Inverclyde council

AGENDA ITEM NO: 3

Report To:	**Health & Social Care Committee**	**Date:**	**23rd April 2015**
Report By:	**Brian Moore Corporate Director Inverclyde Health & Social Care Partnership**	**Report No:**	**SW/04/2015/C**
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 update the Sub-Committee on progress towards achieving the target for Delayed Discharge from April 1st 2015.

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 progress towards achieving the target and the ongoing work to maintain performance.

Brian Moore
Corporate Director
Inverclyde Health & Social 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.

4.2 From April 2015 the current target which has been in place since 2013 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 forward, 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.

4.3 Performance towards the new delayed discharge target continues to be challenging however we have recently seen a reduction in the number of acute bed days lost particularly for those over 65 years of age (chart 1) and in both the number of delayed discharges and the length of time which individuals are delayed. (chart 2)

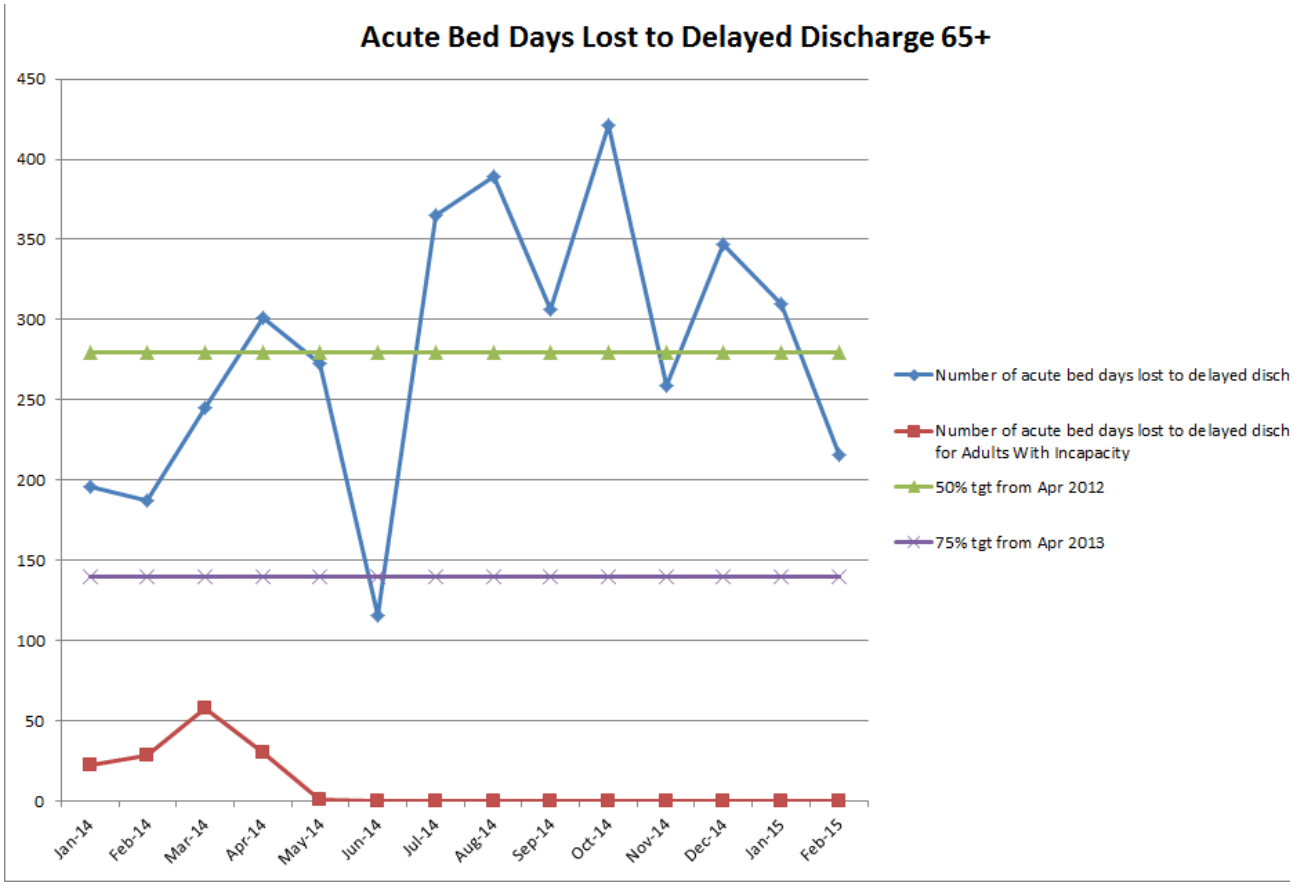

Chart 1

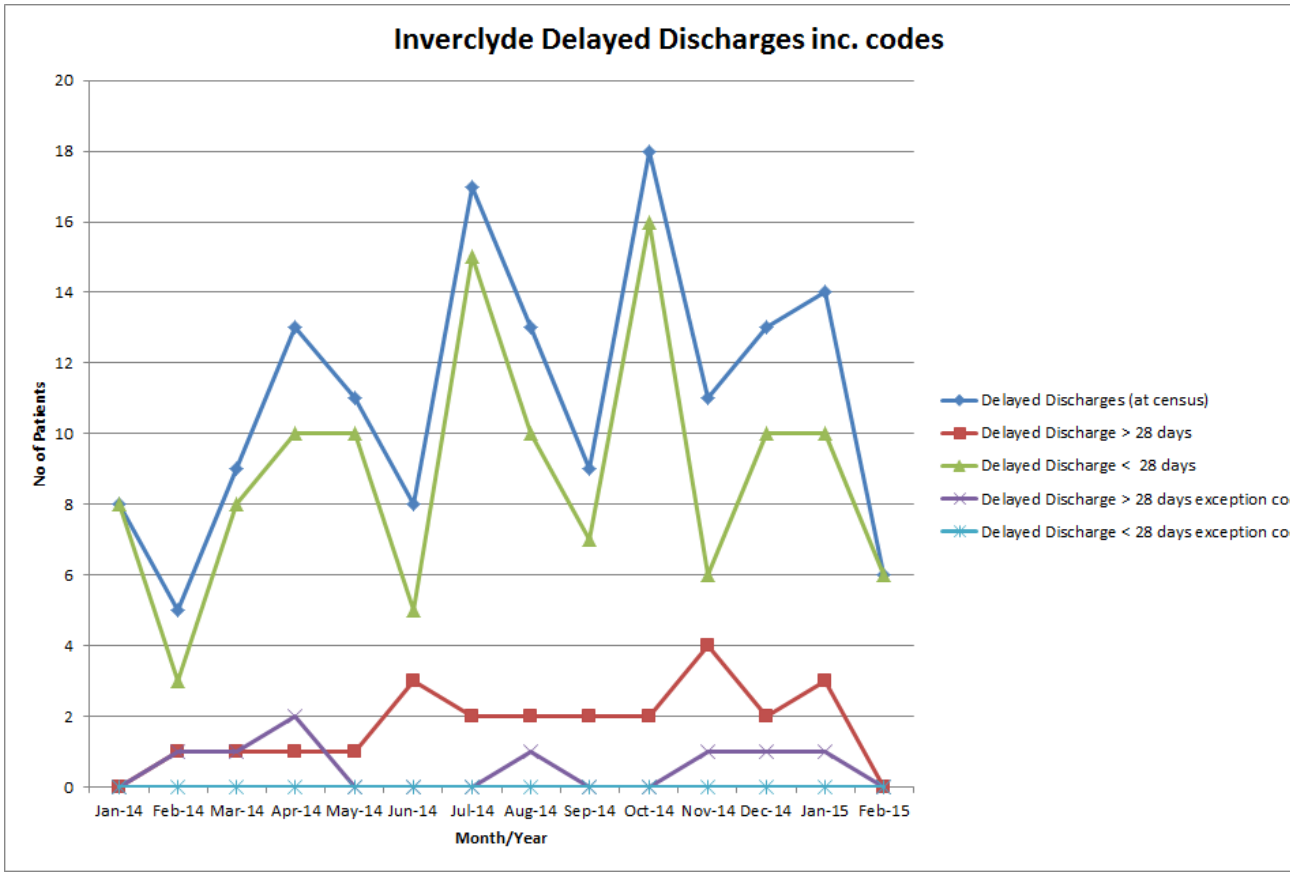

Chart 2

4.4 Delayed Discharge Census data reported for March 2015 shows nine delays with seven of these being delayed for less than two weeks and two being delayed for between two and four weeks. Whilst it is possible to evidence reduced bed days associated with admissions, we continue to see a rise in emergency admissions for those over 65.

4.5 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, to increase the number of patients discharged within 72 hours of becoming fit and, critically, to avoid admission to hospital in the first place.

4.6 We have taken time to fully assess our requirement for the use of Intermediate Care beds. Ongoing reflection of Delayed Discharges does not indicate the use of 'step down' beds as a mechanism to reduce delays in Inverclyde but rather for many individuals this adds a further unnecessary step in the discharge process. Of much more significance locally is the development of 'step up' beds which can offer an alternative to hospital admission for those not requiring acute medical care.

4.7 Inverclyde has in recent years been a relatively high user of care home beds with an average length of stay for residents of 2.9 years, reflecting the second longest length of stay in Scotland. More recently we can evidence that residents are being admitted when they are older and staying for a shorter period of time, reflecting the shifting balance of care in sustaining people in their own homes for longer.

4.8 Recent reductions in the number of care home placements (chart 3) offer the opportunity to commission care home beds differently, enabling the development of intermediate care beds. We are currently working on the service specification to allow dialogue with independent providers to take place with beds aiming to be available during summer 2015.

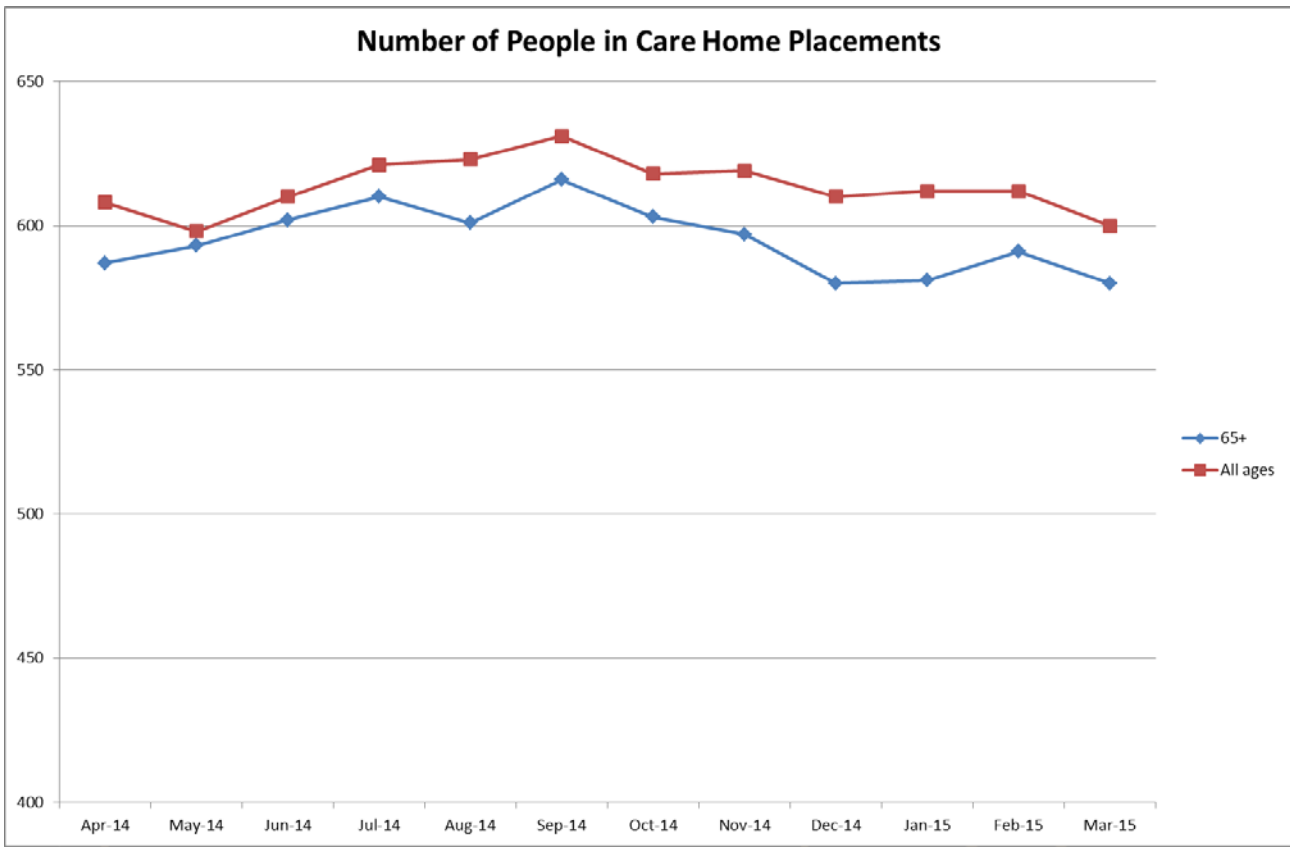

Chart 3

4.9 Most people discharged from hospital to their own home will receive support from the Home Care reablement service. This service continues to deliver positive outcomes with 30% of service users regaining full independence (chart 4) and of those service users transferring to mainstream care at home, a reduction of 33% in packages of care is seen.

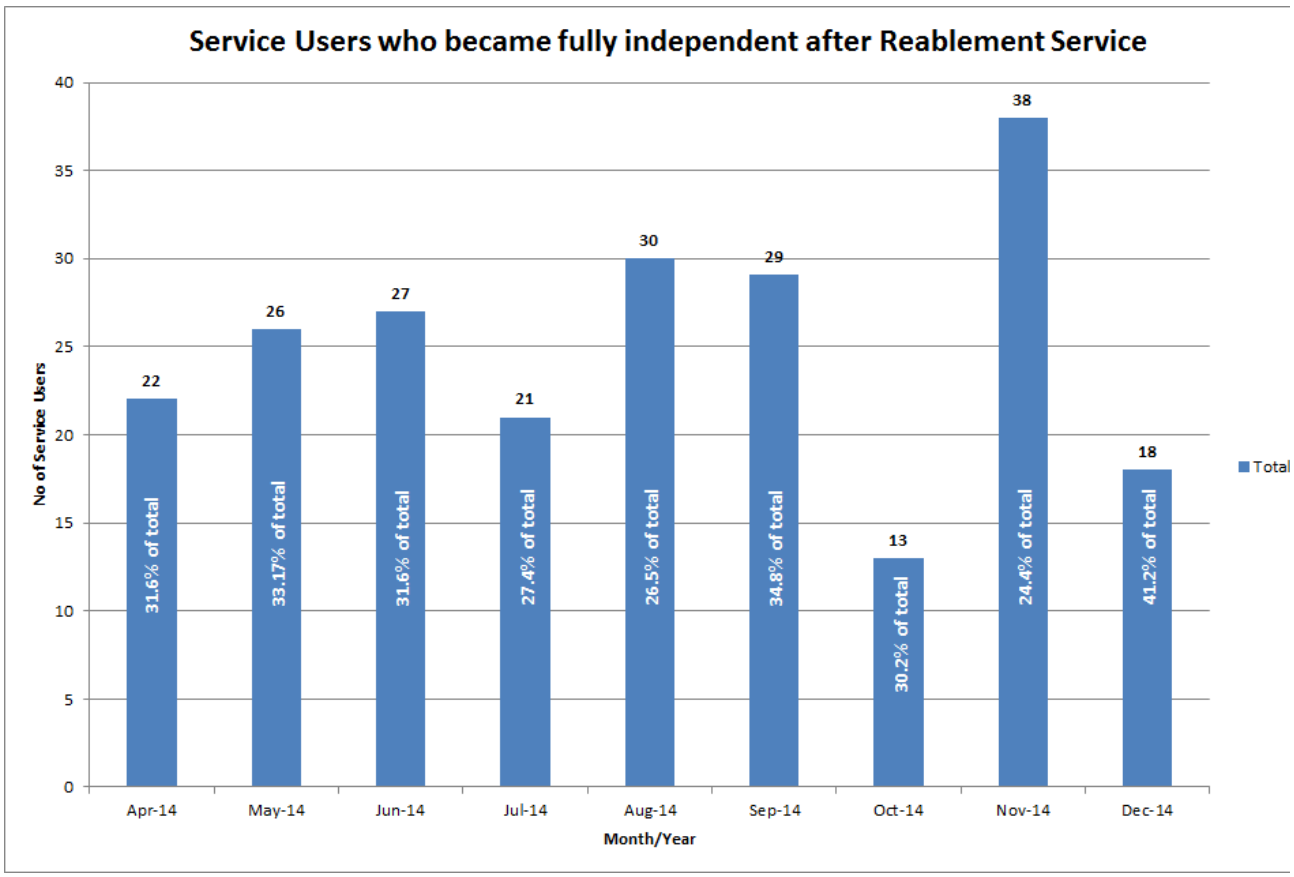

Chart 4

4.10 The re-organised and dedicated Assessment and Care Management Team within the hospital is now able to demonstrate commencement of assessments at an earlier stage of the patients stay in hospital and in turn, earlier decision making around the care needs following discharge. This has impacted positively on both those returning home and those transferring to long term care settings in that, key decisions are taken in a timelier manner. There is no longer a time lag for decision making around placement and funding of long term care which is evidenced through our monitoring of all discharges which require social care support.

4.11 This report notes the success in shifting the balance of care which is more people returning home from hospital earlier and maintaining people in their own home for longer. This will undoubtedly lead to a further increase on demand for our Home Care Services despite the success of the reablement approach. In part this is due to the increasing number of older people in Inverclyde with support needs.

5.0 PROPOSALS

5.1 Home First – Ten Actions to Transform Discharge

The Joint Improvement Team and the Scottish Government have recently convened a Discharge Task Force to consider short and medium term actions that partners need to take to enable local improvement. JIT's Home First document describes 10 actions that partnerships can take now to transform discharge.

5.2 We have recently started to embed the ethos of *'Home First'* across both the HSCP and within the acute hospital. It is widely recognised that assessing for long term care placement is best done outside the acute hospital environment, and although we acknowledge that this is not always possible for every patient, we wish to see an increase in this practice.

5.3 This means that for the purpose of discharge planning, it should be assumed that each patient will return to their own home at discharge with a package of care and support which ensures

they can live as independently as possible. Decisions on permanent care should only be made by the collective multi- disciplinary team following full assessment by the social worker and informed discussion with the individual, family or carer.

5.4 The Rehabilitation & Assessment Team alongside Care Management and District Nursing will support this approach in an integrated process. The increased provision of through the night care allows the opportunity for further assessment and monitoring at home in order to establish the ability to remain in one's own home. We will monitor and report on the effectiveness of this service in future reports.

5.5 We will also look to measure performance by tracking the patient's journey from admission to discharge measuring timescales and outcomes for the individual service users. This will include measuring the number of prevented hospital admissions and associated bed days saved.

5.6 Following a workshop held on February 18th which assessed our discharge processes within the context of 'Home first' we have updated our strategic action plan and will continue to monitor this via the fortnightly Strategic Discharge meeting attended by senior managers of the HSCP and the Acute Hospital..

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 There are no Human Resource implications at this time.

Equalities

6.4 Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
√	NO -

Repopulation

6.5 None.

7.0 CONSULTATIONS

7.1 The Inverclyde Delayed Discharge Plan is jointly developed alongside our partners in NHS Greater Glasgow and Clyde.

8.0 LIST OF BACKGROUND PAPERS

8.1 None.