AGENDA ITEM NO: 11

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**10 August 2015**
Report By:	**Brian Moore Chief Officer Designate Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/09/2015/BC**
Contact Officer:	**Beth Culshaw Head of Health and Community Care**	**Contact No:**	**01475 715283**
Subject:	**Update on Delayed Discharge Performance**		

1.0 PURPOSE

1.1 The purpose of this report is to advise the Integration Joint Board on performance towards achieving the target for Delayed Discharge.

2.0 SUMMARY

2.1 The Delayed Discharge target reduced from 4 weeks to 2 weeks on 1 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
Chief Officer Designate
Inverclyde HSCP

4.0 BACKGROUND

4.1 From April 2015 the target for Delayed Discharge, which had been in place since 2013, decreased from 4 weeks to 2 weeks. NHS Greater Glasgow and Clyde has also reported on the number of bed days lost due to delayed discharges. This provides a more complete picture of the impact of hospital delays.

4.2 There is a proposal for a new target to discharge a higher proportion of patients within 72 hours of being ready for discharge. We have therefore started to measure the proportion of patients discharged within 72 hours of being ready and the associated bed days lost. This data will be reported on in future reports although at this time it is recorded for May and June (Appendix A Chart 1.)

5.0 PERFORMANCE

5.1 We continue to maintain positive performance in relation to the 14 day Delayed Discharge target.

We have consistently achieved zero delays of more than 4 weeks since February 2015 and zero delays over 2 weeks since April 2015 (Appendix A Chart 1). In July the census data will show that we again had zero service users staying longer than 14 days with 2 service users who were medically fit and waiting on support packages to be arranged.

We have also had a corresponding reduction in the number of acute bed days lost for all adults and particularly for those over 65 years of age (Appendix A Chart 2).

The performance indicates positive outcomes for service users who are returning home, or moving on to appropriate care settings earlier and spending less time inappropriately in hospital.

5.2 There are a decreasing number of service users experiencing a delay in discharge from hospital (Table 1).

Table 1

2015	Jan	Feb	Mar	Apr	May	Jun
No. of Individual delays	23	18	16	19	14	16

This performance is set against a background of increasing referrals for social care and community supports following discharge (Appendix A Chart 3). During June 2015, 152 individuals were referred for social care support of which 34 people required a single shared assessment indicating complex support needs. A total of 16 individuals were identified as being delayed following the decision they were medically fit for discharge.

5.3 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.

5.4 To demonstrate outcomes for service users we have included examples of three recent discharges:-

a) A patient had poor skin integrity which required turning at regular intervals throughout the day and night. The decision to facilitate a return home was based on the service user's wishes and using the Home First ethos. Early identification of needs and collaboration between the Discharge Team, Ward and the Inreach District Nurse identified a safe discharge plan.

   Use of the Through the Night Homecare service, along with District Nurses Night Service, allowed for assessment of overnight care and health needs ensuring appropriate care arrangements were established. This support plan prevented an admission to long term care and was in place before the service user was a delayed discharge.

b) An older service user was admitted to hospital in a very weak condition partly due to physical frailty and dementia. Within a few days of admission the service user was medically fit for discharge. This decision though appropriate was unexpected for the family, who were concerned how to support the discharge within 14 days.

   Intensive support was given to the family by the Discharge Team to manage the impact of the change in their parent's health upon the family. It enabled them to fully participate in the assessment process and to plan for discharge. The discharge subsequently went ahead 9 days after the medically fit date with the full agreement and involvement of the family. The Discharge Team had identified the service user at admission and so were well placed to meet with the family and support them through an emotional time as they took a decision on the long term care requirements of their parent.

   The improved early identification was instrumental in early assessment and timely discharge for this individual. The impact on the family was recognised and addressed early, as this can often be one of the main factors in a delayed discharge.

c) An older service user was admitted to hospital following a stroke. Due to poor balance and an unsteady gait there was an evident risk of falls particularly during the night when attempting to get out of bed to use the toilet.

   Discharge Team staff were able to secure a change in accommodation within a very sheltered housing complex where the service user moved to on discharge.

   The support plan included the Through The Night service for 2 weeks to support a continence management programme devised by the District Nurses. This complemented the Homecare Reablement service which worked with the service user to regain confidence around transfers and mobilising, improving gait and balance reducing the risk of further falls.

This illustrates the effectiveness of discharge planning which in this case meant facilitating an assessment in the person's home rather than in the hospital ward. This allowed for a discharge home and the service user was counted as a delayed discharge.

6.0 PROPOSALS

6.1 Partnership working across the HSCP and Inverclyde Royal Hospital has focussed on improving our discharge processes and is informed by the Joint Improvement Team *'Home First'* document.

6.2 We continue to utilise and update our Home First Strategic Action Plan (Appendix B), monitored at a monthly Strategic Discharge meeting attended by senior managers of the HSCP and Inverclyde Royal Hospital. The attached action plan shows progress in each of the 10 areas.

6.3 There is a continued focus to develop integrated and joint improvements to continually improve the hospital journey and discharge processes.

6.4 Key elements of the work plan include:-

- We are looking at providing staff in A&E with access to the SWIFT database. This will allow for an understanding of current community supports and contacts and will inform decisions around admission
- We are exploring the nursing/medical interventions in the community which could avoid admission
- Following the redesign of the Discharge Team we are now scoping the current Nursing staff (Community and Acute) that has a specific focus on discharge.

6.5 We will continue to develop our performance monitoring with an emphasis on the hospital discharge pathway and in particular the outcomes for service users, their families and carers.

7.0 IMPLICATIONS

Finance

7.1 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

7.2 None.

Human Resources

7.3 There are no Human Resource implications at this time.

Equalities

7.4 Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
√	NO -

Repopulation

7.5 None.

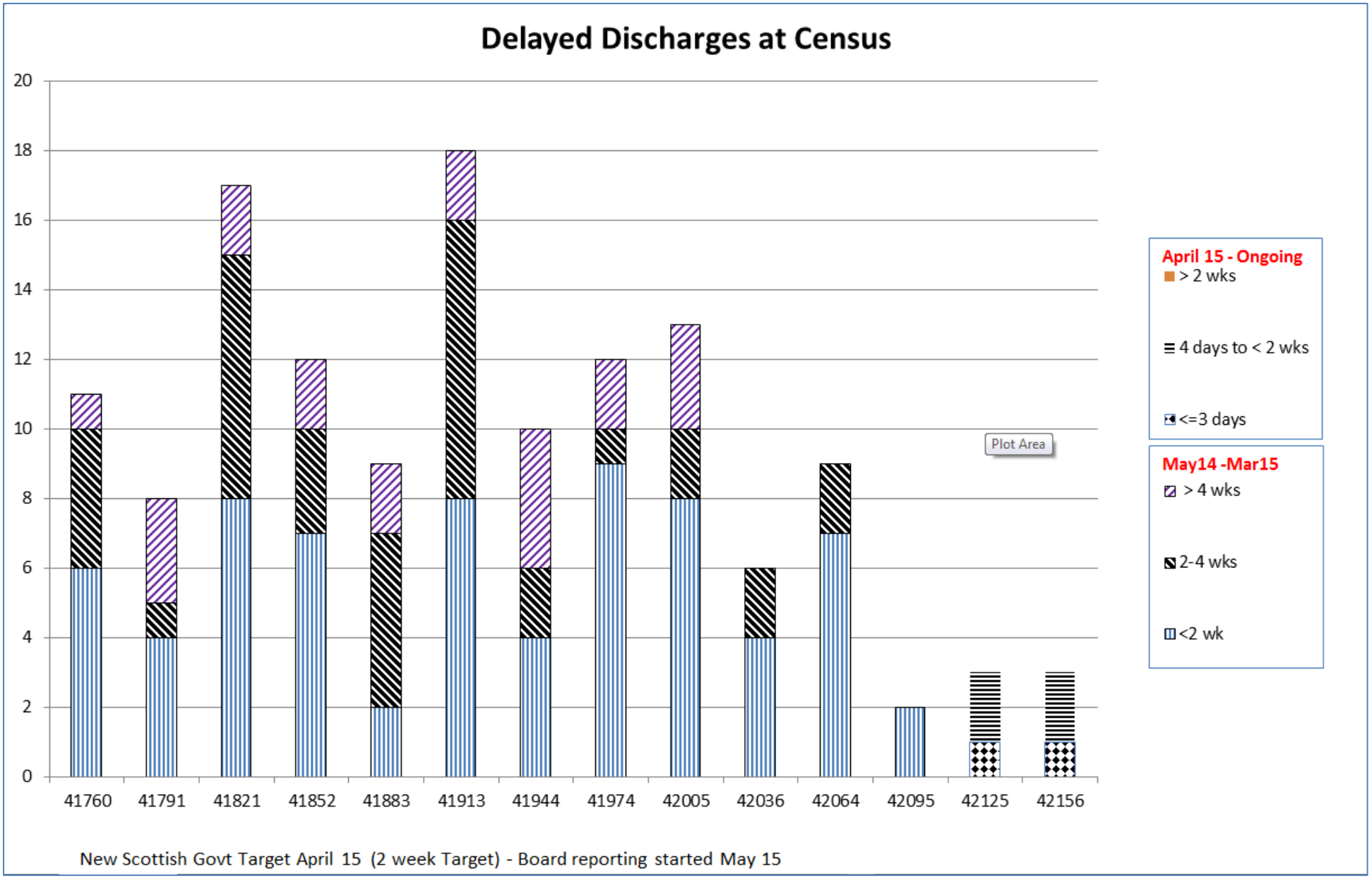
8.0 CONSULTATIONS

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

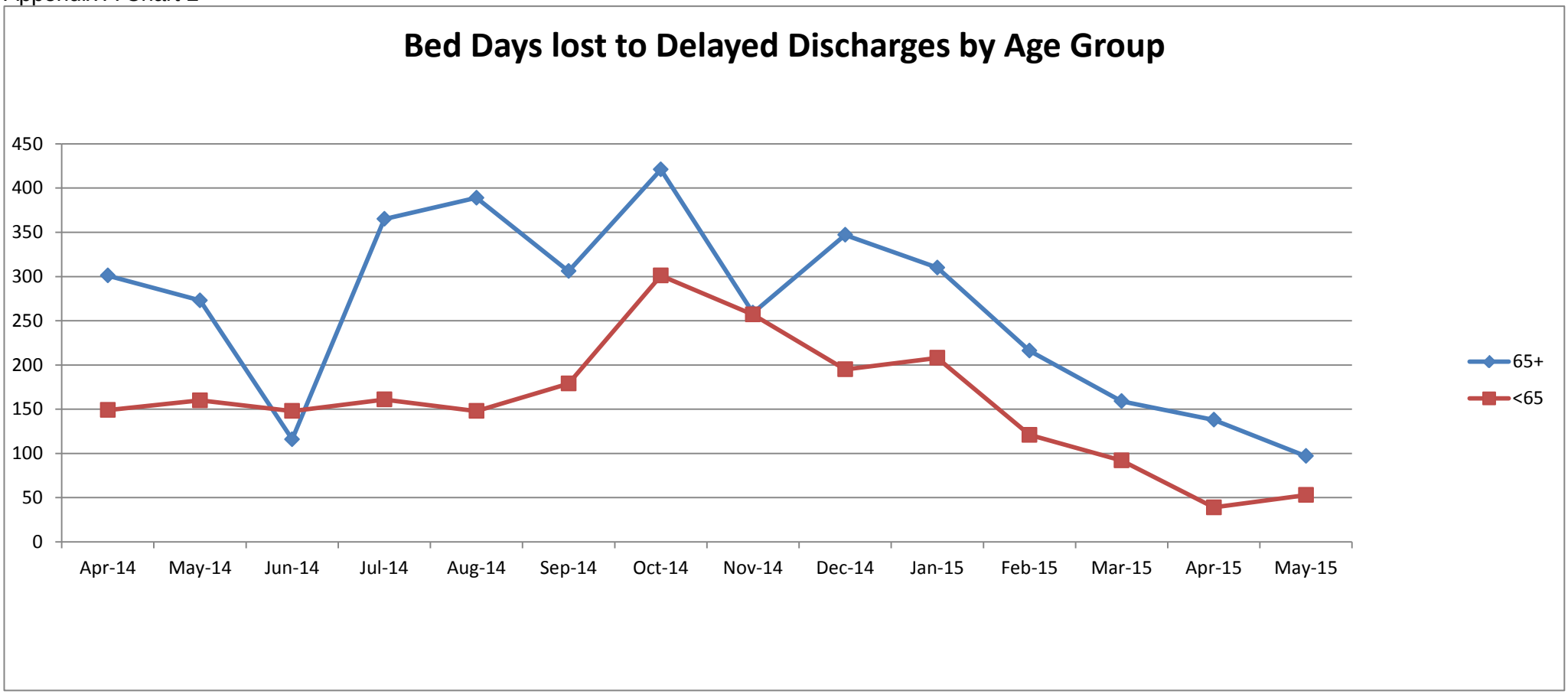
9.0 LIST OF BACKGROUND PAPERS

9.1 None.

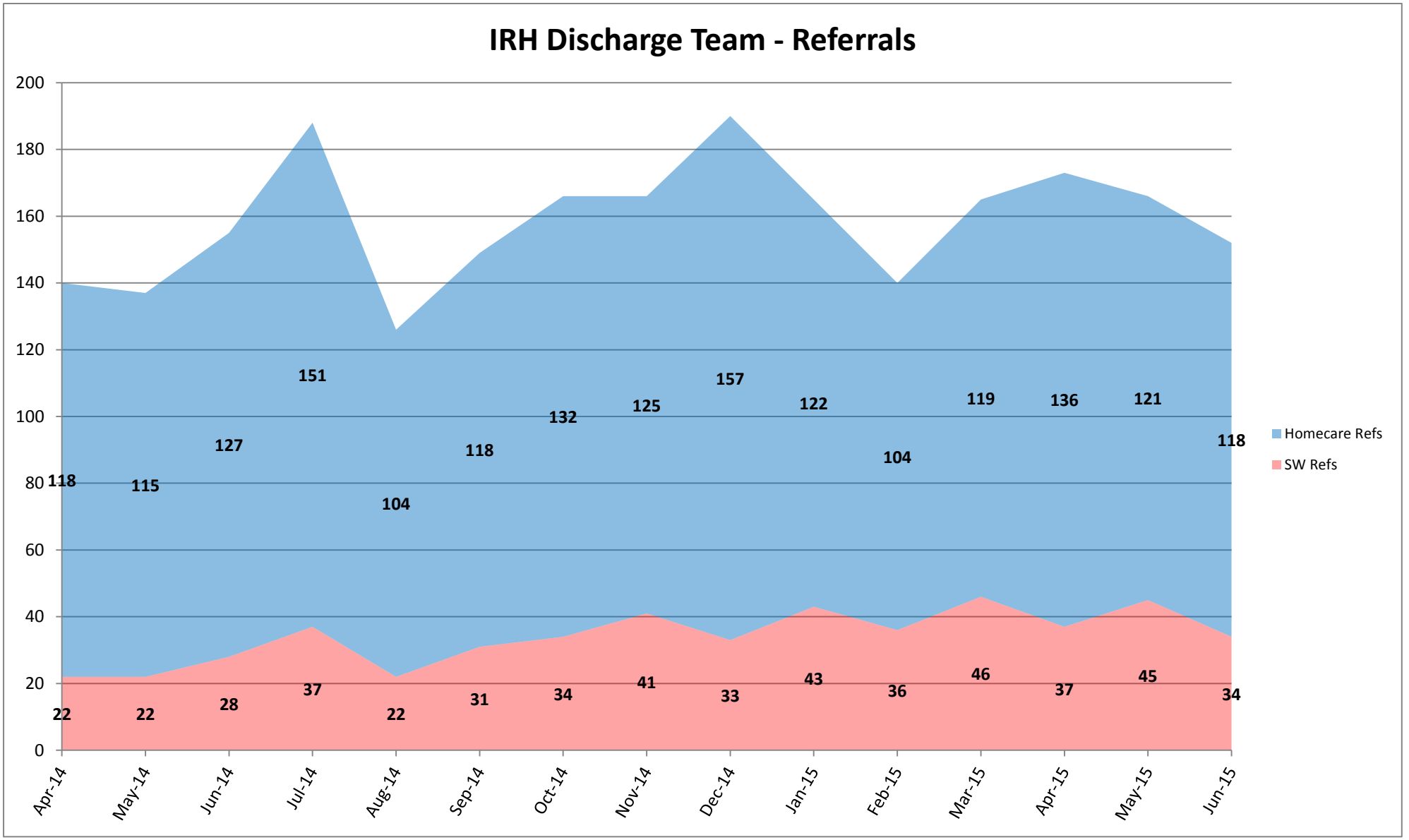
Appendix A Chart1



Appendix A Chart 2



Appendix A Chart 3



Appendix B

Home First- Ten Actions to Transform Discharge
Action Plan July 2015

Action	Task	Responsible	Update	Action	Issues	Timescale
Use Data to Know How You Are Doing	Performance Management	Service Manager Assessment & Care Management	Monitor effectiveness of new processes in SW discharge team New spreadsheet in place to monitor all discharges Capture more comprehensive information Delayed Discharge numbers reduced Lessons learned from Discharges	Monitor use of spreadsheet Identify SU journey key points and develop Performance Management Report Case Review	Capture work of In reach DN Admin support	**Review July 15**
	Embed a change culture	All managers	Admissions from community Older People's Service Development Reference Group (OPSDRG) will be conduit for development monitoring and sharing.	Review Anticipatory Care Plans Utilise case studies and share practice at OPSDRG		**Sept 15 Review**

Action	Task	Responsible	Update	Action	Issues	Timescale
Scale up Coordinated and Anticipatory Care.	Embed anticipatory care approaches in practice	Project Manager- Reshaping Care	Awareness raising and training planned for Summer- links to other pathways, falls, A&E, etc.	Deliver revised objectives and ACP work plan Outcome of eKIS review will inform approaches in acute		**July 15**
	Review where access to read only SWIFT would add value.	Project Manager- Reshaping Care	A&E identified as key area New discharge nurse trained	Consider as part of ongoing intermediate care/falls/A&E response pathway General Manager ECMS will attend next meeting	Discuss key acute lead at next meeting	**July 15**
	Review use of EKIS and ACP's within A&E and wards	Project Manager- Reshaping Care	This is part of the ACP group action plan	GP AP Lead will lead review of medical use	Inputting and sharing information via eKIS continues to be challenging	**July 15**
	Improve knowledge and education in care homes	Independent Sector Lead	Links to intermediate care strategy and specialist nurse review/ role development	CHLN supporting SPAR & ACP's Virtual team of staff established and meeting regularly to establish support and sharing practice.	Monitor admissions via CH liaison nurses.	**Review September 2015**
	Improve knowledge in primary care of community services which can support	Project Manager- Reshaping Care Project Manager- Primary care	CPD group to be arranged by GP ACP Lead	Promote discharge to assess and home first strategy. Promote stroke portal.		**Review September 2015**

	someone to stay at home.					

Action	Task	Responsible	Update	Action	Issues	Timescale
Develop Intermediate Care	Develop Intermediate Care Strategy and deliver step up beds.	Project Manager-Reshaping Care	Draft complete	Establish process and timescales for tender. Comments from partners.		**August 15**

Action	Task	Responsible	Update	Action	Issues	Timescale
Screen and Assess for Frailty	Review role of Fast Track Assessment service.	To be discussed at next meeting	Gerontology nurse is now seeing increased numbers of patients in community working as part of RES	Identify use, capacity and effectiveness of fast track clinic. Develop strategic approach to development of service alongside gerontology role.	Role Geriatrician	**August**
	Consider relevance of early Comprehensive Geriatric Assessment at IRH	General Manager – RAD	Research evidence suggests, more appropriate admissions, reduced LOS etc.	Strategic Group considering a model which relies more on the MDT		**September 2015**

Action	Task	Responsible	Update	Action	Issues	Timescale
Integrate Discharge Planning		Lead Nurse-RAD DN In reach?	Explore tissue viability guidance.	(Re) Assessment from community base	This issue has implications	**July - Dec**

			Prescribed active nursing care.		for care delivery in community and relationships with families.	
	Review number and role of Staff linked directly to discharge in Inverclyde	Lead Nurse RAD DN Team Leader	Looking at restructure of service and use of Nurses/AHP focus on discharge. OT in reach post and ECAN nurse at recruitment.	There will be a SLWG with 2 work streams Starting with nurses and moving on to AHPs EC&CG will attend the first meeting. Aims: -Clarity of roles -Awareness of services -Gaps & overlaps -Processes Ensure active Nursing Support transition from Acute to Community is included	Discharge Nurses x2 DN In reach x1 Gerontology Nurse x1 ECAN x2 (Pending) OT In reach X1 RAS x2 (Physio OT) SW Discharge Team SW x2.5 SWA x2 TL x.5	**July - Dec**
	Monitor new SW assistant role in discharge team	ASM Assessment & Care Management	SW assistant is now managing noncomplex cases and highlighting complex/ potential delayed discharges in	Continue to review		**July**

			advance			

Action	Task	Responsible	Update	Action	Issues	Timescale
Build Capacity for Care & Support at Home	OPMHT	Service Manager Mental Health	Adopted same process as discharge early identification of service users. Dedicated SW to ward 4	Progressing well.		**Sept Review**
	Finalise local hospital discharge booklet	Project Manager-Reshaping Care	Final meeting taken place with Your Voice.	Final editing and to pass to communications group and Strategic group for sign off. Agree how this will be disseminated will raise in huddle for information when ready for use		**August**
	Consider extended/revised hours and access to community rehabilitation, enablement etc.	RES Team leader Lead OT ASM Assessment & Care Management	Links to intermediate care strategy, falls pathway etc. Extended hours for Discharge Team	Review referral data Identify current demand and capacity Identify options for changing / extending hours to best effect.		**August 2015**
	Lack of access to transport out of	Discuss at next meeting		Consider models of provision elsewhere	This has potential	**Timescale to be agreed at**

	hours				to compromise use of extended hours services and future OOH developments for supporting discharge/ admission avoidance	**next meeting**

Action	Task	Responsible	Update	Action	Issues	Timescale
Assertive Management of Risk	Awareness Campaign Embed Home First ethos	Project Manager- Reshaping Care	Lead Nurse Meeting for ECMS to be completed	Discharge Nurses to be involved	Discuss acute lead at next meeting	**July**
	Risk awareness training	Project Manager- Reshaping Care	Utilise the above meetings to raise awareness prior to formal training	Identify Training Facilitator Plan Training Lessons learned from recent discharges- case studies.	Discuss acute lead at next meeting	**July**

Action	Task	Responsible	Update	Action	Issues	Timescale

Support People Moving on to Long Term Care	Supporting individuals wishes & supporting families and carers and decision making	ASM Assessment & Care Management	Utilise the home first meetings to raise awareness prior to formal training. Use of ward meetings and DPM. Carers In reach worker.	Investigate advocacy at an early stage. Identification of SU and Families wishes at referral stage. Arrange meeting to review carers input	 Referral stage too early?	**July** **June** **July**
	Ensure Choice Guidance is understood and followed.	Discharge Manager	Discharge manager updated strategic meeting on 01/04/15	Continue to raise / discuss on an individual case by case basis.		**Completed**

Action	Task	Responsible	Update	Action	Issues	Timescale
Understand Adults with Incapacity Issues	Ensure process for assessing capacity and 13za is timely and within legislation	Service Manager Assessment & Care Management	Process more transparent on Larkfield wards due to use of 5 point action plan	Continue to monitor and review	Retain for monitoring	**August**