AGENDA ITEM NO: 19

Report To:	**Inverclyde Integration Joint Board**	**Date: 14 May 2019**
Report By:	**Louise Long Corporate Director, (Chief Officer) Inverclyde Health and Social Care Partnership (HSCP)**	**Report No: IJB/32/2019/AS**
Contact Officer:	**Allen Stevenson Head of Health and Community Care Inverclyde Health and Social Care Partnership (HSCP)**	**Contact No: 01475 715283**
Subject:	**Delayed Discharge and Winter Plan 2018/19**	

1.0 PURPOSE

1.1 The purpose of this report is to update the Board on the effectiveness of the Winter Plan for 2018/10 within the context of the HSCP performance around delayed discharge.

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 Inverclyde HSCP and Acute colleagues have been able to sustain a high level of performance minimising unnecessary hospital admissions and facilitating timely and safe discharges responding robustly to the pressures presented by this winter.

Home 1st is a year round approach which successfully manages the health and social care discharge process including seasonal surges in demand

3.0 RECOMMENDATIONS

3.1 The Integration Joint Board is asked to note the effectiveness of the Winter Plan in sustaining positive performance whilst addressing the seasonal pressures presented by winter.

Louise Long
Corporate Director (Chief Officer)
Inverclyde HSCP

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, including the reduction in the number of bed days lost.

Partnership work with colleagues at Inverclyde Royal Hospital continues to demonstrate the effectiveness of the Home 1st approach. The result is that the majority of individuals are assessed and discharged home as soon as they are deemed medically fit, including those requiring a complex home care package or a care home placement.

Over the past 3 years Inverclyde has continued the Home 1st approach across the winter period, ensuring a consistency of approach along with sustained activity around maintaining or returning people to their own home.

Based on learning from previous years, Inverclyde HSCP put in place extra capacity as a contingency measure utilising the transformation fund. This focused on increased assessment capacity within the discharge team as well as Home Care response team for out-of-hours and weekend cover to allow safe discharge over 7 days.

4.2 **Winter Plan 2018/19**

It is acknowledged that this winter has provided exceptional challenges to the Health and Social Care system in Greater Glasgow and Clyde. Though we have not experienced the adverse weather conditions of previous winters, there was a high level of respiratory illness and high rates of acuity amongst the frailer members of our community.

4.3 **What didn't work well?**

There is an ongoing issue around winter pre-planning and agreeing extra resources earlier in year; this will allow for recruitment of staff and putting into place contingency plans. In Inverclyde there was early agreement to release funds from Inverclyde's Transformation Board to cover potential pressures last August however this was still late in terms of implementing plans and the suggestion is to begin planning in early summer to ensure we are ready in time for winter.

There was a move to arranging discharge for earlier in the day, such as mornings. This requires a corresponding earlier referral to Community to allow for confirming that a package is in place. The Inverclyde Interface Group will address this and agree timescales for referral for a morning discharge.

A clear pressure on the service was staff absence which was peaking at around 20% across community services including Community Nursing. This required some remedial action to maximise the operational staff levels and respond to health needs of our service users. Workforce planning is a year round process however the intention is to run a stronger campaign this year around the winter flu immunisation programme as well as having in place contingency to utilise all staff where required.

4.4 **What worked well?**

The emphasis was to ensure continuity and sustainability of existing services across Community and Acute in Inverclyde and to take a measured planned view of 'winter' as opposed to a reactive response. It was noted that it was important to maintain adherence to existing successful procedures and processes, including:

- Early Referral – on admission
- Rapid Assessment Process
- Discharge Planning

- Getting it Right First Time on discharge

Inverclyde HSCP also increased additional assessment capacity at the Discharge Team (IRH) which meant less need to draw in community staff to support discharges and maintaining community services allowing for safe discharge as well as prevention of unnecessary admissions or presentations. This was supported by increase in Homecare capacity around out-of-hours and weekends which allowed picking up discharges including those at weekends or evenings.

With the introduction of Access 1st we also introduced emailing of referrals from Acute to the discharge team. This has increased effectiveness by reducing time taken receiving phone calls by ward staff and the HSCP. The quality of referrals has improved allowing for improved response to discharge requests.

4.5 **Prevention of Hospital Admission**

The Rehabilitation Service has utilised Integrated Care Funding to develop a step up service to avoid Hospital Admission. This is a fast track AHP services to support people with complex needs at home or by admitting to a local care home where the home environment was not conducive to Rehabilitation. There was also increased capacity around step up beds which resulted in 23 admissions that avoided Hospital Stay between December 2018 and March 2019

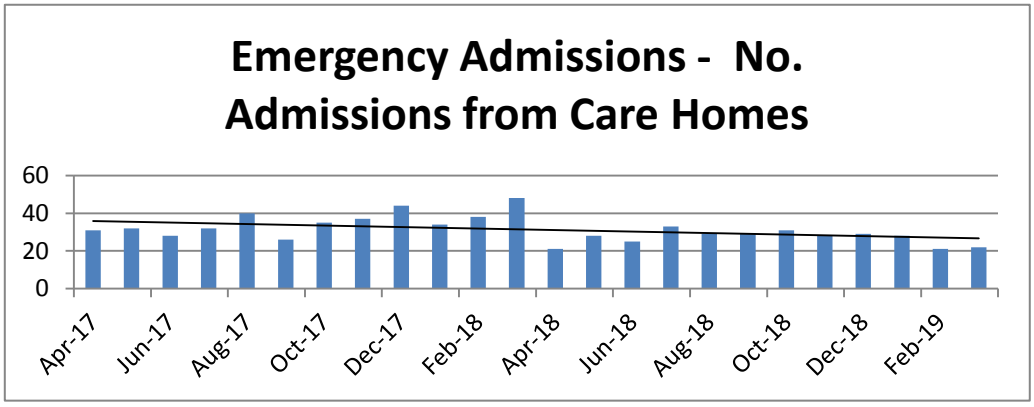
We work closely alongside the Scottish Ambulance Service to provide a fast response assessment and rehabilitation at home to people who have fallen, again to prevent inappropriate admission to hospital.

For the financial year 2018/19 the service enabled 289 people to remain in their own home where a Hospital Admission was being considered.

We based the AHP link worker within the Emergency Department at the Hospital in the mornings to facilitate quicker response as well as increase resource around equipment and rehabilitation service. The service supports people to come home from A&E thus avoiding an admission,

The social media campaign around Choose the Right Service was also run again to ensure that people are aware of the right resource to contact for support around health issues. This campaign will in future cover direct reference to attending ED.

We continued our partnership work with Care Home providers around retaining residents in care home rather than presentation at Hospital This includes work with Primary Care and the Care Home Liaison Nurse. The Winter Flu immunisation programme proved to be very effective in terms of take up by Care Home residents, 80% received the vaccination and this was a factor in low figure (1.2%) of the Inverclyde Care Home residents requiring a period in hospital over the winter.



4.6 **Key lessons and actions**

It is important to continue to plan an all year round response under Home 1st that covers seasonal pressures, surge in demand and ensure continuity and sustainability of approach:

It is important to keep to agreed processes and procedures even at times of high pressure on the system across Acute and HSCP.

We are aware that referrals from ED at IRH account for 34% of referrals to rehabilitation service and believe there is an opportunity to focus upon this area to increase referrals to avoid hospital admission in partnership with Acute colleagues.

Roll out electronic referral to all Wards and ED within IRH which reduces duplication and time taken to process the referrals. It also markedly improves quality of service requests and therefore outcomes for service users

Improved communication through dialogue at the Weekly Winter Planning meeting which allows for earlier identification of issues to allow for a problem solving approach and early resolution.

4.7 **Primary Care**

Along with other services, Primary Care continues to see an increasing demand throughout the year and faces particular demand in winter due to increases in respiratory and viral illness including Influenza. Levels of Influenza have remained around or below the expected baseline this winter with low levels of related primary care consultations. Inverclyde residents and GPs benefit from the support of the wider MDT developed as part of the Primary Care Improvement Plan including in some practices, ANPs and Paramedics responding to unscheduled care home visits meaning those acutely unwell can be seen and treated earlier in the day.

4.8 **7 Day Service**

Inverclyde HSCP agreed to take on the identified issue of a 7 day service in regard to the discharge process. Many community services already work over a 7 day period and the identified issue was around ensuring service were in place in Acute and Community to cover discharge over 7 days if required.

The agreed outcome was to reduce the number of delayed patients over the weekend and these required key actions in Acute and Community. This was supported by the Home 1st approach but also looked at earlier referrals in terms of day of the week and also looking at timing of consultant ward rounds and introduction of criteria-led discharge which would assist in the discharge planning process.

We also worked with Community Service to extend the weekend and out-of-hours service and with local Care Homes who were supportive in accepting weekend discharges. A result was that we increased discharges in the days before the weekend as well as some discharges over the weekend. Over the winter period 2018/2019, we arranged 6 discharges to care homes on a Saturday and Sunday.

It is early in this process to discuss the impact and effectiveness of this development but this will be built into the Home 1st plan and will look to set a firmer process and pathway to be in place later this year.

4.9 **Red Bags**

In a development led by Glasgow City Council, all Care Homes in Inverclyde were provided with a Red Bag. This was to be used to go with any resident admitted to a Hospital setting and would contain clothing medication and essential information relating to the residents health and wellbeing.

Feedback from Care Homes within Inverclyde is that the scheme is useful in reminding staff of everything that requires to go with the resident to hospital and also ensured improved communication between the home and the hospital.

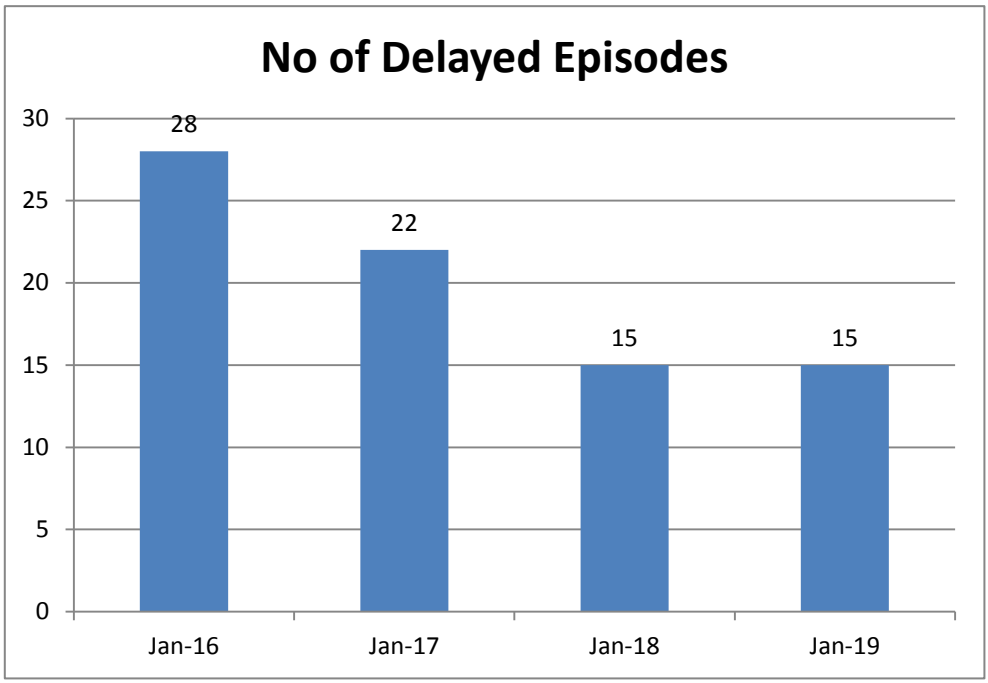
There have been 94 admissions to hospital from Care Homes since the Red Bag Scheme was initiated in November 2018, and only 6 reported issues which covered the bag not returning with the individual to the care home and lack of documentation. However overall, there was a feeling that communication had improved.

The Red Bags Scheme is additional to the current Inverclyde process which is in place around supporting care homes to retain service users and developing the trust which Primary Care and GPs have in the service care homes can provide or level of care needs.

4.10 **Delayed Discharge Performance**

Chart 1 is local data which gives the number of Patients Delayed in any given calendar month from 01/01/2016; this demonstrates how performance has been maintained over the winter period. Comparing the number of individuals delayed during January of each year we see a consistent move down from 28 to 22 to 15 and again 15 in January of 2015.

CHART 1

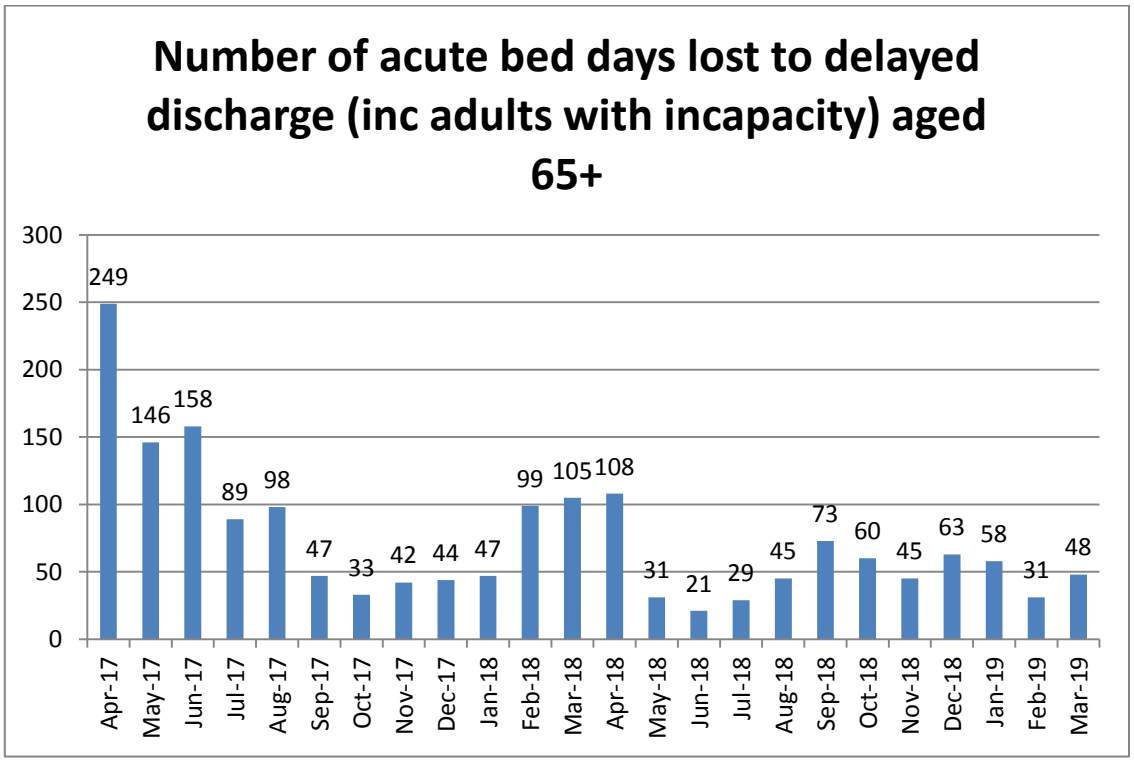


4.11 **Bed Days**

Another important factor is the number of days individuals are waiting for discharge - this is the bed days lost figures. These figures cover all Patients who are delayed including under and over 65 and those with a mental health or wellbeing diagnosis.

Chart 2 presents the statistics for all people over 65 since April 2017 and demonstrates a marked reduction in bed days lost which has been sustained over the winter period.

CHART 2

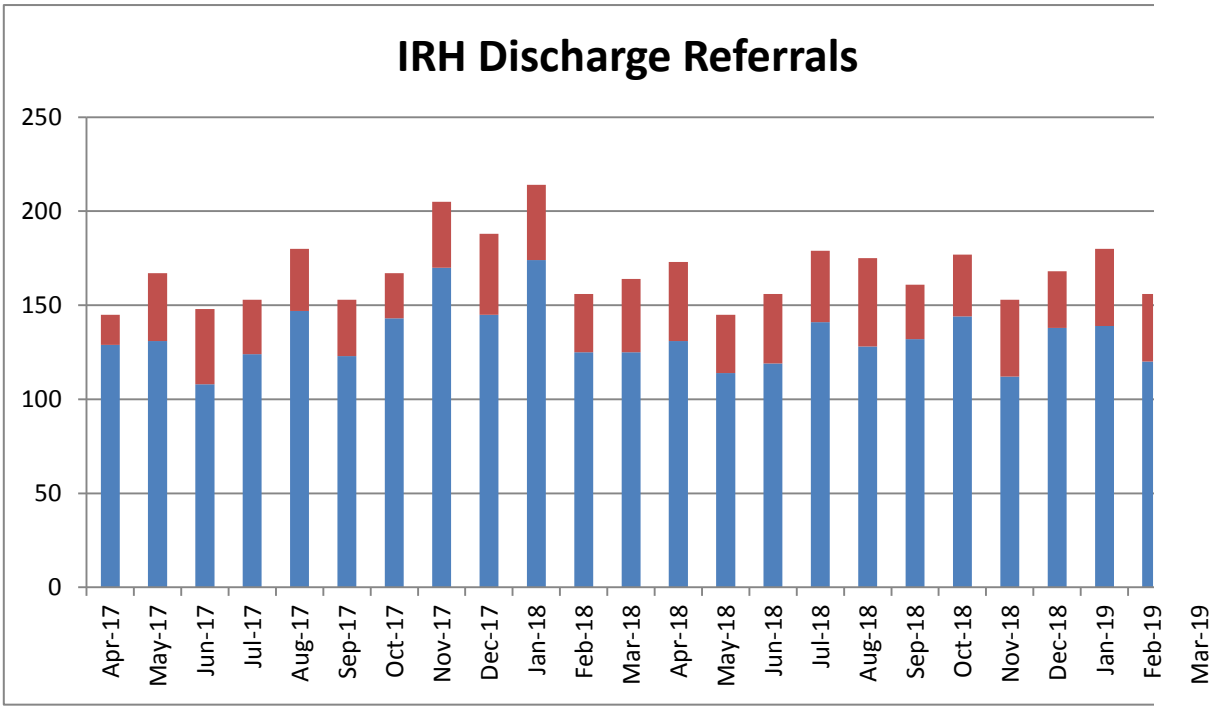


4.12 **Demand and Activity**

This performance has a context of a continued high level of referrals for social care and community supports following discharge. Despite a milder winter and more effective flu immunisation, demand was still comparable to previous years

Chart 3 demonstrates the referrals from Acute to Health & Community Care.

CHART 3



During January 2019, 180 individuals were referred for social care support of which 41 people required a single shared assessment indicating complex support needs. A total of 15 individuals were identified as being delayed following the decision they were medically fit for discharge. This equates to 9% of all discharges requiring social care support.

Local Data for March 2019 indicates that the number of bed days lost for all ages was a total of 48 with 10 people being classed as delayed for that month. This equates to less than 6% of all discharges requiring social care support.

4.13 **Benchmarking across Scotland**

Scottish Government figures allow for some benchmarking against other Partnerships across Scotland. Chart 4 shows Inverclyde is the leading partnership in terms of Bed Days lost in February 2019 This compares well to Chart 5 which shows Inverclyde leading on bed days lost as a percentage of the population.

Chart 4 Bed days lost – February 2019

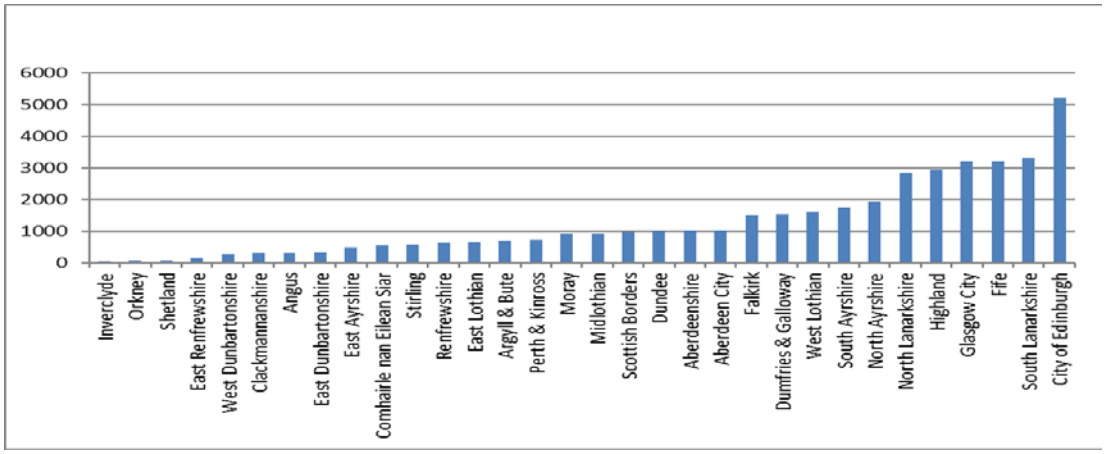
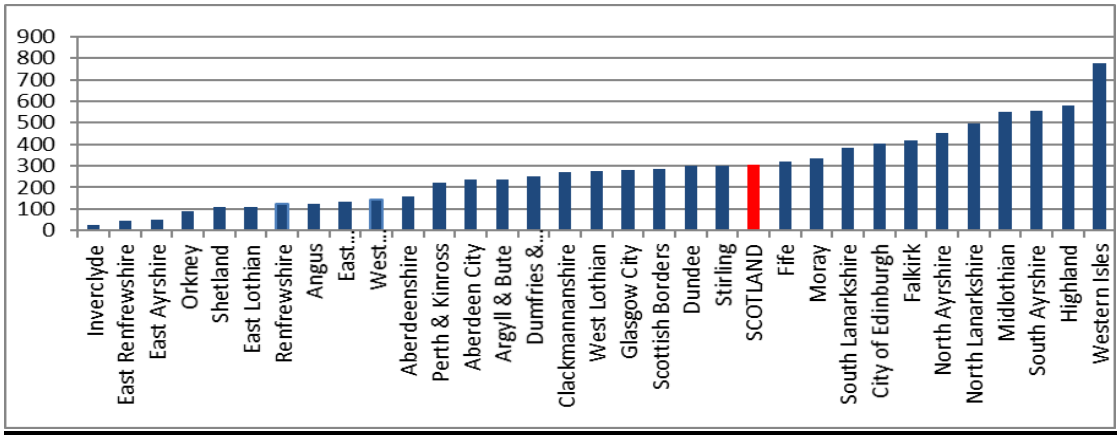


Chart 5 Rate per 100,000 over 75s – weekly data



4.14 **Summary**

The content of this report is for noting, and to ensure that Board members are informed about performance in relation to hospital discharge which was sustained over the winter period. Certainly it would appear that delays and bed days lost had a minimal effect upon the pressures felt by the Acute sector in Inverclyde.

Along with colleagues in the Acute sector, we will also review the Home 1st 2018/2019 action plan to engage fully in the Unscheduled Care Collaborative Planning to ensure services relating to discharge are focused on the key performance targets as well as ensuring the best outcomes for service users and carers.

The Scottish Government has requested a review of local arrangements and Inverclyde HSCP will contribute to this, reviewing the Home 1st plan to ensure additional seasonal pressures are responded to.

There has also been a significant focus around the complexity of health and social care needs ot the people who are supported to return to and remain at home. This is

in part due to changes in NHS Complex Care Guidelines and an increasing older and frailer population.

The current system in Inverclyde is working at capacity and there is little opportunity to take on extra demands associated with winter pressures. Improved community based resources are essential to mitigate the risk around the increase in admissions and additional delays resulting in unnecessary increased demand on IRH. Earlier planning will ensure resources are in place for next winter.

5.0 IMPLICATIONS

FINANCE

5.1 Financial Implications:

One off Costs

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

Annually Recurring Costs/ (Savings)

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

5.2 LEGAL

There are no legal implications in respect of this report.

5.3 HUMAN RESOURCES

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

5.4 EQUALITIES

There are no equality issues within this report.

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 HSCP takes an equalities-sensitive approach to practise.

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.**

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

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

Hospital Discharge and processes and guidance apply to adults with learning Disability and apply to the work of the Community Learning Disability Team.

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

Hospital Discharge processes and guidance apply to all adults including those from the refugee community in Inverclyde.

5.5 CLINICAL OR CARE GOVERNANCE IMPLICATIONS

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.**

The 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.**

The 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 at 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.

7.0 DIRECTIONS

8.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	X
	4. Inverclyde Council and NHS GG&C	X

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.