AGENDA ITEM NO: 6

Report To:	**Community Health & Care Partnership Sub-Committee**	**Date:**	**26th February 2015**
Report By:	**Brian Moore Corporate Director Inverclyde Community Health & Care Partnership**	**Report No:**	**CHCP/19/2015/BC**
Contact Officer:	**Beth Culshaw Head of Health & Community Care**	**Contact No:**	**01475 715283**
Subject:	**Update on Delayed Discharge Performance**		

1.0 PURPOSE

1.1 The purpose of this report is to inform the Sub-Committee of the changing target for delayed discharge and the local actions underway to address this.

2.0 SUMMARY

2.1 The delayed discharge target reduces from 4 weeks to 2 weeks on 1st April, 2015, reflecting the ongoing strategic commitment to Shifting the Balance of Care.

3.0 RECOMMENDATIONS

3.1 Members are asked to note the changing target and range of initiatives in place to achieve this.

3.2 Members are asked to note that they will receive further details of progress against the target in due course.

Brian Moore
Corporate Director
Inverclyde Community Health & Care Partnership

4.0 BACKGROUND

4.1 For some time it has been recognised that consistently achieving safe, timely and person centred discharge from hospital to home is a key indicator of quality and a measure of effective and integrated care.

This is embodied in the Scottish Government's vision:

"Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting.

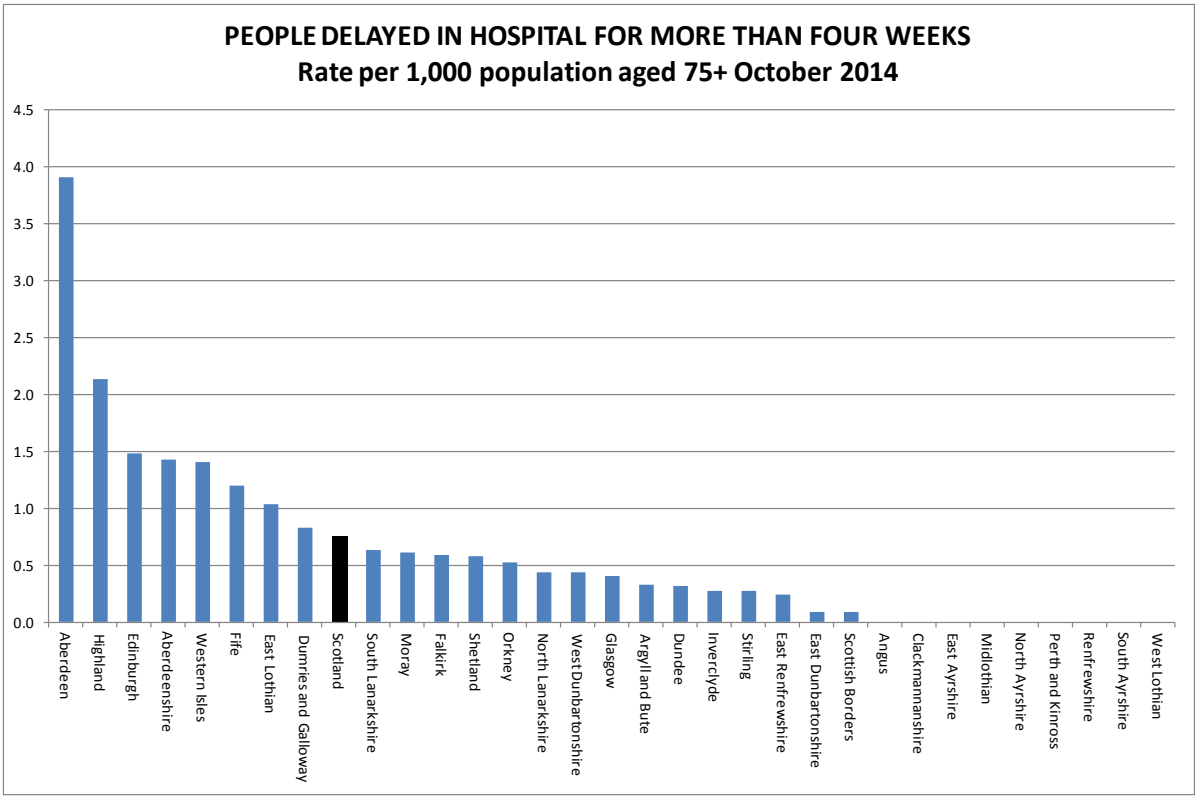
- We will have a healthcare setting where we have integrated health and social care, a focus on prevention, anticipation and supported self management.
- When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm.
- Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions.
- There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission."

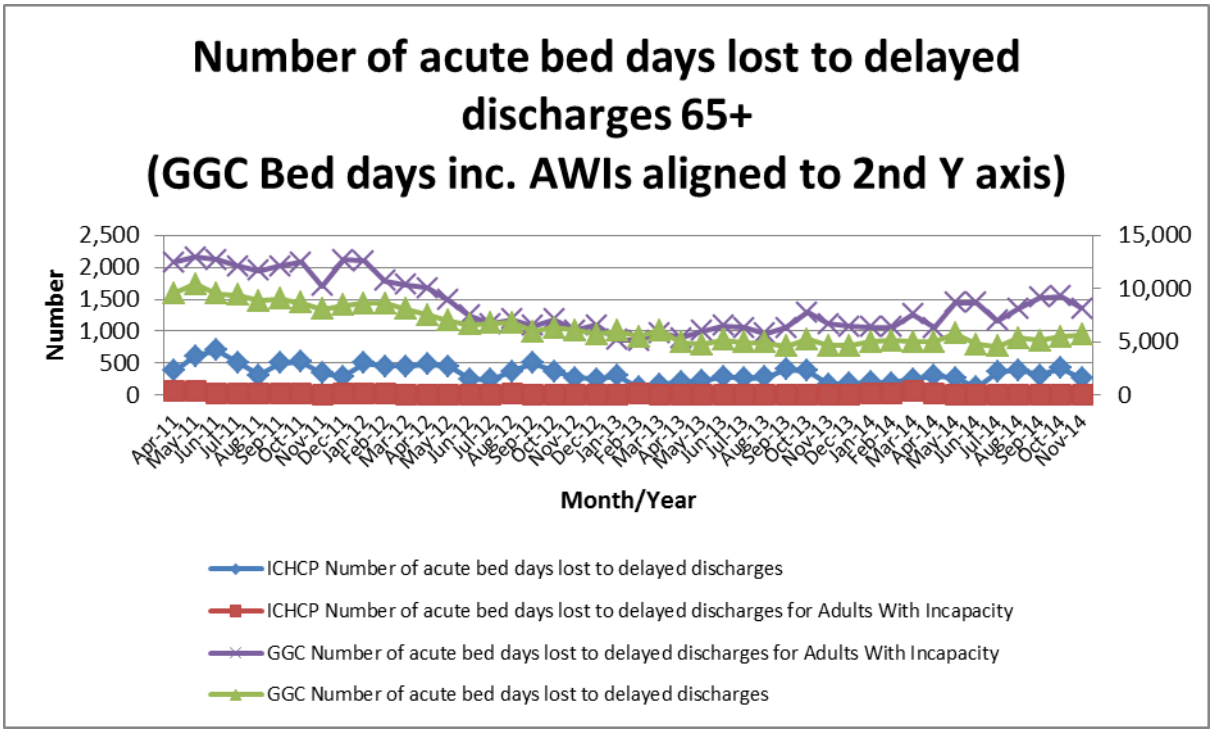
4.2 Potentially, being in hospital disconnects people from their family, friends and social network, and can result in a sense of isolation, loss of confidence and depression. Visiting hospital for a long period may heighten an already stressful situation for family carers, and older people can experience functional decline as early as 72 hours after hospital admission. Extended stays in hospital may increase the risk of an adverse outcome for individuals, may increase the demand for institutional care, therefore increasing the costs associated with ongoing care.

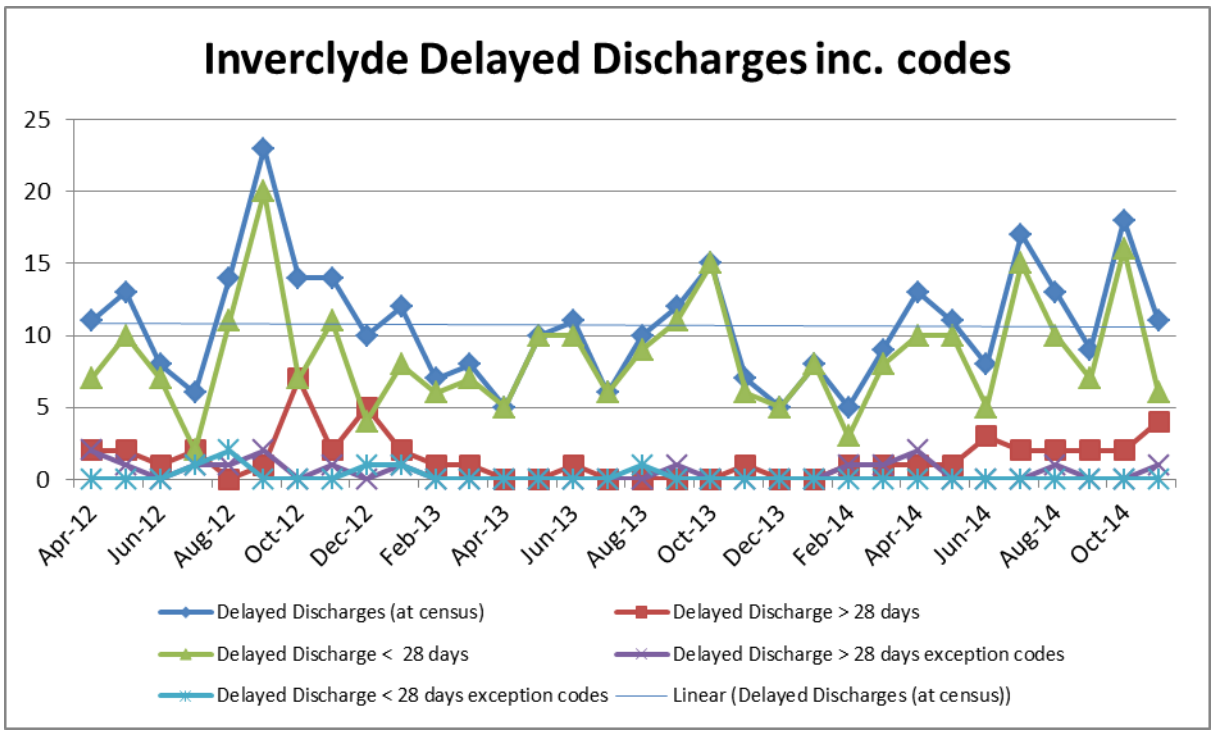
4.3 In recognition of the detrimental effects of delayed discharge, and to ensure appropriate organisational focus, for a number of years, performance in this area has been subject to both targets and scrutiny. In April, 2013 the target for people to be delayed in hospital following multi-disciplinary agreement that they were fit for discharge, reduced from 6 weeks to 4 weeks. In April, 2015 the target will decrease from 4 weeks to 2 weeks. In addition to the target, for some time scrutiny has also surrounded the number of bed days occupied by delayed discharges to provide a more complete picture of the impact of hospital delays. Going forwards, it is suggested that we also focus and measure the proportion of patients discharged within 72 hours of being ready for discharge and the associated bed days.

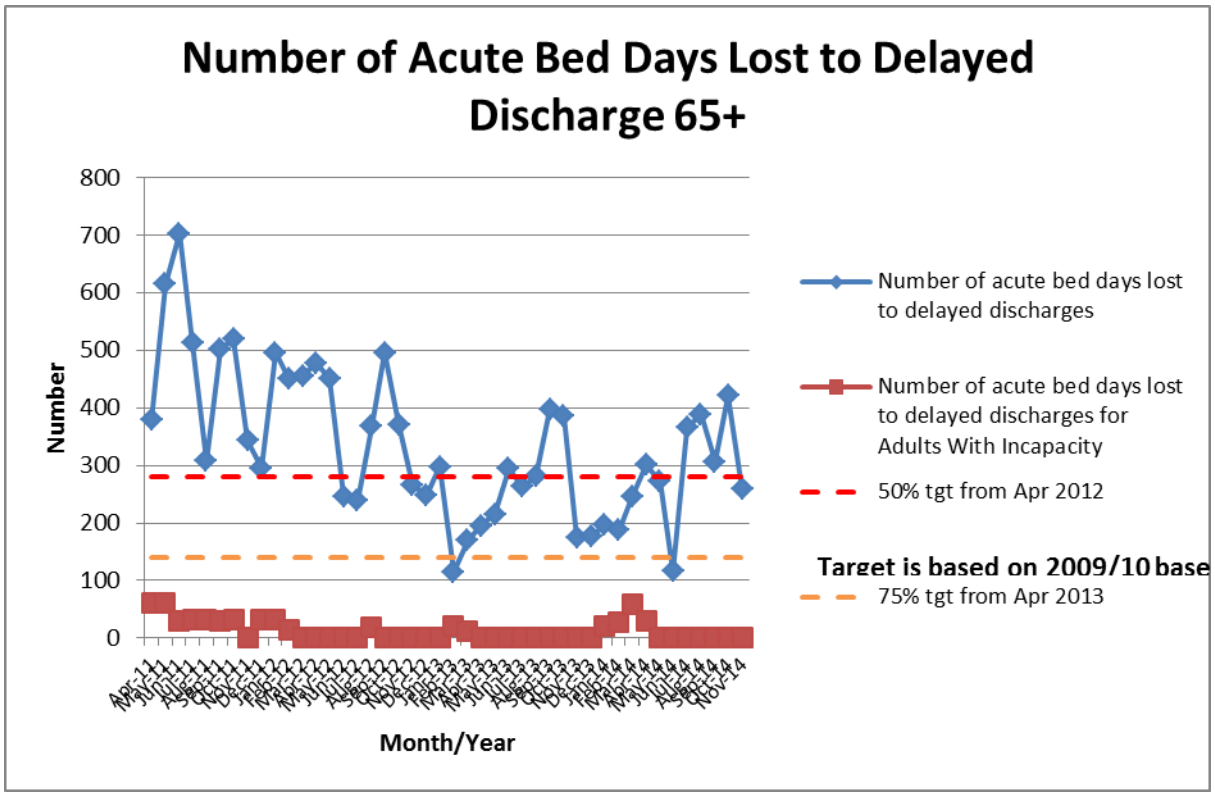
5.0 PROPOSALS

5.1 Performance against the delayed discharge target has proved to be both challenging and variable across Scotland.


PEOPLE DELAYED IN HOSPITAL FOR MORE THAN FOUR WEEKS
Rate per 1,000 population aged 75+ October 2014
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
Aberdeen
Highland
Edinburgh
Aberdeenshire
Western Isles
Fife
East Lothian
Dumries and Galloway
Scotland
South Lanarkshire
Moray
Falkirk
Shetland
Orkney
North Lanarkshire
West Dunbartonshire
Glasgow
Argyll and Bute
Dundee
Inverclyde
Stirling
East Renfrewshire
East Dunbartonshire
Scottish Borders
Angus
Clackmannanshire
East Ayrshire
Midlothian
North Ayrshire
Perth and Kinross
Renfrewshire
South Ayrshire
West Lothian


Number of acute bed days lost to delayed discharges 65+
(GGC Bed days inc. AWIs aligned to 2nd Y axis)
Number
2,500
2,000
1,500
1,000
500
0
15,000
10,000
5,000
0
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Month/Year
ICHCP Number of acute bed days lost to delayed discharges
ICHCP Number of acute bed days lost to delayed discharges for Adults With Incapacity
GGC Number of acute bed days lost to delayed discharges for Adults With Incapacity
GGC Number of acute bed days lost to delayed discharges





5.1.1 Within Inverclyde we continue to work in a variety of ways, across organisational boundaries, to support the vision of Shifting the Balance of Care, to prepare to achieve the 14 day delayed discharge target and to increase the number of patients discharged within 72 hours of becoming fit, and critically to avoid admission to hospital in the first place.

5.1.2 We have completed the re-organisation of Assessment and Care Management Teams, to ensure social workers are organised as a dedicated resource to address the pressures of fluctuating demand in hospital discharge. The variability of demand requires continual focus: recently on a Friday there were 9 delayed discharged, by the Monday increasing to 23.

5.1.3 We are utilising hospital systems to progress discharge prior to someone becoming delayed,

reviewing daily hospital admissions to identify existing care users and anticipate needs at discharge.

5.1.4 We have introduced a District Nurse Inreach service, to collaborate with primary, secondary and social care, facilitating early and seamless discharge.

5.1.5 We are about to increase our overnight community alarm responders, to support more people overnight in the community, through toileting, repositioning and general care. This will both avoid hospital admission and reduce risk in people's own homes, avoiding the need for admission to care homes.

5.1.6 We are finalising an option appraisal to agree a way forward on the use of Intermediate Care beds, likely to lead to the introduction of "Step Up Beds", i.e. to use to avoid hospital admission rather than facilitate discharge. This reflects our ongoing positive performance in relation to delays, and the multi-disciplinary view that admission avoidance will require greater resources. To successfully develop this area will require close working with GPs and care providers in particular.

5.1.7 We continue to analyse the processes supporting admission and discharge, to identify bottlenecks and improve patient flow, with a strategic workshop planned for February, including stakeholders from Primary, Secondary and Social Care.

5.2 For many years in Inverclyde we have worked locally across organisational boundaries, building effective mutually supportive relationships between primary, secondary and social care. This has been particularly apparent since operating as an integrated Community Health and Care Partnership.

Detailed analysis of our performances over a number of years demonstrates that we have made significant progress in reducing the impact of delayed discharges. At the same time, we have introduced a variety of techniques to avoid hospital admission and believe this is an area requiring further focus. Consensus locally is emerging that whilst we may benefit from the development of Intermediate Care beds, these should adopt a "Step-up" role, with admissions directly from the community, rather than a "Step-down" role, with admissions directly from hospital.

5.3 The complexities and risks in this service area cannot be underestimated. We need to be realistic as to what is both achievable and demonstrable. Our data and performance management are consistently becoming more comprehensive. However the particular target of 72 hours discharge requires careful consideration and management. Realistically, for those patients moving towards care homes, with complex family discussions, care assessment and care home selection, 72 hours is a challenging target.

Additionally a crude target in relation to numbers of delayed discharges, simplifies this complex issue. In recent years the rate of hospital admissions has been seen to rise as older frailer people are maintained at home, requiring shorter more frequent admissions as their conditions exacerbate. Therefore we need to consider the number of delays and bed days lost, within the changing landscape of our demographics.

5.4 It is recognised that the improvements in performance required are at a time of increasing pressures, both from service demands and reducing resources. To assist, a variety of non-recurring monies have been provided over a number of years, including the Reshaping Care for Older People Change Fund, Winter Pressures Monies, the Integrated Care Fund and Delayed Discharge Funding.

The funding is particularly important at this stage for Integrated Joint Boards as it will provide some financial flexibility to support the establishment and consolidations of new relationships at a time when local authorities are under significant financial pressure.

6.0 IMPLICATIONS

Finance

6.1 There are no specific financial implications from this report. All activity will be contained within existing budgets.

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

6.2 None.

Human Resources

6.3 Staff affected by the reorganisation of the Assessment and Care Management Teams have been advised of the proposal and there are no Human Resource implications.

Equalities

6.4

Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
√	NO -

Repopulation

6.5 None.

7. CONSULTATIONS

7.1 All staff affected by the reorganisation of the Assessment and Care Management Team have been consulted with. The Inverclyde Delayed Discharge Plan is jointly developed alongside our partners in NHS Greater Glasgow and Clyde.

8. LIST OF BACKGROUND PAPERS

8.1 None.