AGENDA ITEM NO: 12

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**8 November 2016**
Report By:	**Brian Moore Corporate Director (Chief Officer) Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/64/2016/BC**
Contact Officer:	**Beth Culshaw Head of Health and Community Care**	**Contact No:**	**01475 715283**
Subject:	**UPDATE ON DELAYED DISCHARGES, UNSCHEDULED CARE AND WINTER PLANNING**		

1.0 PURPOSE

1.1 The purpose of this report is to advise the Integration Joint Board on activity in relation to Unscheduled Care, preparation for winter and to provide an update on ongoing activity to achieve the Delayed Discharge target.

2.0 SUMMARY

2.1 Throughout the year, as an integral part of day-to-day working, there is collaboration between the range of partners, professionals, service users and carers to ensure effective transitions at points of admission and discharge. As activity rises over the winter months, and pressure on the system mounts, it becomes increasingly important to operate effectively. Review of previous winters' activity, and lessons learned from this, inform comprehensive planning arrangements across social, primary and secondary care on a local, sector and Board-wide basis.

3.0 RECOMMENDATIONS

3.1 Members are asked to note the progress towards maintaining achievement of the Delayed Discharge target, risks associated with this and planned arrangements for addressing winter.

Brian Moore
Corporate Director (Chief Officer)
Inverclyde HSCP

4.0 BACKGROUND

4.1 The current target for Delayed Discharges nationally is for patients to be discharged from hospital within 14 days of being agreed to be clinically fit.

4.2 The Board has also introduced a target of 72 hours which is proving to be challenging for all Partnerships.

4.3 Nationally there is also a target for patients presenting at an Emergency Department (ED) to be seen and action agreed within 4 hours. Performance against this target is a key indicator of hospital performance throughout the year, and particularly in winter as attendances at EDs rise, increasing demand on the range of hospital services behind the front door.

5.0 PROPOSALS

5.1 **Delayed Discharge**

Since February 2015 in Inverclyde we have consistently achieved zero delays over 2 weeks at the census date. Additionally, Appendix A illustrates that there continues to be a downward trend in the number of bed days consumed by Delayed Discharges in Inverclyde.

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 reablement or resumption of a homecare package.

To date our performance against the Delayed Discharge target has been maintained despite the increasing pressure we are seeing in demand for care home beds, leading to reduced local availability and increased costs. As we enter the winter the issues associated with this change in activity present the greatest challenge. The tables at Appendices B and C clearly demonstrate the increasing demand offset by a continuing downward trend in the length of stay following admission, i.e. individuals are appropriately being admitted at a later stage with greater needs, resulting in care homes largely providing end of life care.

Complementing care home provision are a range of community-based services, enabling service users to remain in their homes for longer. Since the turn of the year we have piloted step-up beds, providing intermediate care within care home settings. Service users who have escalating needs but are clinically stable are admitted from the community for up to 6 weeks, supported by comprehensive Allied Health Professionals and Housing input. We have also utilised this service to provide wraparound care at home with positive outcomes.

5.2 **Unscheduled Care**

During 2015/16, NHS Greater Glasgow and Clyde has delivered an extensive programme of improvement work across the North, South and Clyde Sectors. Recognising that significant improvements have been made, there is still work to be done to consistently achieve the 95% Unscheduled Care Compliance (UCC) standard. Implicit in achieving the target is the recognition that it is not only a measure of efficiency of the service but also correlates with the safety and quality of care for patients. A Programme Board, chaired by the Chief Executive, has been established underpinned by the following work streams in each sector:-

Analysis of Demand, Flows and Resources – comprehensive analysis, the effectiveness of our service responses, source of referrals, nature of presentations and alternatives available to patients.

Assessment Processes – with increasing demand we must ensure that our assessment processes are fully effective and equitable: this will include improved use of Ambulatory Care and the provision of rapid access clinics as an alternative to admission. An important priority is move as much unscheduled care onto a scheduled basis when clinically appropriate.

Inpatient Flow Processes – develop existing programme of improvement work to reduce delays in the system and optimise capacity over the 24 hour period.

Integrated Facilities Processes – develop programme of integrated work to understand bottlenecks and service constraints.

Scottish Ambulance Service – develop programme of joint work with SAS around admission avoidance and better scheduling of care.

Interface with GPs – identify key issues in interface with GPs.

Work with HSCPs – establish an agreed programme of work which will be led by HSCPs.

Develop a Matrix for Performance Improvement – we need to understand and address variation.

The improvement projects will progress as a series of tests of change with pilot work established as proof of concept.

As well as participating in the Clyde Sector programme of work, locally in Inverclyde we continue to work closely with hospital colleagues. Current work is focusing upon the principles of Home First, as well as developing plans for Comprehensive Geriatric Assessment Beds as part of an Older Adults Assessment Unit.

5.3 **Winter Planning**

In common with previous years, we have developed a local operational winter plan which reflects lessons learned from previous years' winter activity.

The plan identifies and addresses the local issues across primary care and community services for which Inverclyde Health and Social Care Partnership is responsible and complements the Acute winter plan, generating a whole system approach. Similarly it aligns to Inverclyde Council's contingency planning for winter.

The Winter Planning Operational Group with representation from each relevant HSCP service will meet on a weekly basis from mid-November. This provides the forum to examine local performance data to plan responses to extra pressure on the system as it arrives, with daily overview on pressures provided by Social Work attendance at the hospital morning huddles.

A rolling action log will be maintained and reported weekly to the Chief Officer; a report analysing the activity, performance and pressures during the winter will be provided to the IJB at the end of the winter period.

6.0 IMPLICATIONS

FINANCE

6.1 Financial Implications

None

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)
√	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.

6.4.1 How does this report address our Equality Outcomes?

6.4.1.1 People, including individuals from the above protected characteristic groups, can access HSCP services.

6.4.1.2 Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.

6.4.1.3 People with protected characteristics feel safe within their communities.

6.4.1.4 People with protected characteristics feel included in the planning and developing of services.

6.4.1.5 HSCP staff understands the needs of people with different protected characteristic and promote diversity in the work that they do.

6.4.1.6 Opportunities to support Learning Disability service users experiencing gender based violence are maximised.

6.4.1.7 Positive attitudes towards the resettled refugee community in Inverclyde are promoted.

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

6.5 There are no governance issues within this report.

NATIONAL WELLBEING OUTCOMES

6.6 How does this report support delivery of the National Wellbeing Outcomes?

6.6.1 People are able to look after and improve their own health and wellbeing and live in good health for longer.

6.6.2 People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

6.6.3 People who use health and social care services have positive experiences of those services, and have their dignity respected.

6.6.4 Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

6.6.5 Health and social care services contribute to reducing health inequalities.

6.6.6 People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.

6.6.7 People using health and social care services are safe from harm.

6.6.8 People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

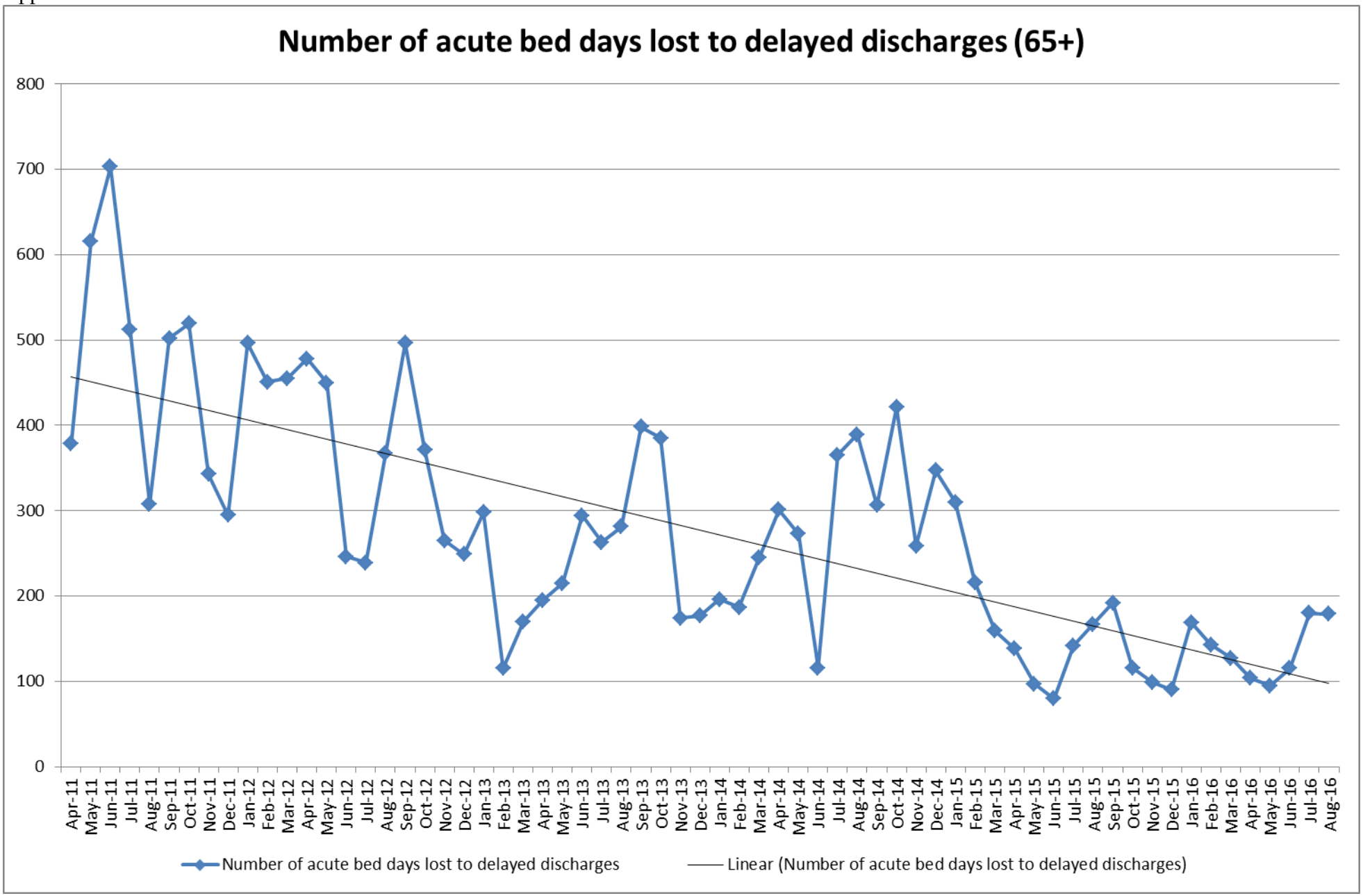
7.0 CONSULTATION

7.1 None.

8.0 BACKGROUND PAPERS

8.1 None.

Appendix A


Number of acute bed days lost to delayed discharges (65+)
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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Feb-15
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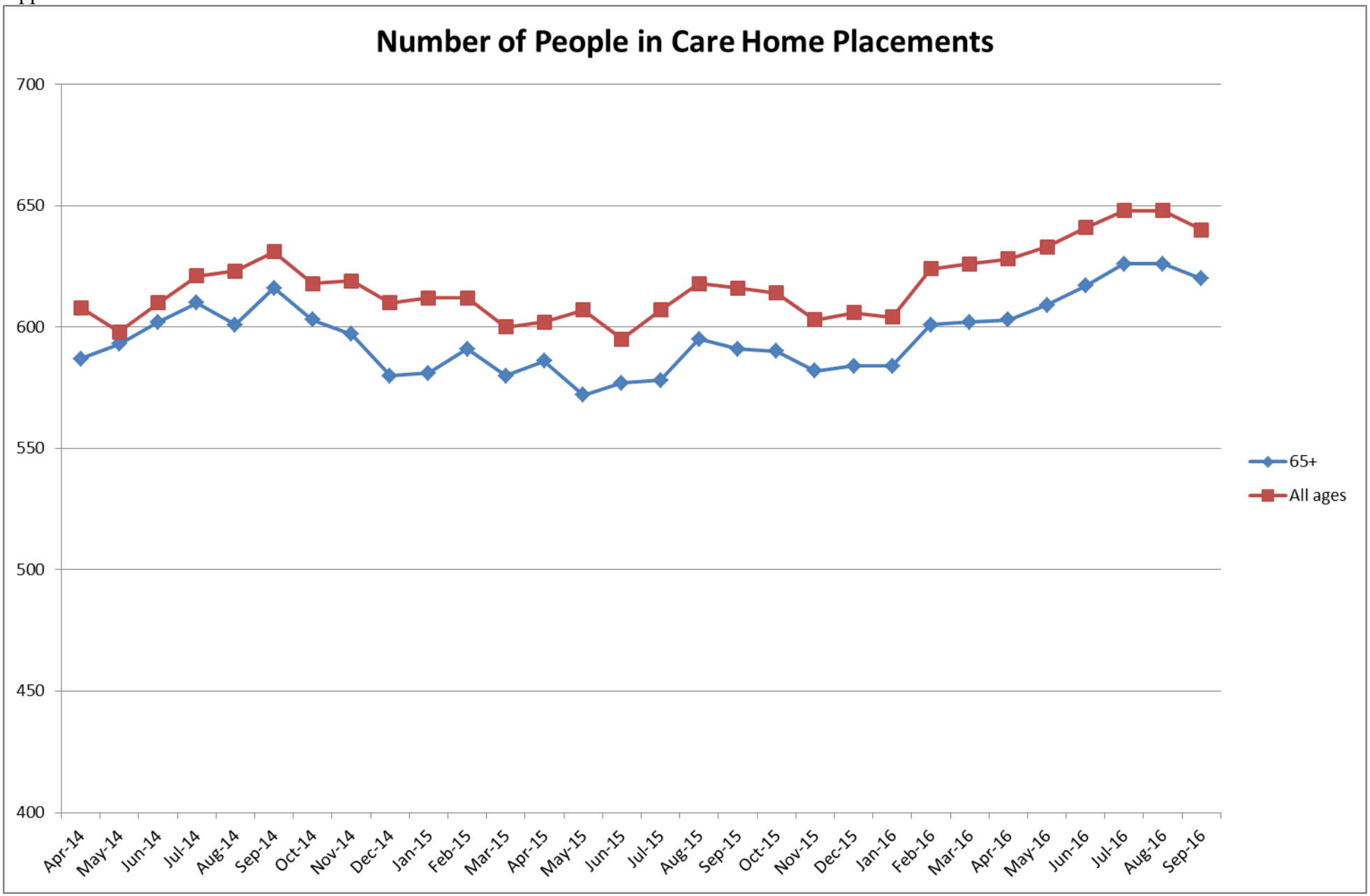
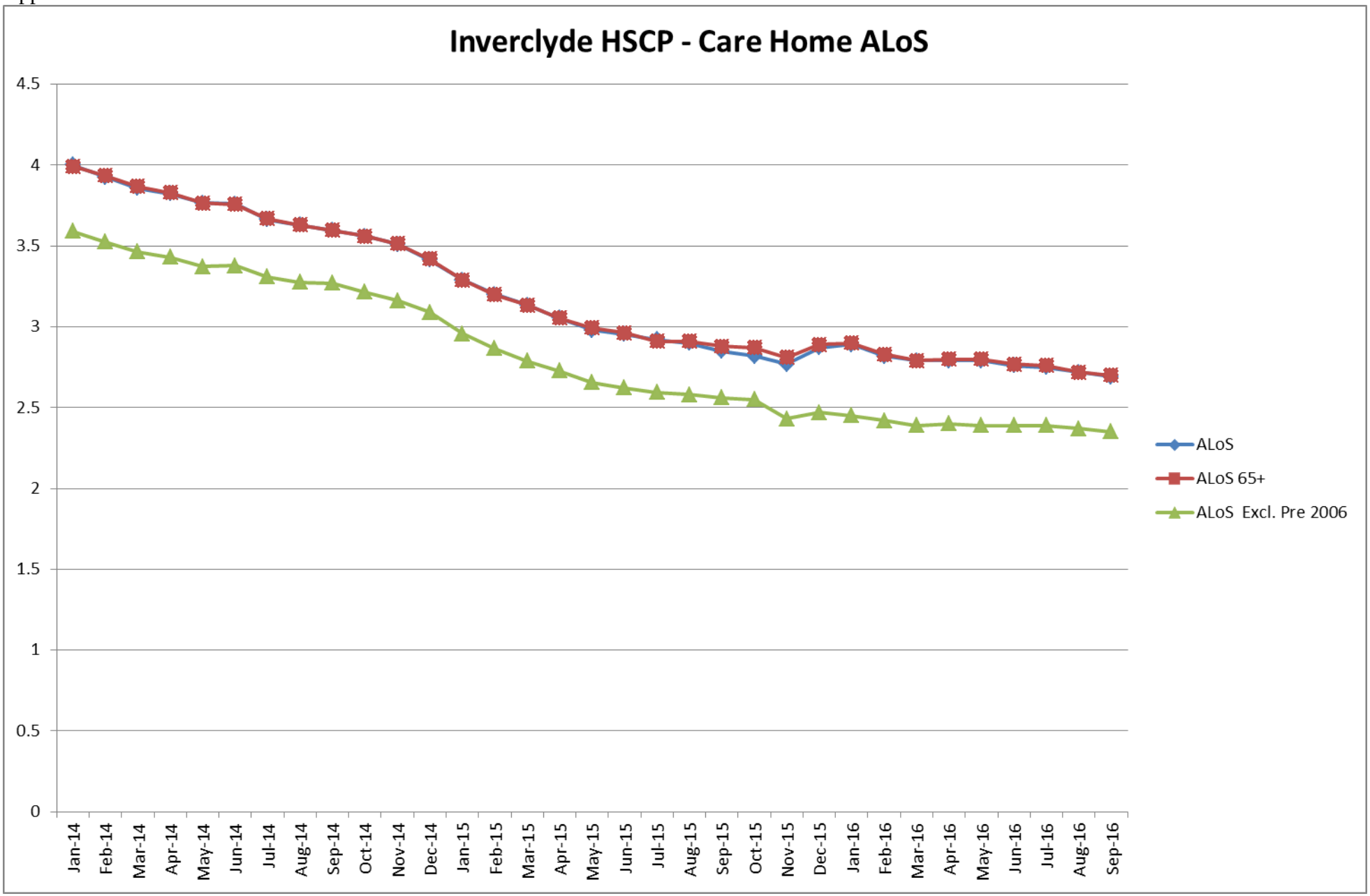
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Number of acute bed days lost to delayed discharges
Linear (Number of acute bed days lost to delayed discharges)

Appendix B


Number of People in Care Home Placements
700
650
600
550
500
450
400
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
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
65+
All ages

Appendix C


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
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
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
ALoS
ALoS 65+
ALoS Excl. Pre 2006

Appendix D

HSCP Winter Planning Work Plan 2016/17

Alan Brown, Service Manager
Updated 24/09/2016

Key Issues	Status & Issues	Task	Lead	Progress
Ensure community services are available when required	Clear Service Pathways are in Place Process of referral and response is timely	Established Direct Access Point for community Services in particular out of hours Out Of Hours pathway finalised	EC	Completed
	Ensure up to date information re access to service is available	Update information sheet with 2 main contact numbers • Office Hours (ACM 01475 715010) • Out with Office Hours (DN OOH) Information supplied to partners of community based services		5/10/2016 31/11/2016
	Operational Discharge Meeting is attended by key operational individuals including community Leads who assist in planning discharge of complex cases	ODM to be arranged	AB	31/10/2016
		Report into WPDP (Winter Plan Data Pack) Include discussion of HC packages including restarts Agreed process require to update HC by Tue lunchtime Information around hospital admissions Need to check if home care info is being communicated to wards on		in place
	Homecare has a fast flexible service to respond to referrals and discharge on a enablement model	Identify potential pressure on service	JA	completed
		Advise of HC service over Winter/Holidays Referral Process for discharge prior to Festive period		31/10/2016
	The Community Nursing service and Homecare service provide a service 24 hours, 365 days per year inclusive of	These teams, in partnership with Acute and Out of Hours services, will support safe and effective hospital discharges during weekends and holidays.	A Best	In place

	bank public holidays.			
Focussed recovery from periods of limited cover	HSCP Rotas over winter period to be confirmed	Based on previous years CACM/ Duty cover IRH in terms of back up & support	AB	31/11/2016
		Arrange Annual Leave for period to ensure sufficient cover		
	CACM duty rota to cover peak holiday period and January 16 (Dec15 -Jan 16)	Home Care Reablement RES District Nurses Liaison Nurses	AB	
	Peer immunisation clinic	HSCP Staff are actively encouraged to be vaccinated and local peer vaccination sessions were organised	TB	31/10/2016 Passed to communication teams
	Access to Joint Store	CIL Access Point in place Social Work Occupational Therapy is staffed week days and can respond to prevent escalation leading to potential admission. This provision is maintained across the holiday period with the exception of the public holidays.	JA	In place
Planning GPs cover for 2 bank holiday periods	GP practices will put in contingency arrangements for winter period	AB to liaise with Pauline for arrangements by GP's over Dec/Jan	PA	Raised with practice managers and GP forum by Oct 2015 PA to link with Practice Managers to confirm BCP
		practices to ensure their business continuity plans are up to date and that emergency contact details are accessible in the event of an incident		
		GPs will implement suggested contingency arrangements over the festive period as per LMC guidance. In addition Practices will advise Patients of closure via SOLUS Screens and also prompt patients to order prescriptions in advance.		
Service Capacity	Home Care capacity	Exception reporting agreed to be included in Winter Plan Data Pack	AB	In Place

	Care Home Capacity is monitored daily with pressures identified	Link with care home providers to maintain daily reports around pressure	AB	In place
	Equipment Stock Take	A predictive stock order of essential equipment will be submitted early November to ensure availability of supplies for the Community Home Care teams during the holiday period.	JA	31/10/2016
		A predictive stock order of essential equipment from wound dressings, pharmacy, and syringe drivers will be submitted early December to ensure availability of supplies for the Community Nursing and Rehabilitation teams during the holiday period.	A Best	31/10/2016
	Care Homes have BCP in place	Identified at Governance Meetings AB email Care Homes requesting confirmation of BCP in place	AB	31 October 2016
Prioritising emergency patients	Currently have early identification in IRH	Managed through weekly Operational Discharge Meeting early identification of potential discharge Meeting attended by Acute and Comm Staff	AH	In place
		Increase access to read only SWIFT in wards Plan to include A/E In progress for Wards J and Lakefield Unit	AB	Review by 31/10/2016
		Identify discharge of New Home care packages	JA	In place
	Early identification process of vulnerable people at risk of admission to IRH in community	Criteria for identification of most vulnerable adults at risk of admission Mental Wellbeing Il health/elderly carer Complex cases	AB	Review 31/10/2016

		Development of Friday Allocation Meetings to identify capacity issues complex cases	AB	
		The Community Nursing teams introduce *Patient Status at a Glance Team have daily meetings update*. details of vulnerable patients as well as patients with changing needs. To identify those at risk of admission. The nurses will link with GPs and HCC to identify patients who may potentially be vulnerable during the winter period	A Best	In Place
		The Home Care/ Social Work team maintain a note of vulnerable people known to them living in the community. Link with OPMHT to ensure list is updated Identification or flag on SWIFT	JA	31/10/2016
		Contacts with private providers of Homecare services include monitoring their capacity for delivering services as commissioned. Team leaders Home Care/ACM?DN speaking to managers about identifying critical cases Note local up to date information is vital and require facility to add to WPDP		31/10/2016
		Review role of Fast Track Assessment service Identify use, capacity and effectiveness of fast track clinic. Develop strategic approach to development of service alongside gerontology role Gerontology nurse is now seeing increased numbers of patients in community working as part of RES	EC	Review 31/10/2016
	Health Improvement	Link to GCC generic information and add local focus	AH	Review 31/10/2016

Reducing Numbers	Early identification of patients requiring supported discharge	Home First Action Plan is moving towards achieving 72 hour target Recorded as part of performance	AB	Review 31/10/2016
Reduce Admissions	Step Up Beds – Through the Night care teams in place and functioning	In place continue pilot over winter period Link with OOH DN service	EC EC	Review at 31/10/2016
Single Point of Access	Discharge Team/CACM now have single point of access based at GHC	Ensure contact information is circulated Generic email to be created for CACM Ensure telephone contact is available	AB	Review resource requirement 31/10/2016
Care Home support	HSCP Governance arrangements with Care Homes established. Care Home Providers Forum in place Enablement input to Nursing Homes	Liaison Nurses/ AHP peer group agreed to support work with care homes identification of residents at risk of admission Explore fast track discharge for existing residents liaison between ward and home	TB	Review 31/10/2016
Anticipatory Care	ACP in place for residents in care homes	Access to ACP	A Best	Review 31/10/2016
Capacity for AWI Patients	MHO rota in place and increased capacity of MHO service Early identification of AWI issues on wards with TL CMHT attending ODEM	Monitor the impact of AWI on IRH	CG	Review 31/10/2016 Review 31/10/2016
Equipment	Fast Track in place for discharge Joint Store single access in place	Access to equipment out with working hours. A stock of equipment is left at several points across Inverclyde and there is the provision of a folding hoist and slings based within the community alarm team. The district nursing service also holds moving and handling equipment, mattresses, commodes etc. The main sites where equipment is stocked are within Greenock Health Centre and at Hillend House although there is also a stock at IRH OT department and the Larkfield Unit. This is a long standing arrangement between services. The Joint Equipment store staff ensures that	DM	Review 31/10/2016

		equipment is always stocked at these venues. This allows for 24 hour access to equipment if required. The Occupational Therapy service has a Response team that respond to urgent requests for equipment within 24 hours Mon-Fri. This service often follows up where equipment is provided out with working hours to allow for a more comprehensive assessment of the home environment.		
In reach to Hospitals	Home First Action Plan	A District Nurse and OT in reach have been appointed to facilitate communication between Acute and Community and assist assessment and support planning for quicker discharge home	AB	Review 31/10/2016
Rehabilitation	Home First Action Plan	Establish the principle of assessment at home Use of OPDG to develop this Discharge Performance is good		
		RES team specialist input around COPD	JA	Review 31/10/2016
		Falls pathway in place and linked to initial referral to HSCP to take preventative approach.		
Develop agreed indicators to monitor performance	keep current PI so to compare performance on DD bed days lost	Staffing numbers capacity	EC	Review 31/10/2016
		Outcomes for step up to be determined		
		Identify escalation point and triggers- agree when and how huddle information should be escalated		
		Contingency plan for weekly meeting over winter period to evaluate performance and risk management	AB	
		Develop Data Capture Tool	DP	
		Produce weekly data pack	RM	
		Link this date to IRH daily Huddle information	AB	
		Capacity of services reported weekly HSCP Team leaders will report every Friday with pressure on service, availability and absence	Service managers	
Develop local communications plan	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	Winter Planning to be on agenda at HSCP communication group 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,	AB	HSCP communications group in place to coordinate communication Review 31/10/2016

		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.		
	Advice to Patients with chronic conditions on source of help	Public Health information to be circulated Local Contacts to be included Link to communication Plan Link to CR Plan on preparing for Winter Link to GCC generic information and add local	AH	Review 31/10/2016
	Twice daily huddle established in IRH	Identify how HSCP can input to Huddle during this time as well ODM	AH	Discharge Team Lead attend Huddle daily
	Advice to Patients with chronic conditions on source of help	Public Health information to be circulated Link to communication Plan Link to CR Plan on Preparing for Winter Local Contacts to be included Comms plan to be refreshed	focus on winter issues	AB/AH Review 31/10/2016