Inverclyde council

AGENDA ITEM NO: 13

Report To:	**Health & Social Care Committee**	**Date: 26 August 2010**
Report By:	**Robert Murphy Corporate Director Inverclyde Community Health & Care Partnership**	**Report No: SW/26/10/GMcG/JH**
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Subject:	**Delayed Discharge**	

1.0 PURPOSE

1.1 To update Members on the current position regarding people who have had their discharge from hospital delayed after they are considered clinically fit for discharge.

2.0 SUMMARY

2.1 The target set by the Scottish Government for people delayed in hospital beds longer than a six week period after being deemed clinically fit for discharge remains at zero.

2.2 The initial six week period is the expected time required for completion of an assessment of need and the accessing of resources to meet the identified needs.

2.3 A number of categories of people are exempt from inclusion in these figures and these include:-

- Adults with incapacity who are undergoing guardianship application.
- People who will be discharged within 3 days of the figures being collated.
- People with complex needs where there is no suitable facility.
- People who are in facilities that are in the process of reprovision and a service plan and financial plan has been agreed.

2.4 The target of zero delays over six weeks was reached in October 2008 and maintained continually by the partnership until July 2009.

2.5 In August and September 2009 the figures started to increase both in terms of people delayed under six weeks and over 6 weeks.

2.6 The number of people delayed over six weeks ranged from one to six between July and January 2010, returning to zero in February 2010.

2.7 A number of changes in bed configuration have taken place over the past year within the NHS as part of the programme to close Ravenscraig Hospital.

2.8 While every effort is being made to continue to maintain the zero target of people delayed over six weeks, this target is becoming increasingly difficult to sustain.

3.0 RECOMMENDATION

3.1 That the Health and Social Care Committee notes the trends and issues raised regarding hospital discharges and supports this area of work as a key priority.

Robert Murphy
Corporate Director
Inverclyde Community Health & Care Partnership

4.0 BACKGROUND

4.1 The Inverclyde Partnership has performed well in relation to targets set for reductions in delayed discharges over recent years

4.2 The work has been addressed on an ongoing basis, supported by service improvement processes to ensure pathways of care are as good for people either entering care or transferring from one service to another.

4.3 The challenges facing the partnership include the changing demography of the area with the percentage of older people increasing and the number of people of carer age reducing.

4.4 This, along side the changes to bed configuration within the NHS system, has led to many pressure points in the system.

4.5 The opening of a new 90 bedded care home has also added to the financial pressure within the partnership, with additional beds being available and the balance of care moving towards institutional care as opposed to care in the community.

5.0 PROPOSALS

5.1 The partnership has continued to introduce quality improvements across NHS, community and care home services.

5.2 A range of training for care homes has been developed and delivered by a number of Allied Health Professionals (AHPs) services including dietetics, physiotherapy and speech and language therapy. Dedicated pharmacy input also ensures medication reviews on admission to care homes and ongoing support to the homes.

5.3 Telecare services have continued to expand with new equipment becoming available. Training for ward staff has taken place to ensure they refer appropriately for the service when patients are being prepared for discharge.

5.4 Development of telehealth support to people with Chronic Obstructive Pulmonary Disease (COPD) has supported 10 people to better manage their condition and reduce hospital admissions and also reduce the amount of medication required. An in-depth evaluation of this work is currently being undertaken.

5.5 Information Services Division were commissioned by the partnership to carry out an exercise to determine the level of dependency of people living in care homes (Scottish Care Resource Utilisation Groups - SCRUGs). This information will be used to identify support needs for care homes where dependency levels of residents is increasing.

5.6 Training for the use of a dependency measure tool for older people has been developed and rolled out as part of the assessment process to ensure appropriate care options are accessed.

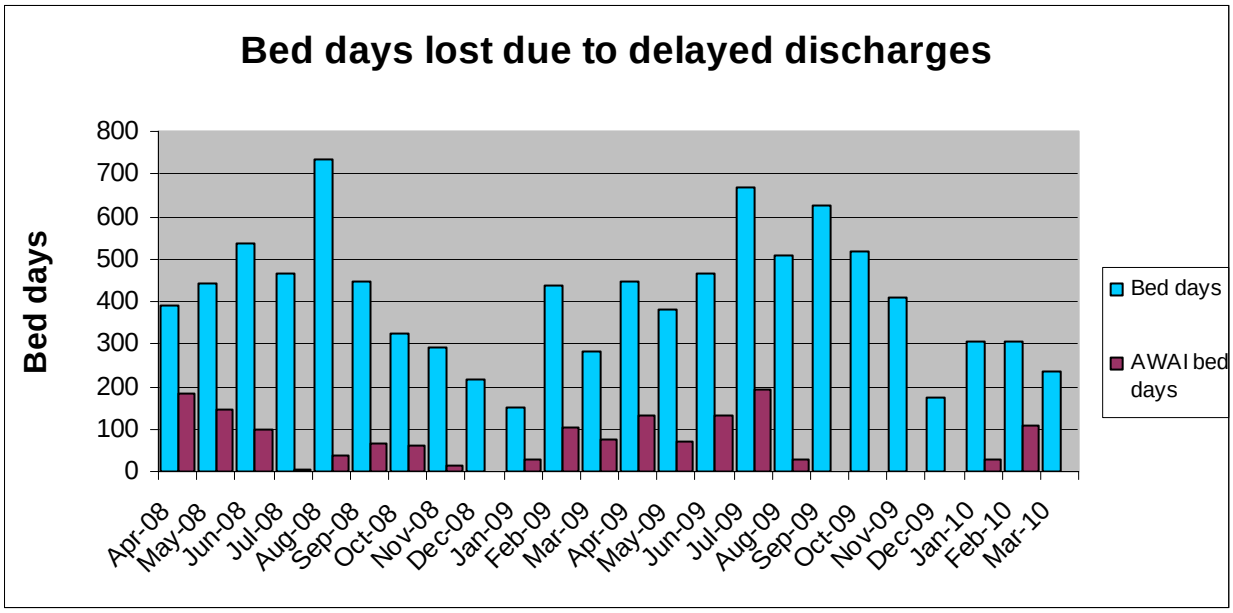
5.7 An information booklet has been developed through the Inverclyde Community Care Forum and will be distributed to people leaving hospital. This leaflet was developed to provide information that people had identified as being required at the point of hospital discharge and includes information on local services and contacts.

5.8 The number of beds available in the NHS system has reduced considerably, with continuing care beds for frail, older people reducing from 51 to 20 and for older people with mental illness reducing from 80 to around 53.

5.9 A redesign of AHPs services is underway as part of the implementation of the Rehabilitation Framework. The outcome of this work should be available by the end of the year, and will link to the wider development of an enablement model of care with services being managed through the Community Health Partnership.

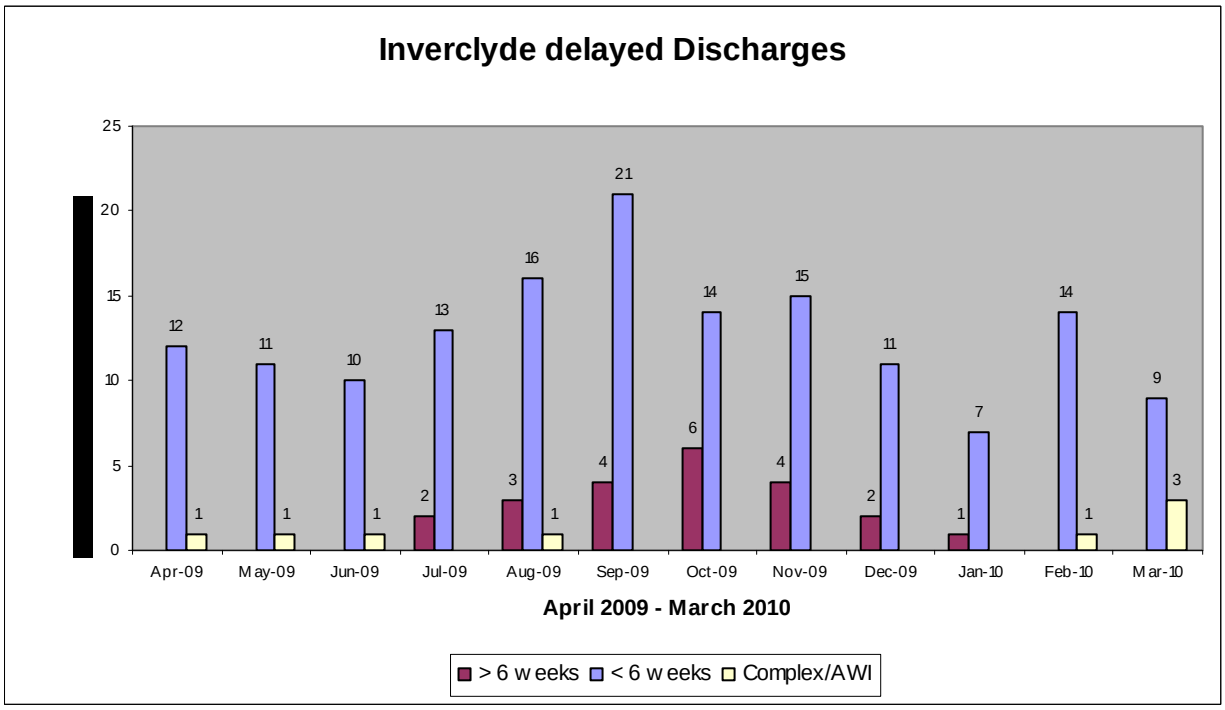
5.10 Bed days occupied by people as they travel through the delayed discharge process have fallen considerably over the past few years, but the level increased from July to October due to a change in the inpatient processes at that point. Below is a chart highlighting the activity. It should be noted that the bed days occupied by adults without capacity are not included in national reporting of delayed discharges while they complete the guardianship application process.

5.11



5.12 The number of people being assessed for discharge within a six week period following identification of a clinically fit for discharge date usually range from between eight and twelve. This figure increased over the months from July, peaking at 21 in September, resulting in a number of delays longer than six weeks.

5.13



5.14 The number of people delayed over six weeks returned to zero in February 2010 and has remained at this figure since then.

5.15 An NHS inpatient Rapid Improvement event was carried out in June within the Rehabilitation and Assessment Directorate looking at the patient pathways to ensure the most effective systems were in place to support the hospital discharge and referral process. This resulted in the acceleration of discharge times with the number of assessments for care packages increasing considerably. This can be clearly seen in the above graphs.

5.16 A working group was established at the point where the zero target was not obtainable. A number of actions were identified through this group that could have contributed to the increase in reportable delays for the partnership. A draft action plan was developed to begin to address the issues raised. Appendix 1

5.17 The pooled budget attached to the joint commissioning plan for delayed discharges has also been scrutinised, with priority being given to safeguard the expenditure in care costs. This has resulted in the termination of a number of infrastructure posts and also the removal of an annual allocation of £50,000 for the joint equipment store.

5.18 The partnership will be actively taking some of the redesign work forward through their involvement with the National Shifting the Balance of Care Improvement Framework, which acknowledges the need to agree local priorities and also recognises the need to achieve sustainable improvements within existing budgets.

5.19 A review of care at home services will focus service on a re-ablement approach following hospital discharge. This should result in a number of people regaining their independence following intensive input from both NHS and local authority services.

5.20 The strict prioritisation of allocation of care home placements will continue to ensure the balance of care is maintained and that people are not inappropriately admitted to care homes on discharge from hospital while at the same time controlling the limited resources available to support an increased number of people coming through the system.

5.21 The proportion of older people in the Inverclyde community will continue to grow therefore pressure will increase over time on the processes across the agencies. Continued monitoring and redesign of services will be required to accommodate these pressures while at the same time achieving the zero target.

6.0 IMPLICATIONS

6.1 Legal:

6.2 Finance:

Cost Centre	Budget Heading	Budget Year	Proposed Spend this Report	Virement From	Other Comments

6.3 Personnel:

6.4 Equalities:

7.0 LIST OF BACKGROUND PAPERS

7.1 Appendix 1 – Delayed Discharge Action Plan.