AGENDA ITEM NO: 10

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**10th November 2015**
Report By:	**Brian Moore Chief Officer Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/20/2015/BC**
Contact Officer:	**Beth Culshaw Head of Health and Community Care**	**Contact No:**	**01475 715283**
Subject:	**Delayed Discharge Performance and Winter Planning 2015/16**		

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 and arrangements for co-ordinated winter planning in Inverclyde.

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.

2.2 It has been agreed through the NHS GG&C whole system planning group that each HSCP will produce an operational plan with a particular focus on the winter period, complementing the Acute Plan, in recognition of the correlations between winter activity and service pressures.

3.0 RECOMMENDATIONS

3.1 Members are asked to note the progress towards achieving the target, including the Winter Plan, and the ongoing work to maintain performance.

Brian Moore
Chief Officer
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, as 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 number of patients discharged within 72 hours of being ready. This data will be reported on in future reports alongside the associated bed days lost

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 3). In October the census data showed that we again had zero service users staying longer than 14 days with 4 service users who were medically fit awaiting support packages to be arranged.

There is an increase in bed days lost for patients under 65 which reflects 2 adults who are currently in a Learning Disability Continuing Care bed facility (i.e., not an acute hospital facility), waiting for support packages and suitable safe accommodation to be arranged. These individuals have complex and changing needs and will take longer than the 14 day target to establish a support plan with accommodation to meet their needs as these facilities do not currently exist. The number of bed days has increased though the HSCP are currently negotiating as to whether they are exempt from the Delayed Discharge targets.

The overall 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 The trend in the number of service users experiencing a delay in discharge from hospital is illustrated below.

Table 1

2015	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept
No. of Individual delays	**23**	**18**	**16**	**19**	**14**	**16**	**20**	**23**	**24**

This performance is set against a background of increasing referrals for social care and community supports following discharge (Appendix A, Chart 1). During September 2015, 135 individuals were referred for social care support of which 37 people required a single shared assessment indicating complex support needs. A total of 24 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.

6.0 STEP UP BEDS (INTERMEDIATE CARE)

6.1 In order to meet the increasing demand on services related to a complex ageing population, we continue to develop new services and increase capacity within existing services. Whilst we are confident in the arrangements to facilitate discharge, we continue to see an overall rise in unplanned admissions and it remains extremely challenging to consistently reduce the level of delayed discharges and lost bed days associated with these admissions.

6.2 From late summer and early autumn each year we begin to see an increase in admissions which continues over the winter period resulting in an increase in inpatient bed days. Evidence suggests that the longer an older person's length of stay, there is an increased likelihood of deterioration in their ability and independence. This impacts on the chances of successfully returning to live in their own home and increases the risk of hospital acquired infection.

6.3 The HSCP are currently developing the provision of Step Up beds located within the care home sector in Inverclyde. The service will be within a residential care setting with rehabilitation and enablement support provided by HSCP staff. This partnership approach may require a tender process to establish a service for 12 months with an option for a further period if the initiative proves successful.

The intention is to fund this service through existing budgets and use of the Integrated Care Fund to specifically allow recruitment of key staff such as a physiotherapist and an occupational therapist.

The ability to provide an alternative such as Step Up beds during the peak winter period should not only reduce unnecessary admissions but contribute to better outcomes for individuals.

7.0 WINTER PLANNING 2015/16

7.1 It has been agreed through the NHS GG&C whole system planning group that each HSCP will produce an operational plan with a particular focus on the winter period. The Winter Plan addresses 12 key themes set out in the Scottish Government guidance *National Unscheduled Care Programme: Preparing for Winter 2015/16* (DL (2015) 20), and the 6 Essential Actions.

7.2 The Winter Plan (Appendix 2) identifies and addresses the local issues across primary care and community services for which Inverclyde Health and Social Care Partnership is responsible. The plan will closely complement the Acute Winter Plan and will support NHS GG&C whole system planning.

7.3 The Winter Plan will also complement and feed into Inverclyde Council contingency planning with particular reference to the 'Planning for Winter' initiative.

7.4 The primary focus of our Winter Plan is to ensure that people avoid admission to hospital wherever possible and have as speedy a journey through secondary care as possible should an admission be unavoidable.

7.5 A Winter Planning Operational Group has been established and includes representation from each relevant HSCP service. The group will meet weekly throughout the winter period. (November 2015 – January 2016) and will use local performance data to plan responses to extra pressure on the system as they arise.

This group will link closely to the Strategic Discharge Planning Group to ensure effective response across the partners building on the current work around the Home First Strategic Action Plan.

7.6 A rolling action log will be maintained and reported weekly to the Chief Officer and Head of Health and Community Care. These actions include:

- Safe and effective admission/discharge continues in the lead up to and over the festive period and also into January.
- Workforce capacity plans and rotas for the winter/festive period are agreed in October 2015.
- Facilitation of discharge at weekends and bank holidays.
- Delivering seasonal flu vaccination to public and staff.
- Communication plans.
- Effective analysis to plan for and monitor winter capacity, activity, pressures and performance.

A report analysing the activity, performance and pressures during the winter will be provided to the IJB at the end of the winter period.

8.0 PROPOSALS

8.1 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.

8.2 We continue to utilise and update our Home First Strategic Action Plan, monitored at a monthly Strategic Discharge meeting attended by senior managers of the HSCP and Inverclyde Royal Hospital. This plan will inform the specific actions identified in the Winter Plan.

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

8.4 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.

8.5 We will work with partners in the care home sector to establish a residential Step Up facility in Inverclyde. The service will focus on avoiding unnecessary hospital admissions and support service users to return to their own home.

9.0 IMPLICATIONS

Finance

9.1 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

9.2 None.

Human Resources

9.3 There are no Human Resource implications at this time.

Equalities

9.4 Has an Equality Impact Assessment been carried out?

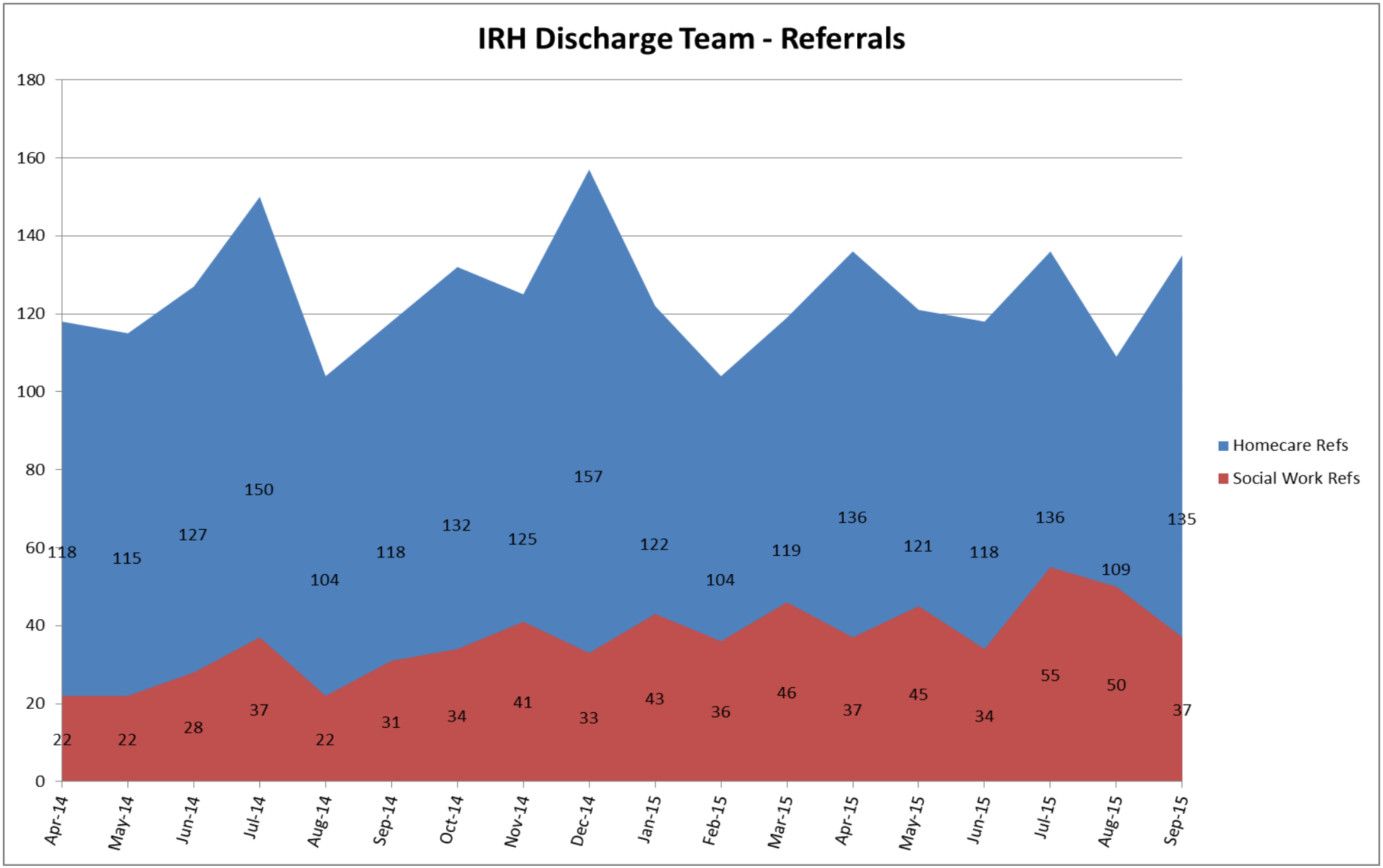
	YES (see attached appendix)
√	NO -

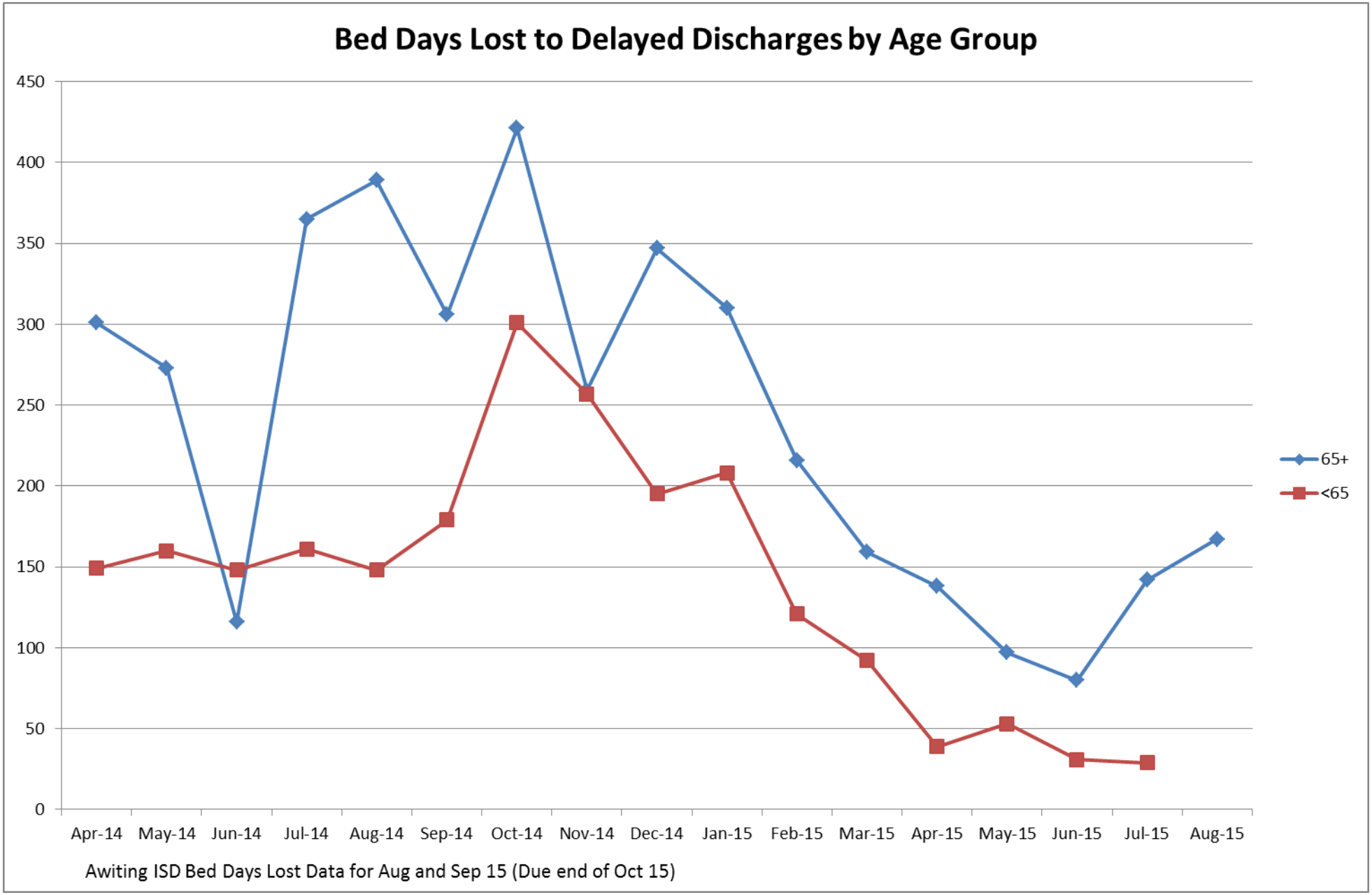
10.0 CONSULTATIONS

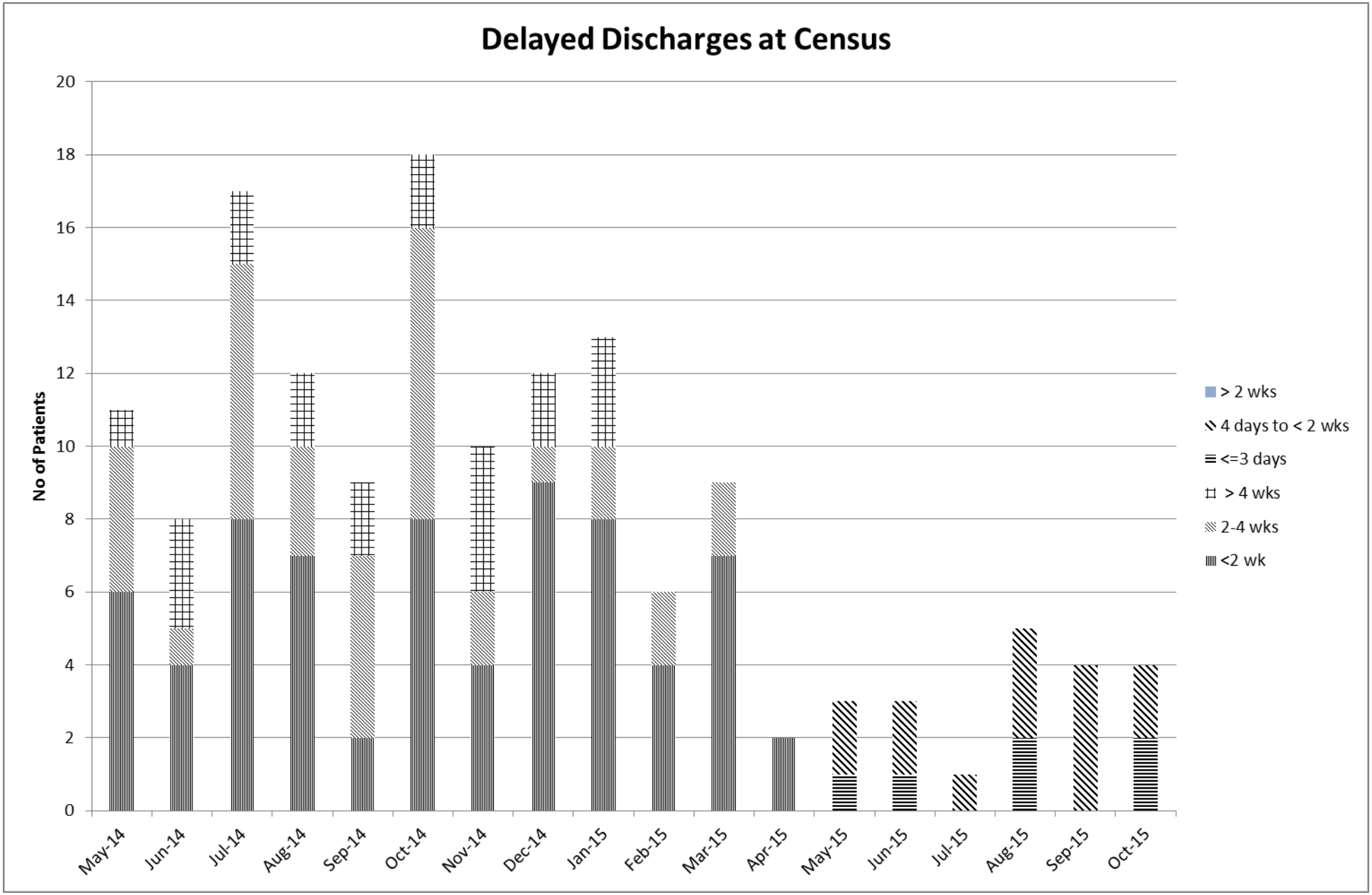
10.1 The Inverclyde Delayed Discharge Plan is jointly developed alongside our partners in NHS Greater Glasgow and Clyde.

11.0 LIST OF BACKGROUND PAPERS

11.1 Inverclyde HSCP Winter Plan 2015/16.


IRH Discharge Team - Referrals
180
160
140
120
100
80
60
40
20
0
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
118
115
127
150
104
118
132
125
157
122
104
119
136
121
118
136
109
135
22
22
28
37
22
31
34
41
33
43
36
46
37
45
34
55
50
37
Homecare Refs
Social Work Refs


Bed Days Lost to Delayed Discharges by Age Group
450
400
350
300
250
200
150
100
50
0
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
65+
<65
Awiting ISD Bed Days Lost Data for Aug and Sep 15 (Due end of Oct 15)


Delayed Discharges at Census
No of Patients
20
18
16
14
12
10
8
6
4
2
0
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
> 2 wks
4 days to < 2 wks
<=3 days
> 4 wks
2-4 wks
<2 wk

Inverclyde
Health & Social Care Partnership

Draft Winter Plan

2015/16

Version 5
16.10.15

(Author: Derrick Pearce, Service Manager Quality and Development and
Alan Brown, Service Manager Assessment and Care Manager)

1. Introduction

Health and Social Care Partnerships have a critical role in the wider service system which enables the delivery of effective unscheduled care. It has been agreed through the NHSGG&C whole system planning group that each HSCP will produce an operational unscheduled care plan with a particular focus on the winter period.

These plans will cover:

- The community service aspects of the 6 essential actions (Appendix 1)
- Delayed discharge
- Measures to reduce admissions and attendances
- Delivery of key service features including single point of access, Care Home support and Anticipatory Care
- Continuity and resilience
- Developing an agreed set of indicators to monitor performance
- Planning with GPs for the two long bank holidays

This Winter Plan identifies and addresses the local issues across the primary care and community services for which Inverclyde Health and Social Care Partnership is responsible, to support the NHSGG&C whole system planning as detailed above.

2. Winter Planning Arrangements

A Winter Planning Operational Group has been established and meetings have been arranged to take place on a weekly basis. The purpose of the group is to discuss the development and subsequent delivery of the Winter Plan and identify any issues that require to be addressed, or escalated, to enable appropriate actions to be put in place. This will help to ensure that service users receive safe, person centred, effective care to minimise unscheduled hospital admissions and reduce delays in discharges throughout the winter, and in particular, the festive period.

The membership of this group is as follows:

- Service Manager – Assessment and Care Management **(Chair)**
- Service Manager - Older People **(Vice Chair)**
- Senior Nurse - Adult Community Nursing
- Programme Manager – Integrated Care
- Project Manager – Primary Care
- Service Manager – Quality and Development

In addition to our Winter Planning Operation Group we will make use of our already established local Operational Hospital Discharge Group and Strategic Discharge Group which meet on a weekly and fortnightly basis respectively, involving staff from across community, primary and secondary care, to harness collective resources to manage demand and capacity.

3. Key Themes

The local planning arrangements are described under the twelve key themes set out in the Scottish Government guidance *National Unscheduled Care Programme: Preparing for Winter 2015/16* (DL (2015) 20).

In addition, the planning arrangements described have integrated the relevant essential actions as outlined in the Scottish Government *6 Essential Actions to Improving Unscheduled Care Performance* (Appendix1).

The 12 Key Themes are:

1. Safe and effective admission/ discharge continues in the lead up-to and over the festive period and also into January
2. Workforce capacity plans and rotas for winter/festive period are agreed in October 2015
3. Whole system activity plans for winter: post-festive surge/ respiratory pathway
4. Strategies for additional winter beds and surge capacity
5. The risk of patients being delayed on their pathway is minimised
6. Discharge at weekends and bank holidays
7. Escalation plans tested with partners
8. Business continuity plans tested with partners
9. Preparing effectively for norovirus
10. Delivering seasonal flu vaccination to public and staff
11. Communication plans
12. Effective analysis to plan for an monitor winter capacity, activity, pressures and performance

Key headlines relating our areas of action are as follows:

From late summer/autumn each year we begin to see an increase in admissions over the winder period and associated increased in bed days used. Once admitted to hospital, the longer the older persons length of stay becomes, the more likely the deterioration in their ability and independence. This impacts on the chances of their ability to return to live independently and increases the risk of hospital acquired infection. **The primary focus of our winter plan, therefore, is to <u>ensure that people avoid admission to hospital</u> wherever possible and have <u>as speedy a journey through secondary care as possible</u> should an admission be unavoidable.**

i. Safe and effective admission/ discharge continues in the lead up-to and over the festive period and also into January

- We have developed a *Home First Strategic Discharge Action Plan* for our area which facilitates partnership working across primary and secondary care. We use our *Home First Strategic Discharge Action Plan* at each Operational and Strategic Hospital Discharge Group to drive joint action in relation to improved hospital discharge
- Ongoing close joint working with colleagues in Inverclyde Royal Hospital (IRH), including making good use of the 'Huddle' model, continues to demonstrate the effectiveness of early commencement of assessment 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 home care packages or a residential care placement.

- We are building on work we are already undertaking linked to the Inverclyde Interface Working Pilot from 2014/15. We intend to link work-streams related to High Resource Initials (HRI), demand and capacity data analysis and intervention space analysis to augment our intelligence across the winter period, and crucially in the post-festive surge which is anticipated. We know that making best use of our the data we have and lessons we have learned will provide richer intelligence about how our local population access and make use of services across the system, meaning we can be more tactical in our approach to managing this.
- Our focus on modernisation and continuous improvement is a core factor in our winter planning, and planning for joint actions related in unscheduled care generally. In order to meet the increasing demand on services related to the aging population, particularly, we have continued to develop new services and increase capacity with existing services. Despite this we do continue to see an overall rise in unplanned admissions to hospital. It remains extremely challenging to consistently reduce the level of delayed discharged and lost bed days which these admissions.
- We continue to progress integrated actions to improve the secondary care journey, transitions across branches of the system, and specifically the hospital discharge process.
- We are actively exploring the potential for staff in A&E to have access to SWIFT (the social work client management database used in Inverclyde). This would allow for real time access to information about the person's current community supports and packages of care and inform decisions around admission. Linked to this we are progressing the development of access to the clinical portal for relevant teams to aid communication and information sharing, alongside data linking programmes with the LIST team from ISD
- We are building on the recent redesign of the hospital discharge social work team inform a review of nursing input to hospital discharge.

ii. Workforce capacity plans & rotas for winter / festive period agreed by October

- Service leads will be responsible for determining that planned leave and duty rotas are effectively managed to ensure an adequate workforce capacity during the festive period, and immediately following the four day holiday periods This will be confirmed by an assurance memo in October
- We are actively scoping the range of nursing/medical interventions in the community to ensure arrangements are fit for purpose and aligned well to support admission avoidance.

iii. Whole system activity plans for winter: post-festive surge.

- The HSCP will contribute to the whole system activity planning and ensure representation at winter planning groups.
- The Chief Officer links with Acute and Partnership Chief Officers to maintain a collective perspective on performance issues and escalation arrangements which require action.

iv. Strategies for additional winter beds and surge capacity.

- The HSCP will respond where possible to support acute services in managing surge capacity. HSCP Assessment and Care Management will provide a reduced staff rota the week between the public holidays with a minimum of two staff on duty to support surge activity. Additional capacity to respond to particular increases in service demand can be resourced from the wider local social work teams if required.

v. The risk of patients being delayed on their pathway is minimised.

- Anticipatory structures have been supported to ensure that potential areas of need, particularly in respect of the adults with incapacity (AWI) are best met and AWI delays minimised.

vi. Discharges at weekend & bank holiday.

- The Adult Community Nursing service and Homecare service are the only HSCP community teams which provide a service 24 hours, 365 days per year inclusive of public holidays. These teams, in partnership with Acute and Out of Hours services, will support safe and effective hospital discharges during weekends and holidays.

vii. Escalation plans tested with partners.

- Escalation plans will be prepared and shared across services to ensure a whole system approach to implementing actions that minimise potential issues.
- The establishment of an early alert system will be explored to enable GP practices to highlight unexpected increases in demand for appointments.
- The Hospital Discharge team will provide a reduced staff rota the week between the public holidays where a minimum of 50% staff are on duty. Additional capacity to respond to particular increases in service demand can be resourced from other social work teams if required.

- Commissioned services have contingency arrangements in place and link between the HSCP commissioners and strategic commissioning team, and providers to share information and identify any issues that require to be escalated will be utilised.

viii. Business continuity plans tested with partners.

- Business Continuity Plans (BCP) for the HSCP are in place and are being reviewed.
- GP Practices and Pharmacies have BCPs in place that include a 'buddy system' should there be any failure in their ability to deliver essential services.

ix. Preparing effectively for norovirus.

- Information distributed to Care Homes will be shared by the HSCP Strategic Commissioning Team. We will do this for all providers as and when any Long Term Care providers advise us of any infection outbreak etc.

x. Delivering Seasonal Flu Vaccination to Public and Staff

- All HSCP staff will be reminded to encourage elderly and vulnerable groups to attend their GP flu vaccination sessions. The Community Nursing service will vaccinate those who the GPs identify as being housebound and consent to receiving the flu vaccination
- HSCP staff are actively encouraged to be vaccinated and local peer vaccination sessions are in place.

xi. Communication to Staff & Primary Care Colleagues

- To ensure that staff and Primary Care colleagues and partner agencies are kept informed, the HSCP will;
  - Ensure information and key messages are available to staff through communication briefs, team meetings and electronic links
  - Circulate information on available community services and clinics during the festive period, including pharmacy open times, to GP practices
  - Collate a range of information regarding staff rotas, service operating hours and lead contact details, and make available to staff throughout HSCP, Primary Care colleagues and NHSGG&C Board.
  - Information regarding GP availability throughout the festive period will be provided through the NHSGG&C Winter Booklet. Posters will also be provided and will be available to the public through public facing websites and by being displayed in GP Practices. The Clinical Director will re-enforce these messages to GP Practices.

xii. Effective analysis to plan for and monitor winter capacity, activity, pressures and performance

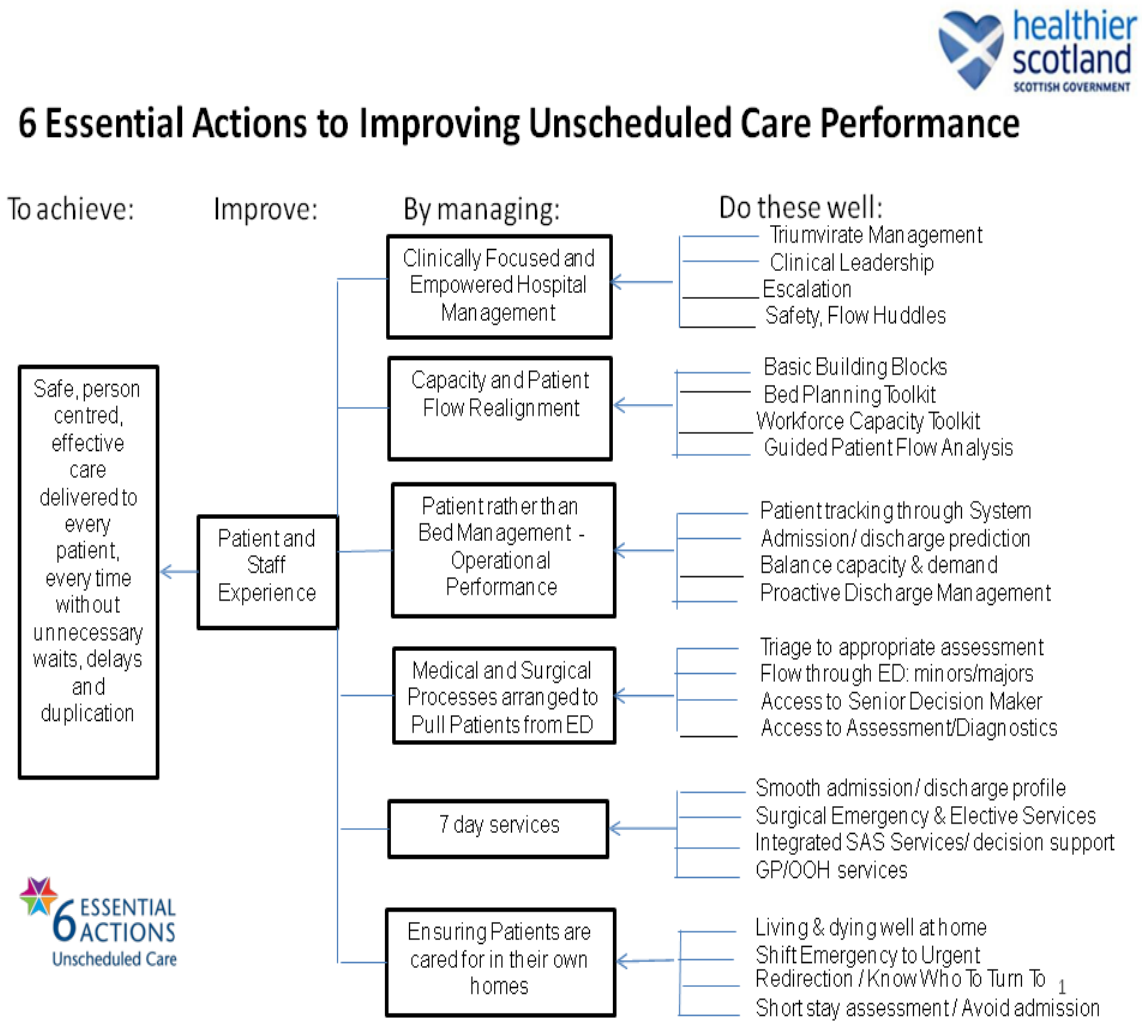
- The actions set out in this Winter Plan will be monitored and analysed to identify and potential improvements to inform future predictive modelling and planning.

Particular measures that will be monitored include;

- Staff levels/absence etc
- Bed days lost to delayed discharge
- Bed days lost to delayed discharge for AWIs
- Emergency admissions age 75yrs+
- Percentage uptake of flu vaccinations by staff
- Percentage uptake of flu vaccinations by GP population
- Demand and capacity (including GP practices)
    - Bombardment rates for key services, such as homecare and community nursing at point of discharge where no package previously in place
    - Long term care bed occupancy and vacancies
    - Admissions to hospital from care homes
    - Referrals to Discharge Team (at point of medical fitness etc)

- A detailed rolling action log will be maintained and updated at each Winter Planning Group meeting. This will be submitted each week to the HSCP Senior Management Team meetings to provide the up to date position and how we are responding.
- A report analysing the activity, performance and pressures will be provided at the end of the winter planning period.

Appendix 1


6 Essential Actions to Improving Unscheduled Care Performance
To achieve:
Improve:
By managing:
Do these well:
Safe, person centred, effective care delivered to every patient, every time without unnecessary waits, delays and duplication
Patient and Staff Experience
Clinically Focused and Empowered Hospital Management
Triumvirate Management
Clinical Leadership
Escalation
Safety, Flow Huddles
Capacity and Patient Flow Realignment
Basic Building Blocks
Bed Planning Toolkit
Workforce Capacity Toolkit
Guided Patient Flow Analysis
Patient rather than Bed Management - Operational Performance
Patient tracking through System
Admission/ discharge prediction
Balance capacity & demand
Proactive Discharge Management
Medical and Surgical Processes arranged to Pull Patients from ED
Triage to appropriate assessment
Flow through ED: minors/majors
Access to Senior Decision Maker
Access to Assessment/Diagnostics
7 day services
Smooth admission/ discharge profile
Surgical Emergency & Elective Services
Integrated SAS Services/ decision support
GP/OOH services
Ensuring Patients are cared for in their own homes
Living & dying well at home
Shift Emergency to Urgent
Redirection / Know Who To Turn To
Short stay assessment / Avoid admission
6 ESSENTIAL ACTIONS
Unscheduled Care