
- ensure that people's health outcomes improve so more people can live at home for longer, especially if services are designed for discharge home to be the default.
- for those people, where home in not an option we ensure that the assessment of their long-term care needs happens outside of hospital and decisions re long term future care is made with the person and their families.

Measuring Performance

The following targets are used to track progress,

- **Reducing length of stay in hospital.**

  It is recognised that a long length of stay in hospital increases the chance of patients acquiring infections, as well as causing patients to debilitate and become more dependent. There is a target to reduce **by 40% the number of patients staying in hospital more than 21 days.**

NWL Performance – Number of people in a hospital bed by Length of Stay. **(snapshot on first Friday of each month)**	**Dec-22**	**Jan-22**	**Feb-22**	**Mar--22**
LOS over 7 days	1,586	1,727	1,623	1,627
LOS over 14 days	867	1,072	962	965
LOS over 21 days	574	689	646	653

Source: NHS England Weekly Discharge Report

Once Optica, the new information system is in place we will seek to provide borough breakdown and greater detail to allow to understand LA issues.

Continuing Healthcare Targets

- **Reduce the number of CHC assessments** taking place in hospital to **under 15%** [Data to be provided]

- **Reduce the time taken** for long term care decisions to be made so that there is **a maximum of 28 days** between checklist and decision [Data to be provided]

In terms of **reablement** the following indicators are key:

- 85% people (65+) are at home **91 days after discharge** from hospital into reablement /rehabilitation, see table below

WCC				2022-23 Plan	Q1 YTD Actual	Q2 YTD Actual	Q3 YTD Actual
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services			Annual %	89.3%	94.2%	96.3%	94.9%
RBKC				2022-23 Plan	Q1 YTD Actual	Q2 YTD Actual	Q3 YTD Actual
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services			Annual %	89.3%	88.9%	92.5%	93.0%

This measurement below reflects the proportion of those new clients who received short-term services during the year, where no further request was made for ongoing support. Since short-term services aim to reable people and promote their independence, this measure will provide evidence of a good outcome in delaying dependency or supporting recovery.

Reablement Outcomes - WESTMINSTER	**Apr**	**Jul**	**Nov**	**Feb**	**Mar**
% people with no ongoing care (cumulative) Plan 80%	81.5%	76.4%	79.1%	79.9%	

Reablement Outcomes - RBKC	**Apr**	**Jul**	**Nov**	**Feb**	**Mar**
% people with no ongoing care (cumulative) Plan 80%	84.2%	89.8%	88.0%	88.6%	

Programmes

Overnight Care pathway

Additional care and support was commissioned to support people who would have previously been placed in Residential care due to safety issues overnight. The additional support allows people to be discharged home with support overnight until they become more confident and independent.

Although a small number of people have gone through the pathway, approximately 40% have been able to stay at home. Environmental factors, such as the home not being suitable to provide the care, people's need increasing in complexity and meant they were not safe between care calls during the day which was a key criterion for the scheme.

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Pathway 1: (Discharge Home)

Health and Adult & Social Care have been working together to develop a new integrated, steam lined pathway 1, offering a single pathway for all hospital discharges to a person's home, with the focus on a person's assessment taking place outside of the hospital setting. With the outcome of a more time efficient pathway with less duplication, less potential omissions due to transitions of information, greater safety and more appropriate use of reablement resource and less long-term care hours in ASC. This pilot will continue into 23/24 with the aim of increasing the number of people being discharged through pathway 1 and therefore support discharge.

British Red Cross:

This winter the BRC have been commissioned to provide additional capacity to support discharge in the first 72 hrs and also a community wrap around service for 4 weeks post discharge, with the aim to reduce re admissions and support flow (see appendix D).

Pathway 3

Additional capacity has been made available through the discharge to fund to secure care home placements for people with residential or nursing needs. The Local Authority block purchases beds and Continuing Healthcare placements have been made available. Joint work across the CHC and LA teams is critical in ensuring those with primary health needs are assessed in a timely way for Continuing health care and that eligibility rates and conversion rates are monitored.