AGENDA ITEM NO: 18

Report To:	**Inverclyde Integration Joint Board**	**Date: 12 September 2017**
Report By:	**Louise Long Corporate Director (Chief Officer) Inverclyde Health & Social Care Partnership (HSCP)**	**Report No: IJB/40/2017/JA**
Contact Officer:	**Joyce Allan Acting Head of Health and Community Care**	**Contact No: 01475 715283**
Subject:	**Hospital Discharge Performance**	

1.0 PURPOSE

1.1 The purpose of this report is to update the Integration Joint Board on the progress the HSCP is making towards achieving the targets relating to hospital discharge.

1.2 This report focuses on the key performance indicator of people currently in an Acute hospital bed whilst deemed as medically fit for discharge. Reducing the number and length of time people are delayed in an Acute hospital bed continues to be a key priority for the Scottish Government, NHS GG&C and Inverclyde Health and Social Care Partnership.

2.0 SUMMARY

2.1 Inverclyde has a positive record in meeting delayed discharge targets and thus ensuring people spend the minimum time in a hospital bed when deemed fit for discharge.

2.2 With a renewed focus on reducing the number of patients who are delayed longer than 72 hours, Inverclyde HSCP and partners with Acute colleagues have agreed to implement appropriate measures identified in the Home 1st Action Plan 2017/18.

3.0 RECOMMENDATIONS

3.1 The Integration Joint Board is asked to note the sustained performance against the Hospital Discharge Targets, the revised Home 1st Plan and discuss and agree the preparation for recording performance for the forthcoming year.

Louise Long
Corporate Director (Chief Officer)
Inverclyde Health and Social Care Partnership

4.0 BACKGROUND

4.1 As has been previously reported to the Board, performance against the Delayed Discharge target in Inverclyde has been positive for some time, as has the reducing number of bed days occupied for older people. Inverclyde's performance is positive in comparison to other authorities across GGC NHS and Scotland.

In the financial year 2016/17 Inverclyde accounted for 6% of all delayed patients across Scotland. We are the 4th placed authority in terms of least number of people delayed. This performance places Inverclyde consistently second behind East Renfrewshire Council within GGC. This may be expected in terms of size of each authority however it should also be viewed in the context of Inverclyde's levels of multiple deprivation and prevalence of long term conditions.

4.2 Partnership work with colleagues at Inverclyde Royal Hospital continues to demonstrate the effectiveness of early commencement of assessments regarding future care needs in achieving an appropriate, timely and safe discharge. The result is that the majority of individuals are assessed and discharged home as soon as they are deemed medically fit for discharge, including those requiring a home care package and care home placement. To assist in achieving this we have worked to a Home1st plan utilising a range of interventions and building additional capacity which has been funded from existing budgets, local authority pressures monies, the Social Fund, the Integrated Care Fund and Delayed Discharge monies.

4.3 **Performance Targets**

The Scottish Government is now releasing monthly data on numbers of patients at the census date who are viewed as a delay, and the local report will reference the national data as well as locally collated information and experience to ensure a local context.

CHART 1

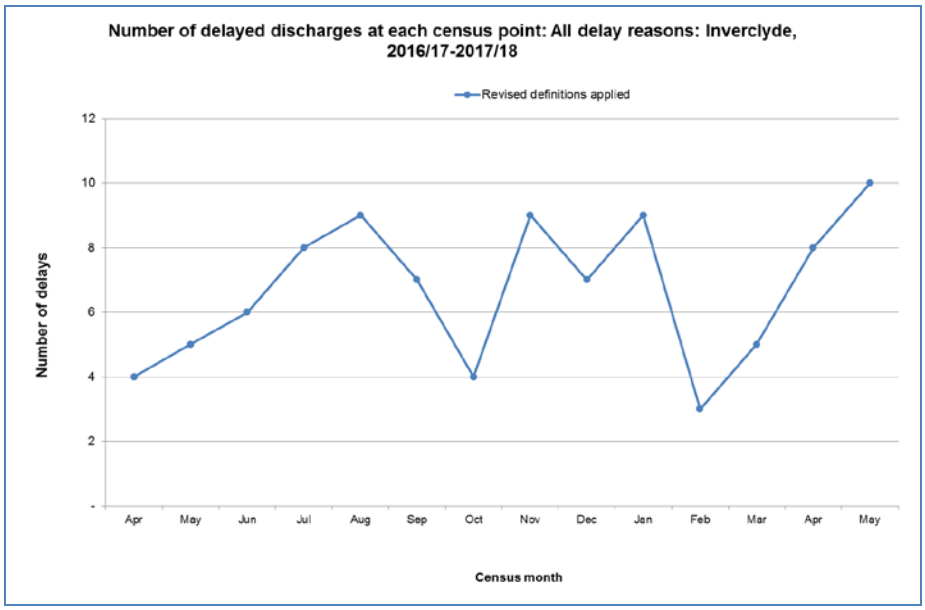
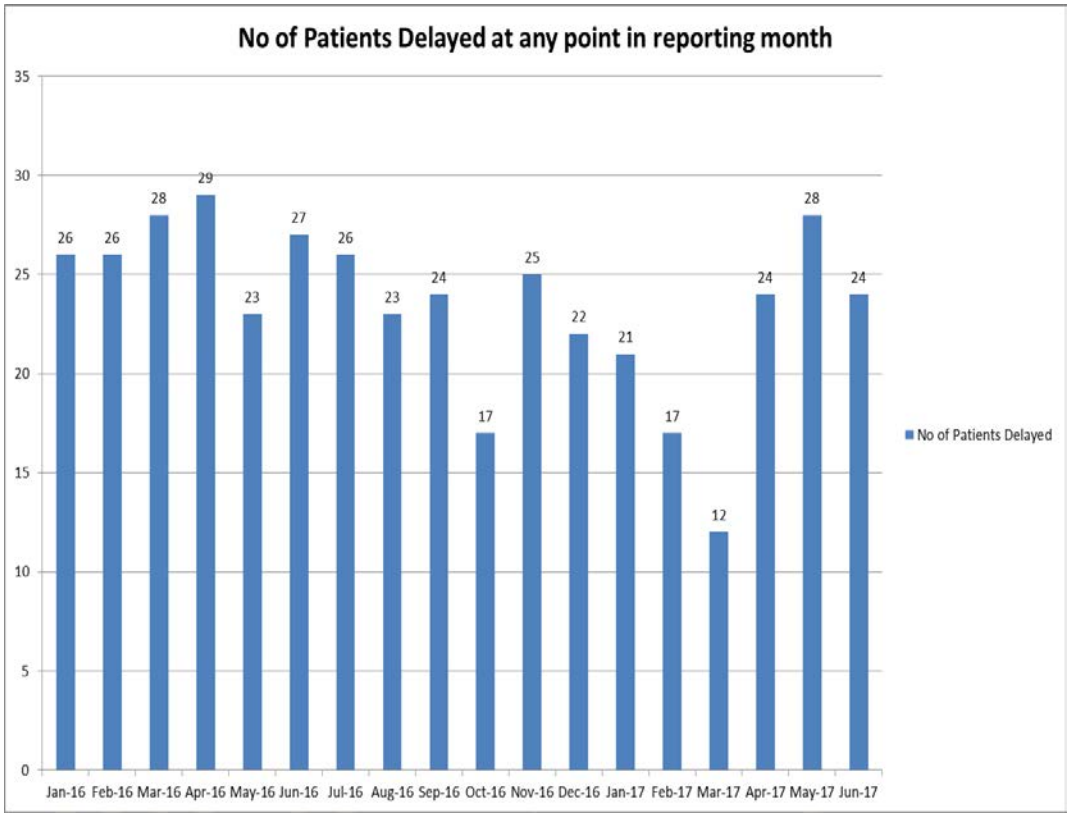


Chart 2 is local data which gives a monthly number of Patients Delayed from 01/01/2016; this demonstrates the wide variance in recorded delays and is dependent on factors such as number of admissions, level of complexity patients and carers exercising choice and how quickly patients move through the hospital pathway.

The usual number (mode) of people delayed on any one day has been between 4 and 6; this local data will allow for reporting on the actual number of individuals delayed each month rather than just at census point.

CHART 2



In April 2015 the Delayed Discharge target was reduced to 14 days; the census return now records a delay as a patient who is in hospital on the last Thursday of each month when considered to be fit to leave hospital.

The Scottish Government has developed a core suite of indicators for Integrated Boards, published in April 2015. Those directly relating to hospital discharge are:-

- Number of days people spend in hospital when they are ready for discharge
- Percentage of people who are discharged from hospital within 72 hours of being ready
- Percentage of people admitted from home to hospital who are discharged to a care home

This data has not been collected in a consistent manner in part due to the information being held on separate systems. As part of the focus on addressing Delayed Discharges we are now in a position of being able to consistently collate and report on these indicators and will start to do so from August 2017.

4.4 **Delayed Discharges: NHS GGC new arrangements from 1st May 2017**

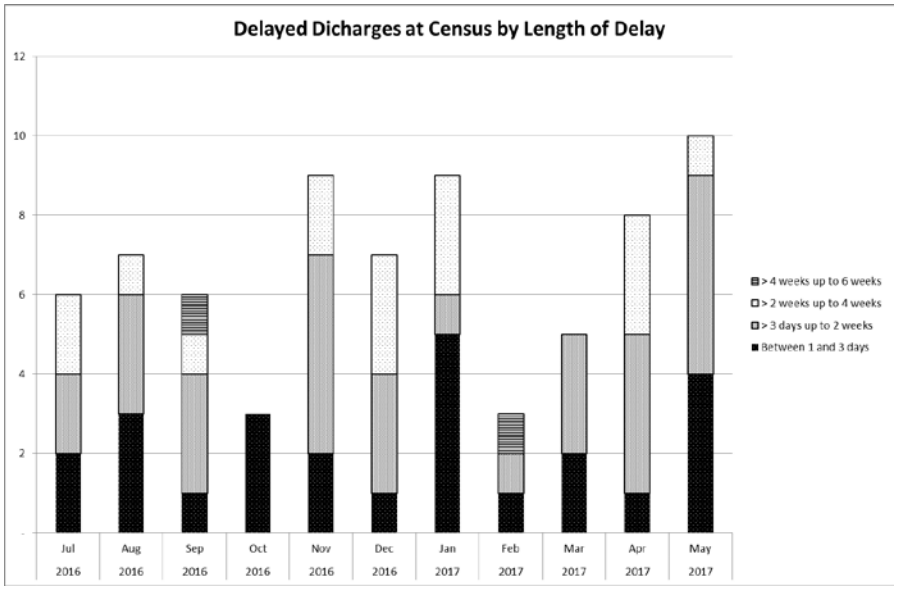
From the beginning of May NHS GGC put in place a target which will establish that all patients are moved from front line acute beds to other facilities once they are viewed as medically fit. This identifies patients who do not have a timely discharge plan in place. The approach has been developed in discussion with NHS GGC Divisional Management Team and with Chief Officers. The ambition target is that no patient will be in an Acute hospital bed when fit for discharge.

4.5 **Bed Days**

Another important factor is the number of days individuals are waiting for discharge - this is the bed days lost figures.

Chart 3 records the total number of individuals delayed at census point and the number of days they were delayed. Generally people at census point in Inverclyde are delayed over 3 days and less than two weeks. This is due to reasons identified in terms of complexity and identification of the appropriate resource in terms of care home placement. No delays at census are due to the inability to provide a home based support package.

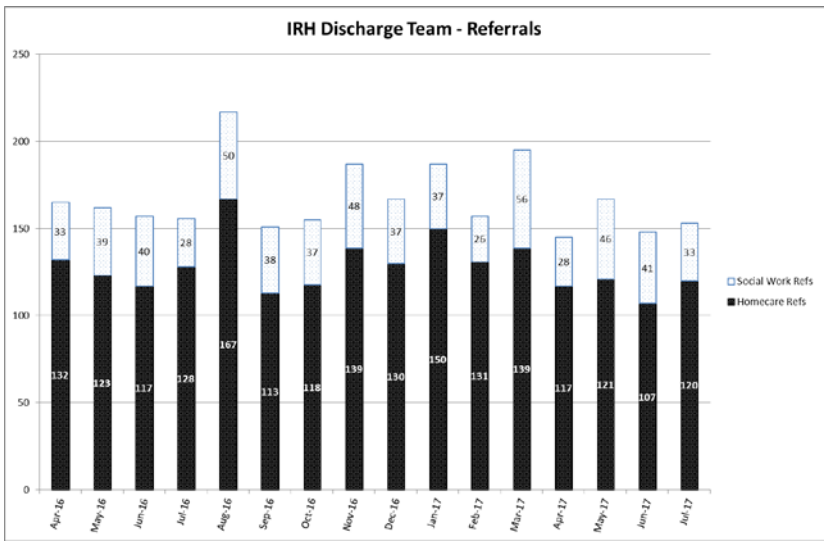
Chart 3



4.6 Demand and Activity

This performance has a context of a continued high level of referrals for social care and community supports following discharge.

Chart 4 demonstrates the referrals from Acute to Health & Community Care.



During May 2017, 153 individuals were referred for social care support of which 46 people required a single shared assessment indicating complex support needs. A total of 8 individuals (at census date) were identified as being delayed following the decision they were medically fit for discharge. This equates to 5.2% of all discharges.

Local data of June 2017 had similar figures; 148 individuals were referred for social care support of which 41 people required a single shared assessment indicating complex support needs.

A total of 6 individuals (at census date) were identified as being delayed following the decision they were medically fit for discharge - this equates to 5.2% of all discharges.

A review of delays as a percentage of referrals was identified for the calendar year 2016 and indicated 97% of service users requiring social care support were discharged within 72 hours of being medically fit.

Future reports will identify actual number of individuals delayed each calendar month as a percentage of total referrals.

The content of this report is mainly for noting, and to ensure that IJB Members are informed about performance in relation to hospital discharge.

4.7 **Home 1st 2017/18 Partnership Discharge Plan**

The positive performance relating to the discharge process has been a result of good partnership working between the Trust and HSCP staff. This work has been underpinned by the Home 1st – Ten Actions to Transform Discharge Approach promoted by the Joint Improvement Team and the Scottish Government's Discharge Task Force. In Inverclyde this has focused on:

- Reduce number of people identified as a delayed discharge.
- Aim to discharge within 72 hours of being fit for discharge.
- Ensure staff are empowered to make changes which improve discharge processes and reduce length of stay.
- Ensure returning home is the first and best option in majority of discharge situations.

This plan has been re-launched for 2017/18 building on the good work in Inverclyde the revised plan is also looking to develop:

- Discharge to assess approach: when an individual is medically fit to be discharged they return home when assessment for future needs is completed by the new Assessment and Reablement Team.

- Review the partnership staff involved in discharge to ensure a smooth patient pathway, early referral for social care assessment and reduce duplication.

- Monitor the impact of the Paramedic Practitioners in Primary Care pilot currently being operated in Inverclyde under the New Ways initiative.

4.8 **Summary**

Inverclyde performance is positive in comparison to other authorities across GGC NHS and across Scotland. Work with colleagues at Inverclyde Royal Hospital continues to demonstrate the effectiveness of early commencement of assessments regarding future care needs in achieving an appropriate, timely and safe discharge. The result is that the majority of individuals are assessed and discharged home as soon as they are deemed medically fit for discharge, including those requiring a home care package and residential care placement.

The intention is to report on the Scottish Government Indicators alongside the published data around discharges on a monthly basis starting in August 2017.

Future reports will account for all patients who are viewed as being delayed with the length of stay identified at each key stage, 72 hours and 14 days. This will be set against a context of all discharges which required social care support on discharge.

Along with colleagues in the Acute sector we will also launch the Home 1ST 2017/18 action plan to ensure services relating to discharge are refocused on the key performance targets as well as ensuring the best outcomes for service users and carers.

5.0 IMPLICATIONS

Finance:

5.1 There are no financial implications in respect of this report.

Financial Implications:

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
N/A					

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (If Applicable)	Other Comments
N/A					

Legal:

5.2 There are no legal implications in respect of this report.

Human Resources:

5.3 There are no human resources implications in respect of this report at this time.

Equalities:

5.4 Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
✓	NO - This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or Strategy. Therefore, no Equality Impact Assessment is required

5.4.1 **How does this report address our Equality Outcomes?**

a) **People, including individuals from the protected characteristic groups, can access HSCP services.**

The hospital discharge process is inclusive in regard to people with protected characteristics, and also has elements within it to ensure the HSCP takes an equalities-sensitive approach to practice.

b) **Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.**

Not applicable.

c) **People with protected characteristics feel safe within their communities.**

Not applicable.

d) **People with protected characteristics feel included in the planning and developing of services.**

The HSCP includes an equalities-sensitive approach to including all groups in the planning and development of services.

e) **HSCP staff understands the needs of people with different protected characteristics and promote diversity in the work that they do.**

Hospital discharge processes and guidance are inclusive of people with protected characteristics. Assessment and Care Management guidance has elements within it to ensure that services and practitioners take an equalities-sensitive approach to practise.

f) **Opportunities to support Learning Disability service users experiencing gender based violence are maximised.**

The hospital discharge processes and guidance apply to adults with learning disability and applies to the work of the Community Learning Disability Team.

g) **Positive attitudes towards the resettled refugee community in Inverclyde are promoted.**

The hospital discharge processes and guidance apply to all adults including those from the refugee community in Inverclyde.

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

5.5 There are no clinical or care governance issues within this report.

5.6 **NATIONAL WELLBEING OUTCOMES**
How does this report support delivery of the National Wellbeing Outcomes?

a) **People are able to look after and improve their own health and wellbeing and live in good health for longer.**

Hospital discharge process is committed to ensuring high-quality services that support individuals to maximise their wellbeing and independence.

b) **People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.**

Hospital discharge process will ensure high-quality services that support individuals and maximise independence.

c) **People who use health and social care services have positive experiences of those services, and have their dignity respected.**

Hospital discharge is an essential element to ensuring high-quality services that support individuals and maximise independence. These principles are important in ensuring that dignity and self-determination are respected and promoted.

d) **Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.**

Hospital discharge is an essential element to ensuring high-quality services that support individuals and maximise independence. These principles are important in ensuring that dignity and self-determination are respected and promoted.

e) **Health and social care services contribute to reducing health inequalities.**

Hospital discharge process supports the outcome of reducing health inequalities.

f) **People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.**

The Carers Act imposes a duty on the HSCP and partners to promote the health and wellbeing of informal carers and in particular around planning of hospital discharge for the cared-for person.

g) **People using health and social care services are safe from harm.**

The HSCP has as its priority to safeguard service users.

h) **People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.**

Staff are part of a programme of ongoing training and awareness around assessment and care management process.

6.0 CONSULTATION

6.1 This report has been prepared by the Chief Officer, Inverclyde Health and Social Care Partnership (HSCP) after due consultation with relevant senior officers in the HSCP and partners in the Acute Hospital Sector.

7.0 LIST OF BACKGROUND PAPERS

7.1 None.