AGENDA ITEM NO: 11

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**26th January 2016**
Report By:	**Brian Moore Corporate Director (Chief Officer) Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/06/2016/BC**
Contact Officer:	**Beth Culshaw Head of Health and Community Care**	**Contact No:**	**01475 715283**
Subject:	**Reshaping Care for Older People and Delayed Discharge Performance**		

1.0 PURPOSE

1.1 The purpose of this report is to advise the Integration Joint Board of progress in Inverclyde's performance in relation to Delayed Discharges, set in the wider context of the range of initiatives in place responding to the national strategy of Reshaping Care for Older People.

2.0 SUMMARY

2.1 The Delayed Discharge target reduced from 4 weeks to 2 weeks from April 2015. Local efforts to achieve this target are informed by the Reshaping Care for Older People strategy, with the overarching aim to provide integrated, planned, person-centred care close to or within people's own homes.

3.0 RECOMMENDATIONS

3.1 Members are asked to note the progress towards achieving the Delayed Discharge target and the ongoing work to maintain performance.

Brian Moore
Corporate Director (Chief Officer)
Inverclyde HSCP

4.0 BACKGROUND

4.1 The 10 year strategy Reshaping Care for Older People - A Programme of Change 2011- 2021 and the subsequent refresh 'Getting On' (2013), set out the vision that "Older people in Scotland are valued as an asset, their voices are heard and older people are supported to enjoy full and positive lives in their own home or in a homely setting".

4.2 Our local intentions are contained in the Joint Strategic Commissioning Plan for Older People (2013) and associated delivery plan; the purpose being to promote involvement, empowerment, enablement and recovery-focused planning and delivery which shift the balance of care from residential to community-based services.

4.3 Change Fund monies were available for a three year period to March 2015. This funding enabled us to trial a range of initiatives to address the demographic challenges of an increasingly frailer, elderly population with the key aim of avoiding unnecessary hospital admission and promoting safe, effective discharge.

4.4 **Home First**

Partnership working across the HSCP and Inverclyde Royal Hospital has recently focussed on improving our discharge processes and is informed by the Joint Improvement team.

Team 'Home First' policy. Home First complements the Reshaping Care for Older People strategy by recognising that safe, effective care should wherever possible be provided in the community and that prolonged periods of hospitalisation can contribute to detrimental outcomes for older people. Wherever possible, we reduce the length of time older people spend in hospital and that, at discharge, older people return to their own home.

We continue to utilise and update our Home First Strategic Action Plan, which is monitored at the monthly Strategic Discharge meeting attended by senior managers of the HSCP and Inverclyde Royal Hospital.

There is robust evidence to support the effectiveness of early assessment and the diagnosis of frailty in older people. Within the hospital environment this approach can have major improvements in outcomes including: positive effects on mortality rates; reduction in readmissions and safe discharge of the individual back to their own home.

In November we held a joint workshop to consider the advantages of the comprehensive geriatric assessment model recently introduced to the Royal Alexandra Hospital, Paisley and how we might utilise resources to achieve this locally. This includes jointly developing the role and remit of the new Elderly Care Assessment Nurse (ECAN) who provides early assessment to older people in hospital in order to identify those who can be discharged home quickly and those who would benefit from rehabilitation within the Larkfield Unit, Inverclyde Royal Hospital.

4.5 **Review of specialist nurses**

We have undertaken a review of all specialist nurses with a remit around discharge based within Inverclyde. This has provided a greater clarity of roles and assisted us to establish processes which ensure appropriate access to information and services to support timely discharge. It is our intention to broaden the scope of this work within both Inverclyde Royal Hospital and the community to include other services supporting discharge such as:-

- Home Care

- Discharge Social Work Team
- Allied Health Professionals
- Care Home Liaison Nurses

4.6 **Delayed Discharges**

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 also reports on the number of bed days lost due to Delayed Discharges, as this provides a more complete picture of the impact of hospital delays (Appendix 1).

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.

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 or residential care placement.

We have consistently achieved zero delays of more than 4 weeks since February 2015 and zero delays more than 2 weeks since April 2015. In November the census data showed that we again had no service users waiting longer than 14 days, with 4 service users awaiting support packages to be arranged.

This performance is set against a background of increasing referrals for social care and community supports following discharge. Between April and October 2015 we have received a 15% increase in referrals compared to the same period in 2014.

In common with other areas across Scotland, we continue to see an increasing number of emergency admissions with an overall reduction in the number of bed days occupied (Appendices 2 and 3). This 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.

4.7 **Step Up Beds (Intermediate Care)**

To further develop our range of community-based options to avoid unnecessary hospital admission, we have engaged with local care home providers to establish step up beds.

During this winter, we will utilise short term placements in care homes to provide 24 hour supervision and intensive rehabilitation. This offers an additional service which can respond at times of crisis where it is not practical for someone to remain at home but for whom hospital admission is not required. We will monitor the effectiveness of this service in reducing the number of emergency admissions to IRH.

Placements will be short term, and may be from as little as a few days up to a maximum of 6 weeks; thus focussing on recovery, reablement and rehabilitation, to enable a return home.

This service will be funded through existing budgets and use of the Integrated Care Fund to provide additional Allied Health Professionals capacity, including physiotherapy and occupational therapy.

Engagement sessions have taken place with providers and representatives of Scottish Care, and we will closely monitor activity over the winter to inform the future specification of the service. There is an intention then to begin a tender process which will enable the development of a 6-bed step up unit within a local care

home(s). The unit will allow provision of dedicated rehabilitation space and an environment focussed on equipping people to return home.

4.8 **Care Home Activity**

In recent years we have been monitoring the average length of stay of clients in care homes, and are pleased to report an ongoing reduction (Appendix 4). This reflects the changing demographic of the care home population; improved assessment and community resources have ensured that those admitted more recently have more acute needs reflecting a greater period of support whilst still in their own home.

4.9 **Providers Forums**

Inverclyde HSCP is committed to working in partnership with social care providers to ensure the best possible services are provided, and that mutually beneficial relationships are sustained with a range of Providers Forums now in place. Working in this way informed the recent development and introduction of the new Homecare Framework as well as the development of proposals relating to step up beds in care homes.

Feedback from providers demonstrates that they find the opportunity to get together in this way invaluable, not only for the information that they receive but also for the ability to network with other providers.

4.10 **My Home Life**

Local care home managers have participated in the 'My Home Life' leadership programme with support provided by Inverclyde HSCP and Scottish Care. This is a UK-wide initiative promoting quality of life for older people living and dying in care homes, and for those visiting and working with them, through relationship-centred and evidence-based practice. The programme highlights include: Improving health & healthcare; Sharing Decision-making**;** and Keeping the Workforce Fit for Purpose. This has also led to increased collaborative working, particularly with District Nurses and Care Home Liaison Nurses (CHLN).

4.11 **Role of Social Work Review Team and Care Home Liaison Nurses**

In March 2015 the HSCP set up a Long Term Care Social Work Review Team whose remit is to ensure regular reviews of residents within care homes, better liaison with care home managers and staff, and monitoring of the care and support residents funded by the HSCP receive. The review team works closely with the CHLN.

As well as offering professional nursing support to nursing homes within Inverclyde, the CHLN are involved in an exercise to review all admissions to hospital from long term care placements. The CHLN are assisting in identifying where admission may have been avoided as well as facilitating timely discharge.

4.12 **Integrated Care Plan**

Since April 2015 and the end of the Change Fund, we have developed our local Integrated Care Plan (ICP) which is supported by the associated Integrated Care Fund. Whilst not solely directed at older people, the themes within the plan continue to deliver on the Reshaping Care for Older People outcomes, and have widened to pay particular reference to individuals with long term conditions.

In particular, the focus continues to be on supporting older people to stay in their own homes for as long as possible by further developing supported self care, anticipatory care, reablement and access to Telecare. A full report on the progress of the ICP will be brought back to a future IJB meeting.

4.13 **Integrated Palliative Care Development Plan**

As part of the partnership approach to care of older people, we have developed a multi-agency Palliative Care Development Plan. This has led to a range of initiatives in line with the aim to embed palliative care in our day to day practice.

The Inverclyde GP Palliative Care Facilitator has led an initiative to increase awareness of palliative care services and support GPs in their care of patients. This has included visits to all local GP surgeries to foster links between the community and Ardgowan Hospice services. This has also led to providing each GP surgery with a copy of the Palliative Care Resource Packs which includes pharmacy advice and prognostication tools.

Following an educational needs assessment survey of local GPs in 2014, GPs are offered regular Palliative Care evening education sessions which include discussion around all these topics and again foster good team working and networking within Inverclyde.

The District Nursing Teams have supported the roll-out of the Supportive and Palliative Care Action Register (SPAR). This tool assists with recognition of deterioration in the health and wellbeing of palliative care patients.

All partners across Inverclyde have been encouraged to be involved in SPAR and this has been particularly successful within care homes and is now being rolled out to care at home services.

4.14 **Day Care Review**

Inverclyde Day Care Services were last fully reviewed in 2003 and it was recognised that a review was necessary in recognition of the ageing population, as well as policy directives such as the Reshaping Care for Older People agenda, Self-Directed Support legislation and the Inverclyde Joint Strategic Commissioning Plan for Older People.
A review of all day care provision for older people across Inverclyde is nearing completion. This will inform the future development of day services across both the HSCP and our partners.

4.15 **Reablement and Homecare**

Reflecting the complexity and increasing needs of our older population we continue to see increasing demands upon both our reablement and homecare services. Homecare is a high volume, complex service interfacing with over 1200 discreet service users each week, many several times per day, and given the need to meet fluctuations in demand has to be able to flex service delivery at short notice.

We are now seeing some consistency in the level of referrals to reablement at around 80 per month and, on average, achieving full independence for a third of these. If this performance continues it places us in a stronger position for the future. However, of the hours transferring, we continue to see increasing demand in both evening and weekend service delivery.

Additional pressure monies are being considered as part of the current process of budget proposals.

5.0 PROPOSALS

5.1 As outlined above, it is intended to continue to utilise the range of initiatives currently underway to achieve the objectives outlined in the Reshaping Care for Older People strategy with the implicit aim of maintaining and improving upon our current performance in relation to Delayed Discharges.

6.0 IMPLICATIONS

FINANCE

6.1 Financial Implications:

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (If Applicable)	Other Comments

LEGAL

6.2 There are no legal issues within this report.

HUMAN RESOURCES

6.3 There are no human resources issues within this report.

EQUALITIES

6.4 There are no equality issues within this report.

Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
√	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

7.0 CONSULTATION

7.1 This report has been prepared by the Chief Officer, Inverclyde Health and Social Care Partnership (HSCP).

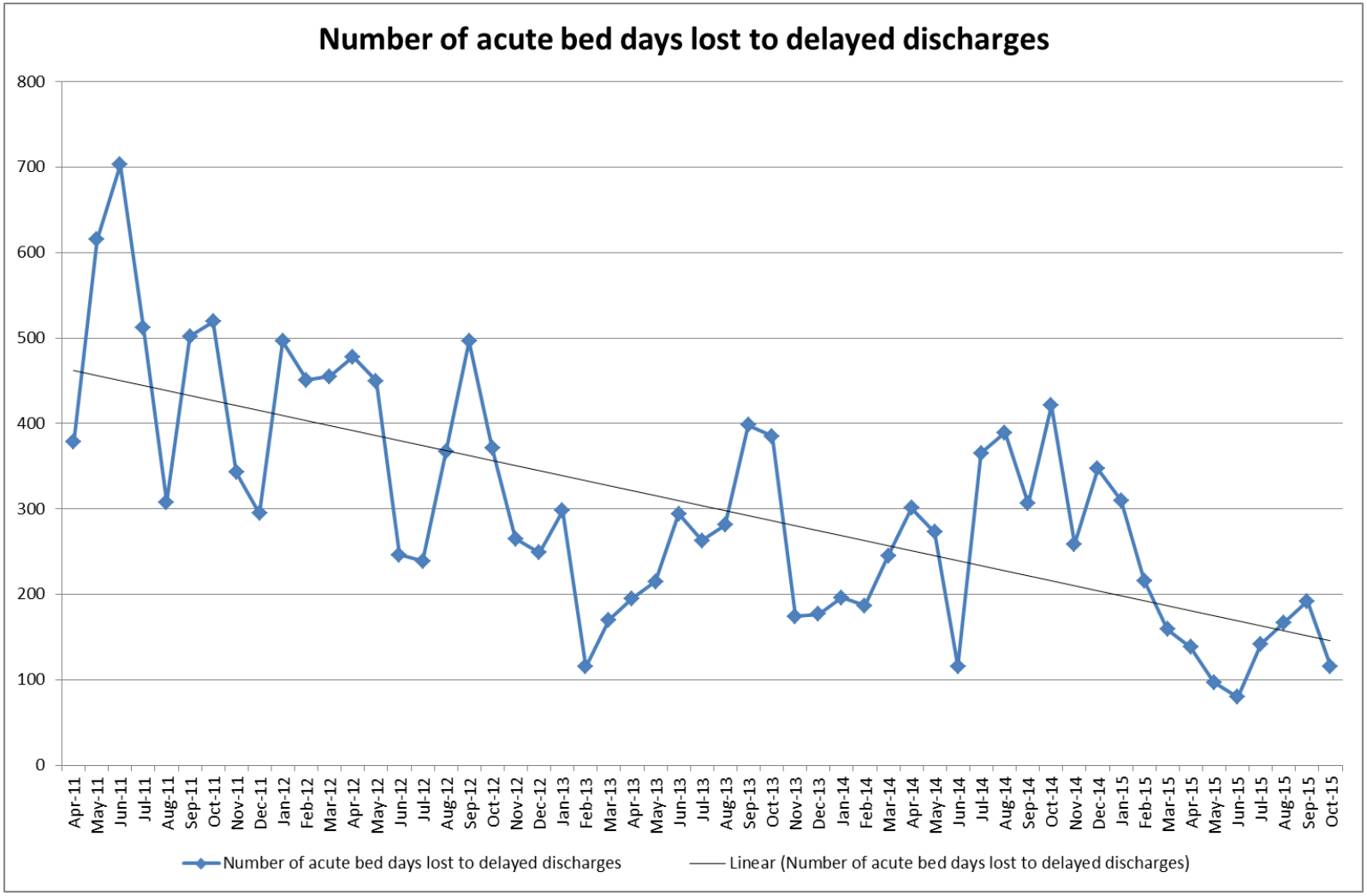
8.0 LIST OF BACKGROUND PAPERS

8.1 Reshaping Care for Older People Strategy – A Programme of Change 2011-2021.

8.2 Reshaping Care for Older People Strategy – Getting On 2013.

8.3 Inverclyde Joint Strategic Commissioning Plan for Older People 2013.

Appendix 1


Number of acute bed days lost to delayed discharges
800
700
600
500
400
300
200
100
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
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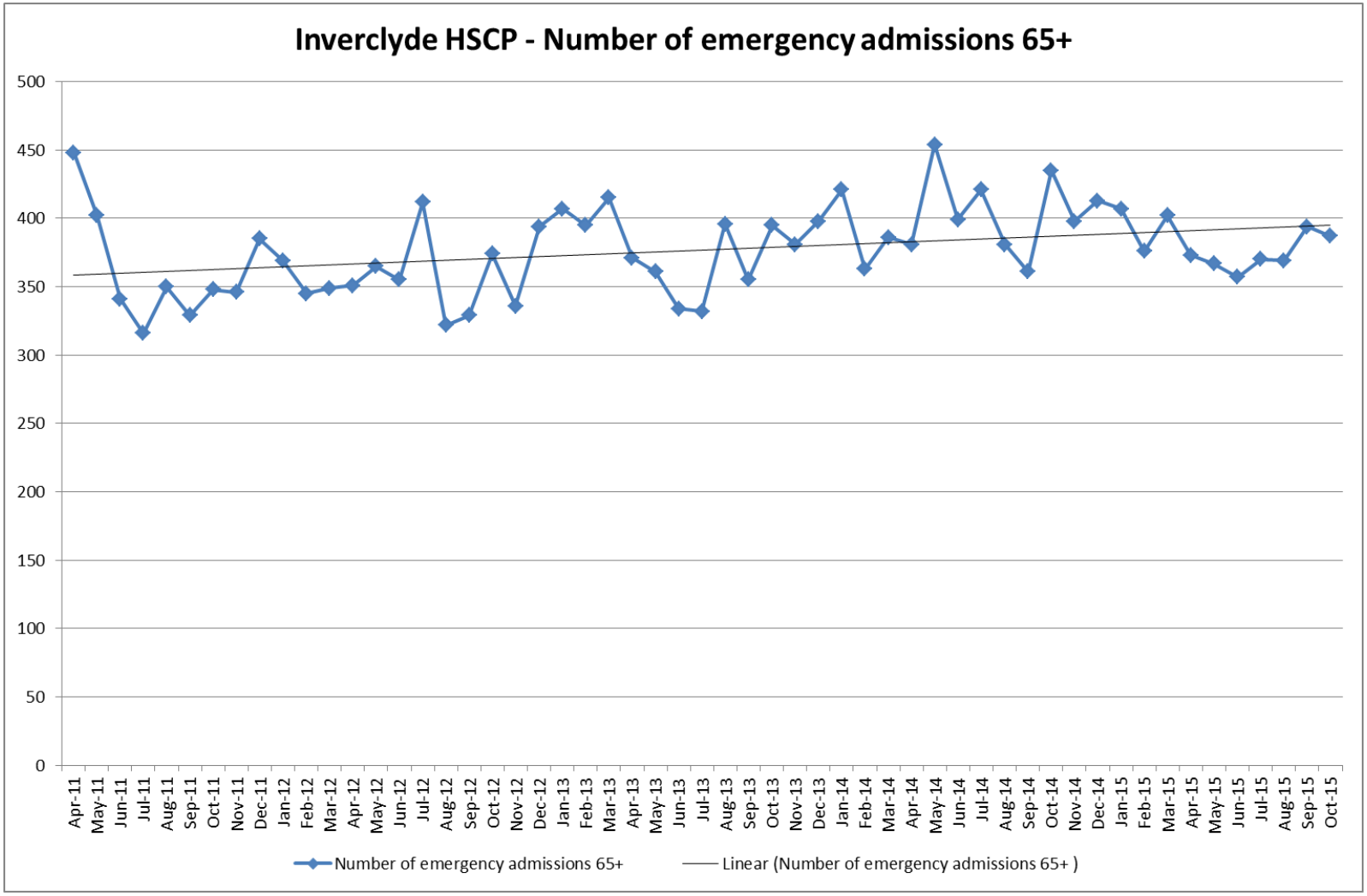
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Number of acute bed days lost to delayed discharges
Linear (Number of acute bed days lost to delayed discharges)

Appendix 2


Inverclyde HSCP - Number of emergency admissions 65+
500
450
400
350
300
250
200
150
100
50
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Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
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May-12
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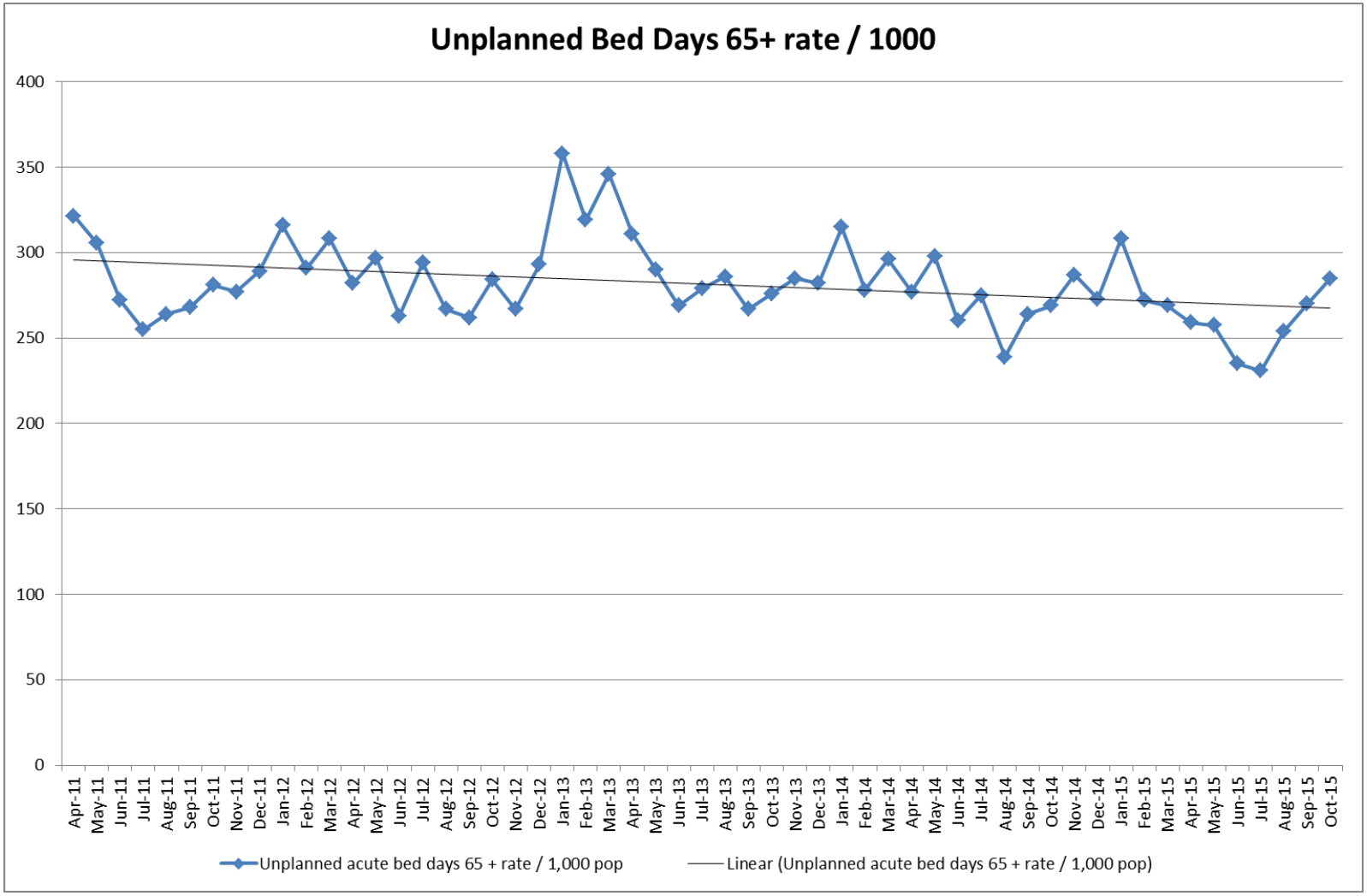
Oct-15
Number of emergency admissions 65+
Linear (Number of emergency admissions 65+)

Appendix 3


Unplanned Bed Days 65+ rate / 1000
400
350
300
250
200
150
100
50
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Apr-11
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Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
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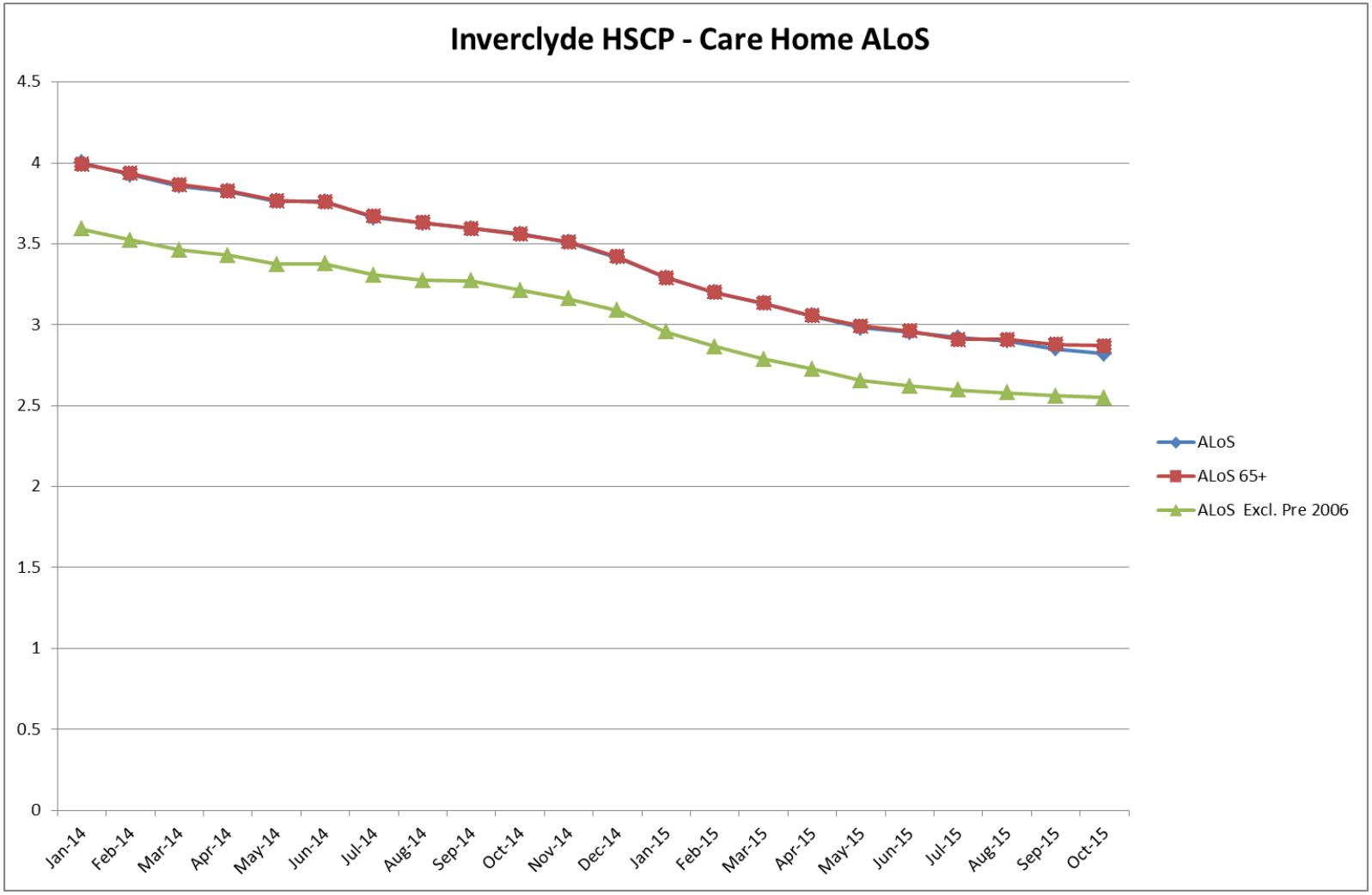
Sep-15
Oct-15
Unplanned acute bed days 65 + rate / 1,000 pop
Linear (Unplanned acute bed days 65 + rate / 1,000 pop)

Appendix 4


Inverclyde HSCP - Care Home ALoS
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
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Oct-14
Nov-14
Dec-14
Jan-15
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Jul-15
Aug-15
Sep-15
Oct-15
ALoS
ALoS 65+
ALoS Excl. Pre 2006