PERTH & KINROSS PARTNERSHIP

DELAYED DISCHARGE / WINTER PLAN

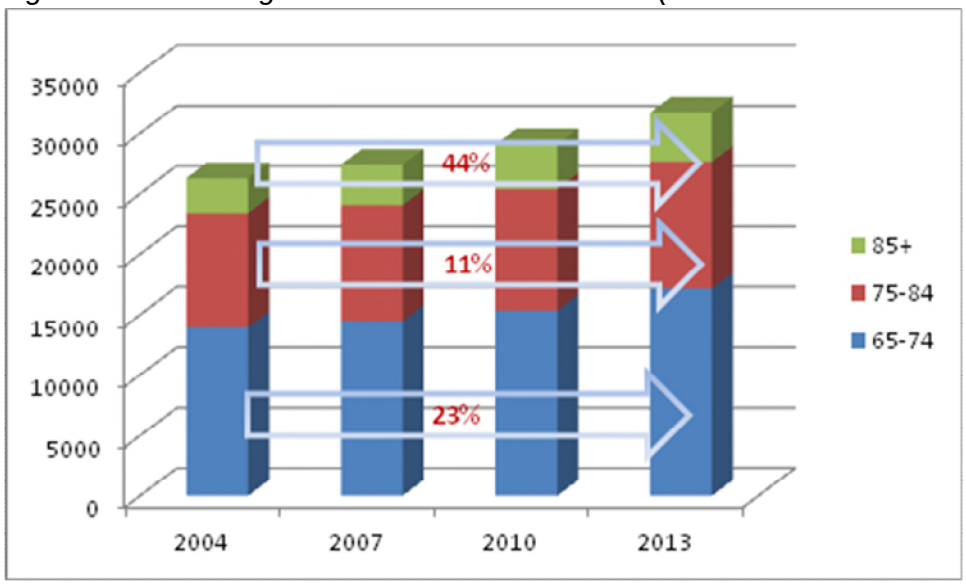
2015/16

Final version 230915

1. Introduction

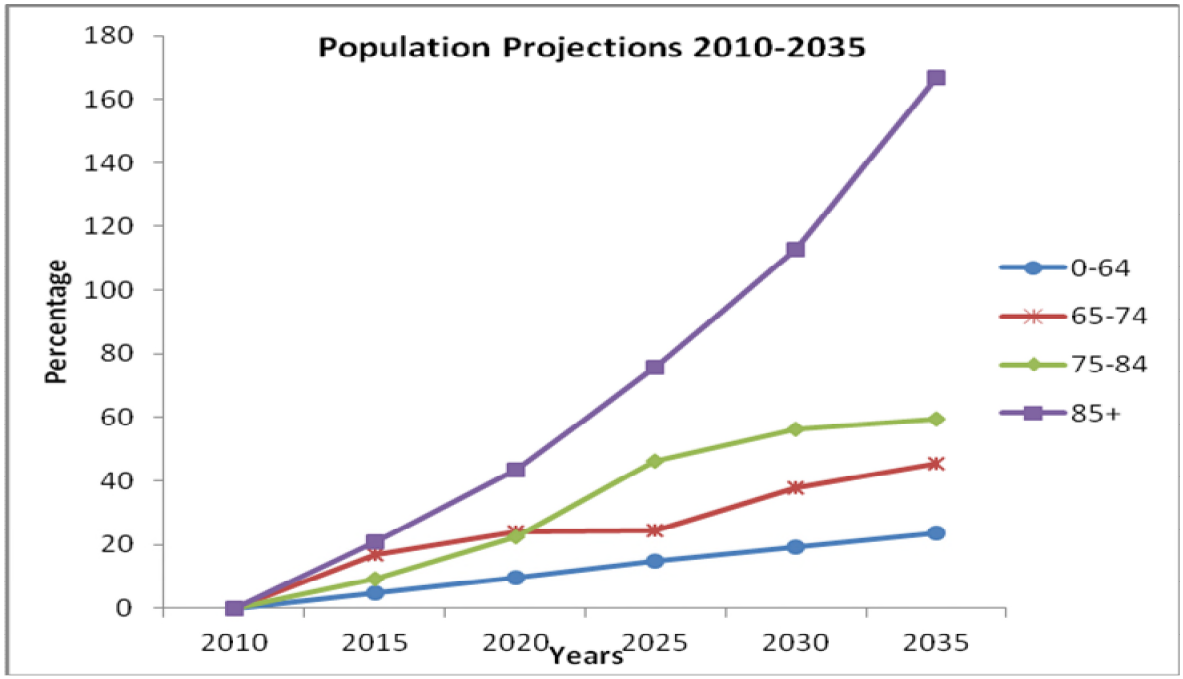
Perth & Kinross have a total population of 147,740 of whom 21% are over the age of 65. Since 2004 there has been significant increases in the over 65+ age group especially in the 85+ age group (44%) – *Figure 1.*

Figure 1 – Percentage Increase in 65+ 2004-2013 (Source National Records of Scotland)



In addition, population projections estimate further significant increases in the older population in Perth & Kinross and that those in the oldest age groups (85+) will continue to increase at the highest rate. It is projected that there will be an increase of 56% in the population aged 75-84 with the biggest increase being in the 85+ by 2037 (167%) (Figure 2).

Figure 2 – Changes in population aged 65 or above in Perth & Kinross, 2010-2035 (Source: National Records of Scotland 2010)

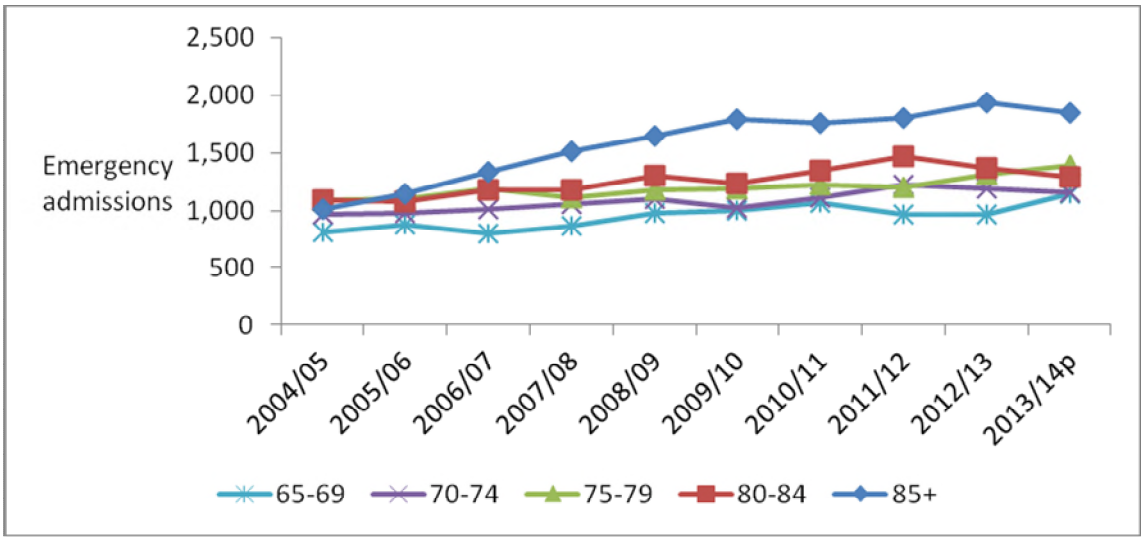


People are generally living longer and many will possibly have one or more long term limiting illnesses and complex needs which are likely to limit their independence and increase the likelihood of hospital care.

2. Unplanned Admissions

Figure 2 below illustrates that from 2004 to 2013 there has been a 38% increase in the number of people with a Perth & Kinross postcode over 65 being admitted to hospital as an emergency admission with a relatively larger increase in emergency admissions for people aged over 85 - 82%.

Figure 2 – Emergency Admissions for 65+ population by age group – Source ISD

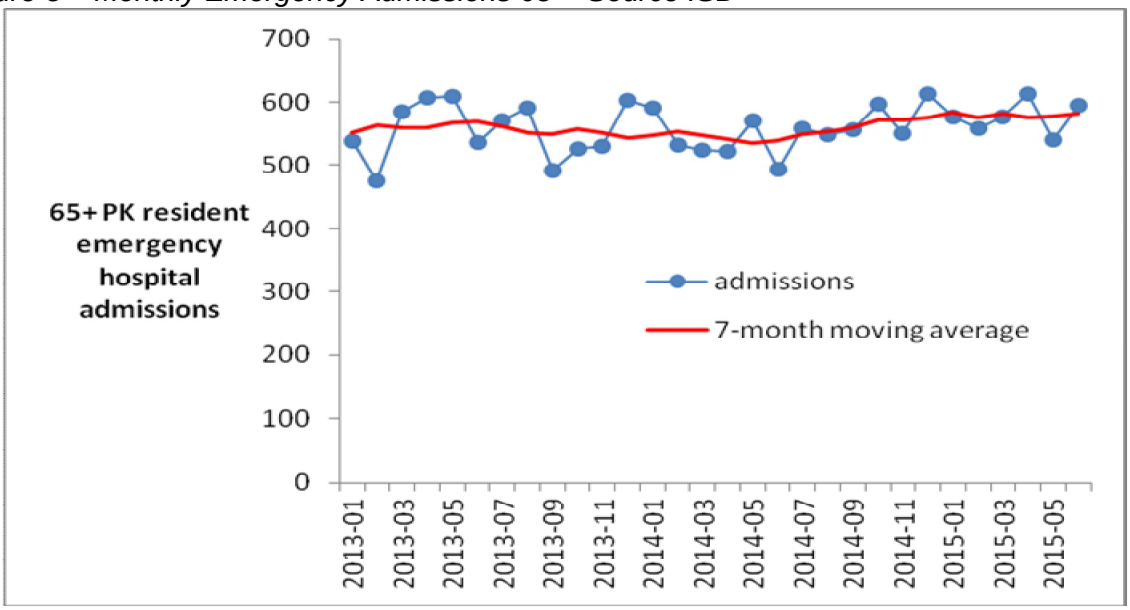


However, since early 2013 there appears to be a levelling in the number of people aged 65+ being admitted as an emergency. Although this cannot be attributed to specific projects, it is believed that the investments made through additional funding streams such as the Change Fund and Winter Planning for alternatives to admission has had a part to play in supporting this move.

The rolling average for 65+ emergency admissions for P&K residents (Figure 3) indicates a reduced rate of increase compared with previous years. Between 2004 and 2012, the rate of increase was around 250 per year (source: ISD). Since early 2013 the rate of increase is tending towards zero, although there has been a slight rise in the rate since the beginning of 2015.

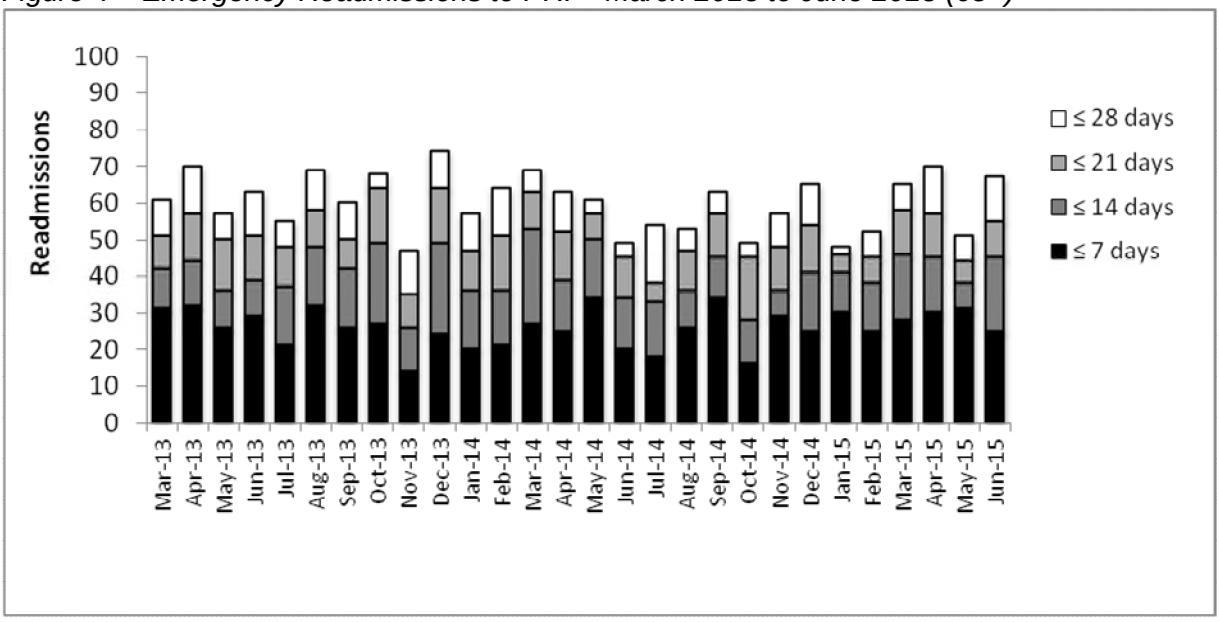
Correlation analysis of monthly data comparing 2013 and 2014 does not indicate seasonal variation (figure 3).

Figure 3 – Monthly Emergency Admissions 65+- Source ISD



In addition, Perth & Kinross have been experiencing an increase in the number of people being readmitted to hospital within 28 days of discharge, with no specific reason as to why (Figure 4)

Figure 4 – Emergency Readmissions to PRI – March 2013 to June 2015 (65+)



The rise in readmissions prompted a real time ward based two month audit in 2014, as well as analysis of historic data. While the picture changes from month to month, there continues to be around 7- readmissions per month to PRI for patients aged 65 and over.

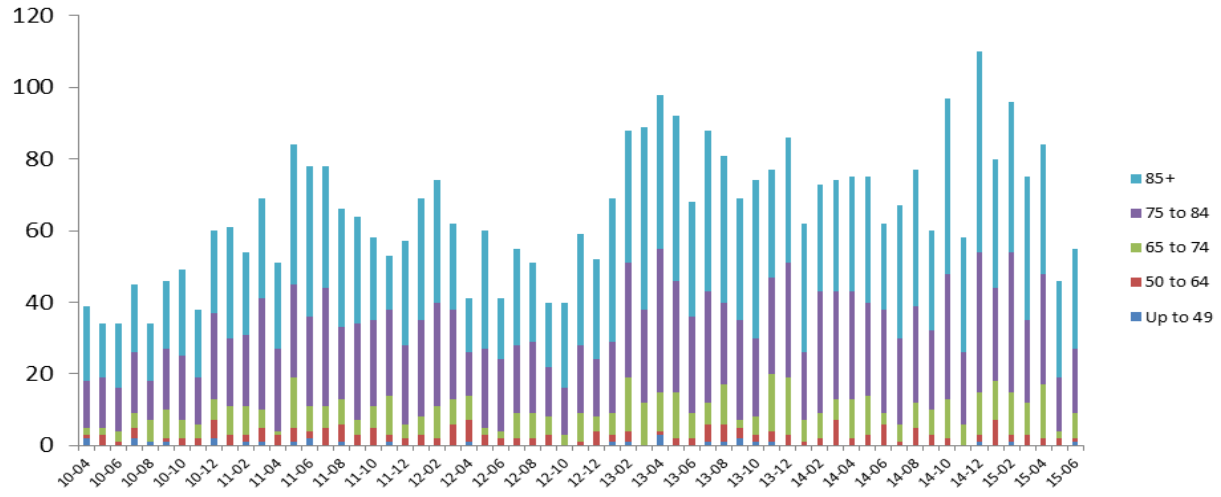
Data was collected over a 2 month period, July and August 2014. 135 patients in total were readmitted in July and 71 patients in August, which averages at 16 patients per week, approximately 2 per day. The analysis concluded that while some readmitted patients (12%) may have been supported in the community with enhanced support, most (88%) required an acute admission due to the acuity of their illness.

Almost half of these patients were readmitted within 7 days of the previous discharge. Two-thirds of the patients readmitted were 75+ and around half had community support (community nursing or care package). Only 2% had an Anticipatory Care Plan in place.

3. Delayed Discharges

Whilst rising emergency admissions are the single greatest source of pressure on the acute sector as a whole, is only the start of a chain of cause and effect within the whole system. They have knock on effects on other parts of the system such as final discharge from hospital resulting in delays. Recent analysis of Scottish data has confirmed that over 90% of patients experiencing delayed discharge were initially admitted as an emergency.

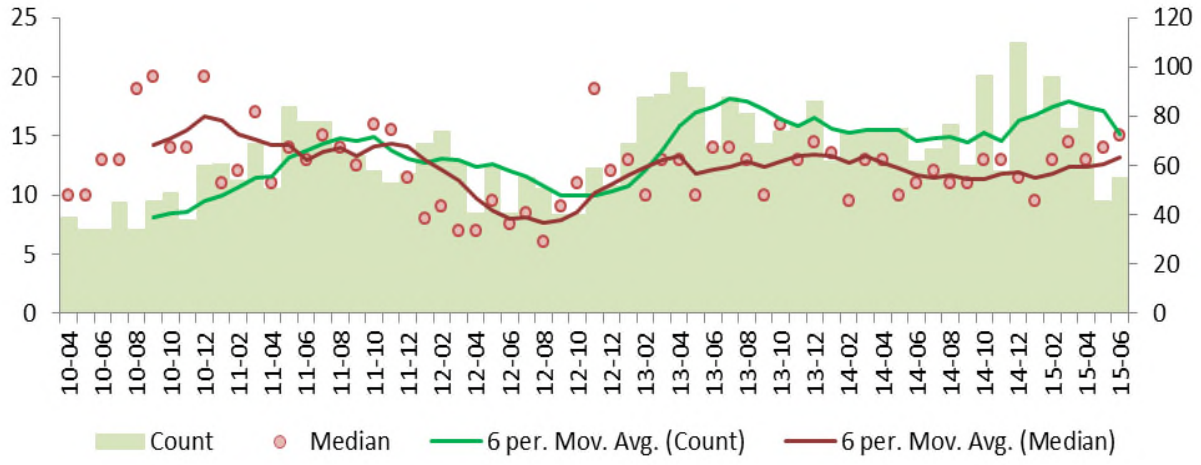
Figure 5- Delayed Episodes by Discharge Month and Age Group, Perth & Kinross CHP, 1 April 2010 to 30 June 2015



Source: *Live Edison, extracted 26 August 2015. Please note that data is unvalidated.*

- Figure 5 shows the number of delayed episodes in each month, by the month in which the person was discharged, by their age group. It demonstrates that in Perth & Kinross CHP, people aged over 85 are the group most likely to be delayed in hospital, with people in this age group making up the largest number of delayed episodes over the time period April 2010 to June 2015.
- Comparing financial year 10/11 with financial year 14/15, the total number of delayed episodes (by month of discharge) has increased by 65%.

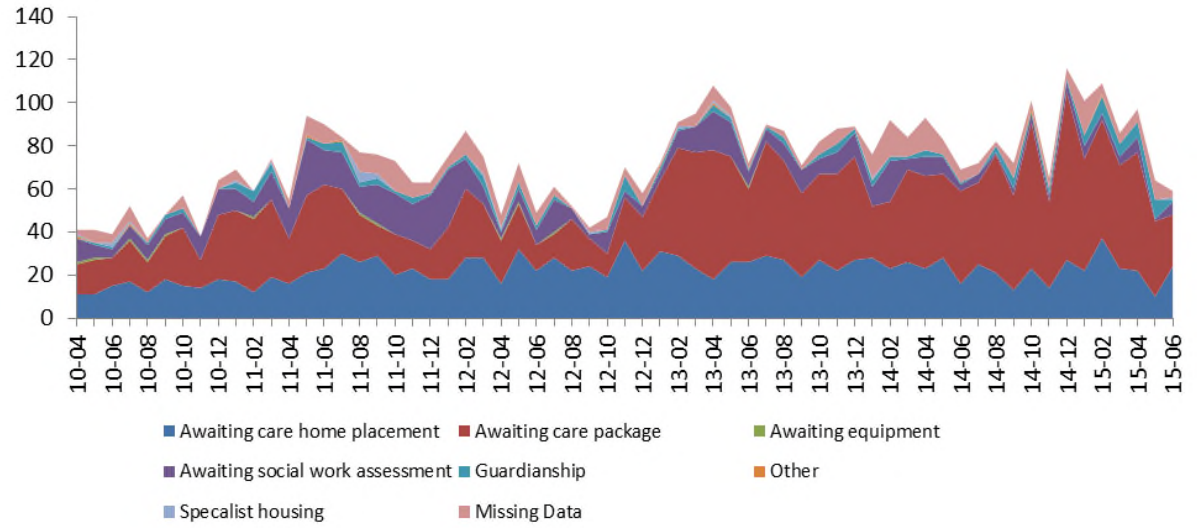
Figure 6- Median Length of Delay and Total Delayed Episodes by Month, 1 April 2010 to 30 June 2015



Source: *Live Edison, extracted 26 August 2015. Please note that data is unvalidated*

- Figure 6 above shows the median length of delay between 10/11 and 14/15 compared with the total number of delayed episodes. It shows a small decrease in the median length of delay against an increasing number of delayed episodes.

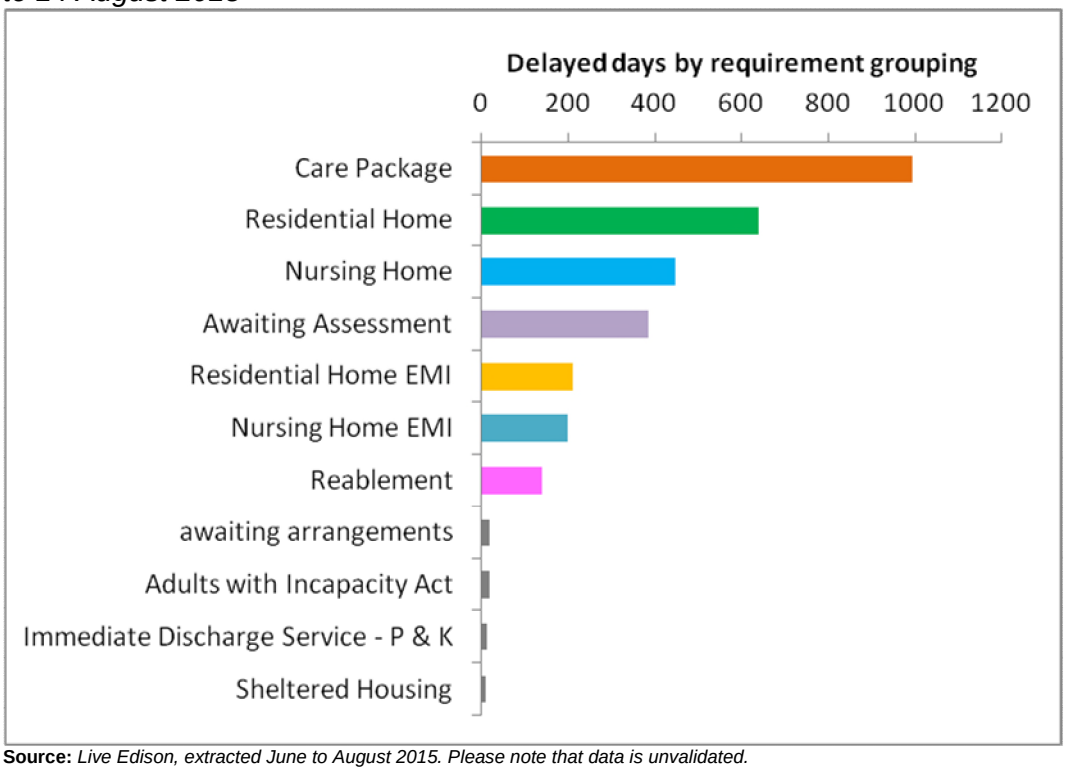
Figure 7- Delayed Episodes by Last Recorded Reason for Delay, 1 April 2010 to 30 June 2015



Source: *Live Edison, extracted 26 August 2015. Please note that data is unvalidated.*

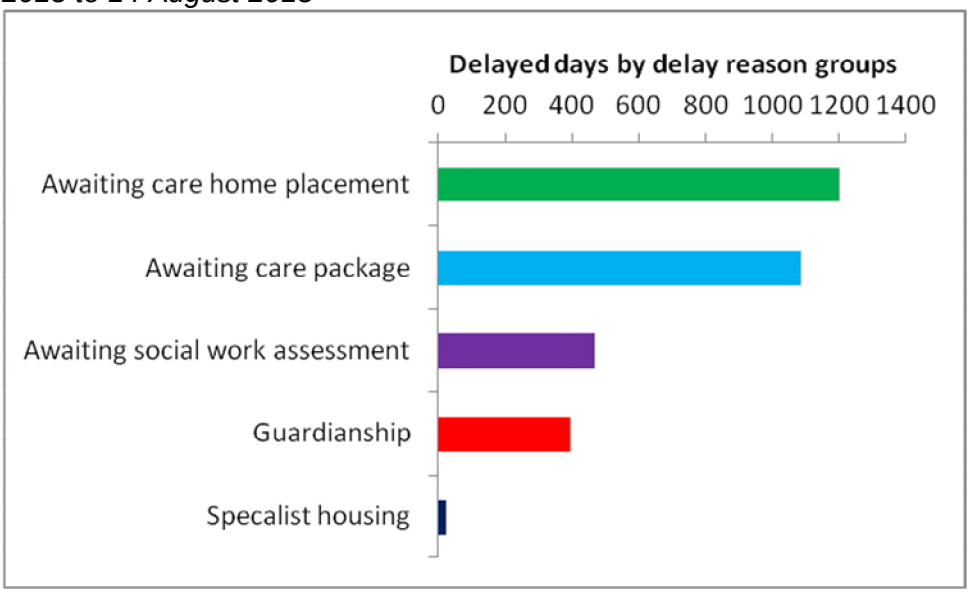
- Figure 7 above shows that the distribution of the last reason for delay on discharge, between 2010 and 2015. Overall, waits for care home placements and waits for care packages account for the largest proportion of delayed episodes. Delays due to waits for care packages have increased the most significantly between 2010 and 2015, in particular since January 2013.

Figure 8- Total Delayed Days by Requirement Grouping, all ages, P & K CHP, 1 June 2015 to 14 August 2015



Source: *Live Edison, extracted June to August 2015. Please note that data is unvalidated.*

Figure 9- Total Delayed Days by Social Reason for Delay Groups, all ages, P & K, 1 June 2015 to 14 August 2015



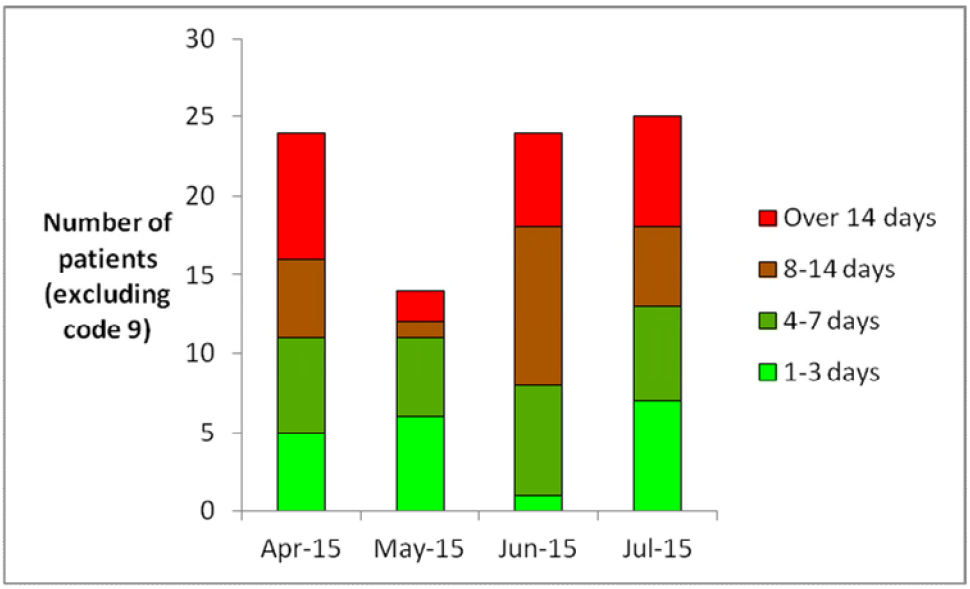
Source: *Live Edison, extracted June to August 2015. Please note that data is unvalidated.*

- Figures 8 & 9 above shows the breakdown of delayed episodes by total days by reason and episode for a 3 month period. Based on a daily extract from Edison, this provides a more accurate analysis of the reasons that people are delayed, and for how long for each reason, than provided by either Census or monthly monitoring. Figure 13 below shows these reasons in terms of the 'requirement' field, to enable more sensitive analysis beyond the ISD/Edison Reasons for delay.
- This analysis shows that waiting for Home Care and all types of Care Home placement account for most delayed days in acute beds.

The delay analysis also highlights that awaiting a social work assessment is the next most common reason for delay.

In preparation for the new 14 day target, NHS Tayside Information Services commenced providing a census report to show the number of people delayed based on their length of delay. Figure 10 shows a breakdown, from April 2015 to July 2015, of the number of people delayed in each of the time periods, within 72 hours; 4-7 days; 8-14 days; over 14 days.

Figure 10- Number of People Delayed by Length of Delay Groups, April 2015 to July 2015



Source – EDISON – Monthly Census Data – Provided by NHS Tayside Business Information Team

4. Care At Home

The pressures being experienced in Care at Home and lack of service availability for both people in the community and those experiencing Delayed Discharge, are impacting significantly on both community and hospital support. In the community there has been a rise in people admitted to care. In the hospital, an average wait of 14 days is the 'norm' for all patients requiring a package of care be it reablement or home care

The current pressure on Care at Home Services is approximately an additional 1,000 hours per week.

The current challenges facing Perth & Kinross Council in relation to care at home are the following:

- Staff recruitment for care at home providers
- Competition in a potentially overcrowded market place
- Care providers competing with other service and tourism jobs paying the same rates
- Variation in hourly rate for care providers

5. Current Services Addressing Unplanned Admissions

Over the last few years, Perth & Kinross Partnership have been moving towards a locality approach working with GP Practices and communities to focus on early intervention and prevention to reduce the demand on hospital admissions. The following provides examples of the approaches currently being tested and implemented in Perth & Kinross to support prevention and early intervention models of care. It is Perth & Kinross's intention to further develop and improve these approaches.

5.1 Front Door Model
This Early Intervention and Assessment team is based within Perth Royal Infirmary and consists of an Occupational Therapist, Advanced Nurse Practitioner, POA nurse and social work assistant, supported by a Geriatrician and Pharmacist. They have direct access to the ACE clinic, Psychiatry of Old Age transitional care service, rapid response and Immediate Discharge Service. The service aims are:

(a) To provide multi disciplinary screening, early referral and assessment thus preventing patients moving further into the secondary care system.
(b) Prompt access to signposting leading to enhanced multi disciplinary assessment and clinical decision making skills in order to facilitate early discharge from MAU and A&E in PRI
(c) Deliver an integrated, patient centred approach to patients through their care journey.

The model is being reviewed and updated for winter with a greater focus on discharge options, including availability of supports to effect discharge promptly.

5.2 Improving Processes & Decision Making
The former Resource Allocation Group was reviewed in late 2014. Various iterations were trialled but all were surpassed by the urgency to make decisions out with the weekly meeting. A more joined up approach to decision making and risk assessment was clearly evident and the ability to make decisions in a timely way proved a compelling driver for change. The Funding Panel therefore now meets on a Monday at midday to provide the greatest opportunity to plan towards actions for that week and capture any 'post-weekend' pressures. The Panel has health representation and this allows areas of risk and pressure impacting on ward areas to be discussed and priority given to addressing pressure points, rather than a reliance on traditional 'census behaviours' that encourage chronological decision making. There will still be a degree of flexibility and agility to make and take decisions on a daily basis when the hospitals are under pressure and urgent action is required to create capacity.

With the introduction of 'Guidance on Choosing a Care Home on Discharge from Hospital', CEL 32 (2013), the Scottish Government provided guiding principles on patients ready for discharge from hospital transfer. It states that a person should move out of hospital as soon as possible to avoid the negative impacts of an extended hospital stay. DL (2015) 11 'Hospital Based Complex Clinical Care' re-states those risks and re-emphasises a need to ensure that people are not delayed in moving to an alternative setting. In response to these Circulars, we have promoted the use of Interim placements and alternative care homes when a patient's home of choice is not immediately available. However, the take up of these options remains low. There have been only 12 interim placements made from 1st April – 31st August. We intend to put forward a new joint process for these discussions at ward level to support all parties in clearly stating the expectation regarding alternative settings out with direct inpatient hospital care. We will also be reviewing the patient leaflet supporting these measures, to ensure that expectations are clear to patients and relatives from the point of admission.

5.3 Immediate Discharge Service
Using funding from the Change Fund for Older People, 15 Social Care Officers have been employed to provide an Immediate Discharge Service (IDS) to directly target support to patients being discharged from hospital This Team provide Reablement support for people with non-complex discharge requirements. The service is directly accessed by hospital based Occupational Therapists, so reducing the assessment burden on existing hospital social work services..

5.4 **Psychiatry of Old Age Transitional Care**
In March 2014, the POA Liaison Team was further developed through the secondment of 5 liaison support workers. The Liaison Support Workers were employed to improve the Team's capacity to provide people with dementia, cognitive impairment or other mental health need with high quality liaison psychiatric support from a single specialist multi-disciplinary mental health team. This support commences during hospital admission and includes, where appropriate, transitional support interventions at home during the immediate discharge period.

5.5 **Psychiatry of Old Age Care Home Liaison**
A Care Home Liaison team has now been established in all 3 localities in Perth & Kinross to provide improved care and support to care homes and to reduce emergency admissions to hospital. The Care Home Liaison model objectives are to:

- Provide patients within the dementia assessment wards with transitional support on discharge, if required.
- Reduce the number of unplanned admissions from care homes to dementia assessment wards.
- Proactively identify residents changing needs earlier to support them to remain in the care home.
- Provide education and training in care homes to improve knowledge and skills of care home staff.

5.6 **Rapid Response**
The Rapid Response service in Perth & Kinross deliver a crisis response service to prevent unplanned admissions to hospital or a care home, when support at home is the most appropriate course of action Health and social work colleagues work in partnership to promote early intervention to maximise independence and wellbeing at times of crisis. The service provides direct access pathways to community nursing, Marie Curie Fast Track palliative care, community physiotherapy, occupational therapy and step-up to a supported care environment when necessary.

Step Up placements are made into a residential or nursing home setting, when a person does not require hospital admission and can be cared for appropriately by the enhanced primary care team.

5.7 Enhanced Community Support Model
GP Practice-based Enhanced Community Support aims to ensure that healthcare professionals provide prompt identification and appropriate, timely response to people's healthcare needs, helping to avoid crisis and unnecessary or prolonged hospital or care home admissions. It is currently being piloted in 3 sites in Perth and Kinross

The key principles are team collaboration, and communication providing proactive co-ordination of care. This is achieved through daily board rounds in the GP Practice, joint action planning and weekly multi-disciplinary meetings. The Teams focus on delivering person-centred support to meet specific need.

The Ardblair Team have been operational for 6months, and Glover Street Victoria Practice ECS, for 3 months. Initial 6-month evaluation from Ardblair Practice, and 3- month evaluation at Glover Street, indicate that people supported by the Teams have a reduced risk of admission to hospital. At Ardblair Practice, of the 48 people supported and discharged to date, 37 (77% of all referrals) have had a potential acute admission prevented. Staff report

that multidisciplinary working and communication is much improved within the MDT resulting in an improvement in communication, quality of care provided and reduction in duplication of assessment and information gathering.

A roll out plan has been developed to provide ECS across all 24 practices in Perth & Kinross over a two year period, using Change Fund monies for year 1 and opportunities presented in Year 2 from ICF/DD funding.

6 Future Improvements

6.1 Enhanced Community Support
Perth &Kinross have developed a roll out plan for Enhanced Community Support looking at rolling out this model over the winter months across Perth City and onwards onto North & South Perthshire. Recruitment has already commenced for this roll out. (Funded through Change Fund 2015/16)

6.2 Extended Working Hours
We are looking to invest an element of the delayed discharge funding to provide a 7 day front door service to provide additional AHP and nursing support to enable early identification and supported discharge using an improved case management model.
Delayed Discharge Funding Required 2015/16:

2 x B6 Nurses (2 days for 4 months)	£10,800
1.5 B6 Physiotherapist (Full-time)	£67,600
TOTAL	£78,400

6.3 Winter Planning Structure (See Appendix 1)
The new General Manager for PRI will oversee the Winter Planning Operational Model which will include daily huddles at ward and partnership level. Investment in a discharge co-ordinator would be required to support the Front of Door model and Daily Huddles.
Delayed Discharge Funding Required 2015/16:

1 x B6 Delayed Discharge Co-ordinator (Full-time)	£46,000

6.1 Redesign Community Hospitals
A review of community hospital activity has commenced to ensure better use of local community hospital beds. This would support our work to reduce the number of people being admitted as an unplanned admission to the acute sector.

Our vision is to move towards community hospitals becoming local community hubs for health, social care and third and independent sector with a range of services and facilities to support health and wellbeing in local communities. This would mean that people are only admitted to acute care only when they require the specialist expertise and equipment, and as soon as they no longer require this, they may be transferred back to their communities with support from the local integrated team. Our current investment in a community geriatrician model will support change and evidence outcomes that measure the impact of community based MDT working alongside the ECS model.

6.2 **MIIU Review**
A review of the provision and function of Minor Illness and Injury Units is underway to provide a realistic view of clinical delivery model and engagement with the public regarding expectations. To take this forward there will be a need for a dedicated Clinical Project Manager to take forward the Perth & Kinross element of Out of Hours Review.
Delayed Discharge Funding Required 2015/16:

1 x B7 Clinical Project Manager	£52,000

6.3 Discharge to Assess
Discharge to Assess will enable patients over 65 years of age to be discharged on the day that they are assessed as clinically fit with a care package. Health professionals within the hospital will assess the level of home care support required on discharge. They will refer to a single point of contact who will co-ordinate the care package. A reablement assistant will provide support within 30 minutes of the patient being discharged and will maintain close contact with the co-ordinator who will continue to liaise with relevant professionals, if any issues occur. The patient will receive ongoing assessment within their own home by the relevant professionals. The proposed benefits would be:

(a) The assessment takes place within an environment familiar to the patient, it is 'context specific' and the patient's immediate and longer term needs can be more appropriately assessed.
(b) Removal of steps, processes and delays in the discharge process
(c) A reduction in length of stay
(d) A reduction in the risk associated with frail older people remaining in a hospital environment
(e) Increasing patient flow through the hospital

This pilot is currently being tested with only social work input. It is proposed that this pilot could be expanded to include Allied Health Professionals and Community Nursing to provide a more flexible integrated approach. This would need additional funding for a Band 7 Occupational Therapist to support this work.

Delayed Discharge Funding Required:

1 x B7 Occupational Therapist £52,000

6.4 **Physiotherapy Pull Out model**
The In-Reach/Community Physiotherapy (IRCP) project was undertaken as a test of change in order to explore the feasibility of implementing a new model of service provision within in-patient and community settings at Perth Royal Infirmary (PRI) from January 2015 – end date ?. The aims of the project were to:

(a) Improve hospital flow / availability of acute beds through the provision of appropriate intervention, thus reducing delayed discharges.
(b) Promote effective transitional care between inpatient and community physiotherapy services, thus enhancing patient experience and quality of service provision.
(c) Facilitate safe and effective patient discharge from hospital.

It is intended to run this service again over the winter period to seek further measures for improvement and establish a model of 'pullout' across all inpatient rehab services.

6.5 **Beechgrove Enhanced Residential Care Model for short stay**
As there is an increasing problem with care home places available in Perth City, it is proposed to trial a nurse supported facility in Beechgrove residential care unit. This unit would provide short stay for people awaiting care home placements, as well as those requiring local intermediate care /stepdown support before returning home. This model, originally proposed in April was to be supported by end of year (2014/15) DD monies. To date, it has not been possible to progress this model due to demand for permanent beds within the care home, and a subsequent lack of identified space in which to trial the model.

Delayed Discharge Funding Required

Interim Placements for People Awaiting Care at Home £100,000

6.6 Short term improvements Care at Home 2015/16
There are still areas of improvement that could be progressed in the short term to 'recycle' current service provision. The active review of clients by health and social care partners, private providers and clients themselves should be acted upon without further re-assessments 'in house' that add delay and extra burden on existing staff and prevent timely reduction in service provision.

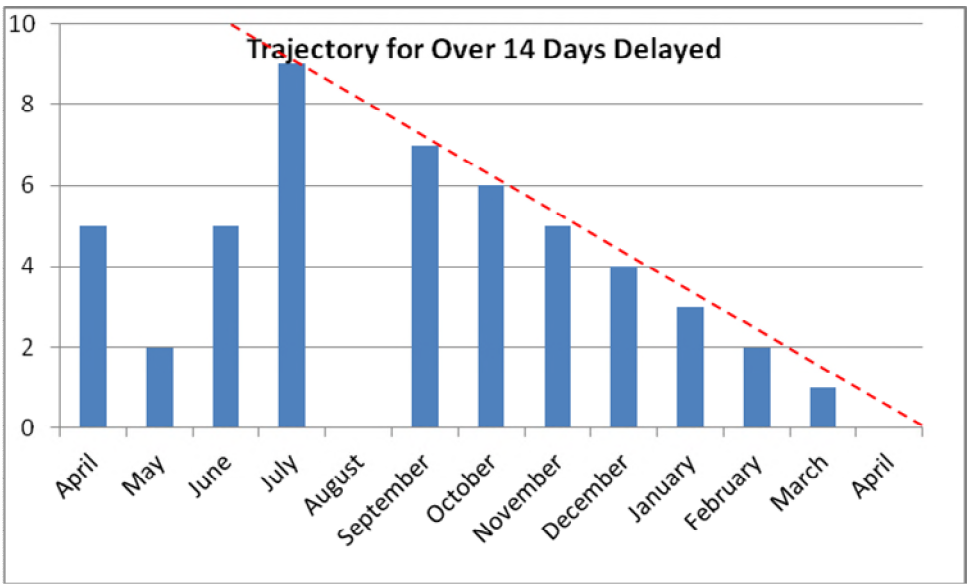
A recruitment fair in partnership with Care at Home providers is to be held in October to incentivise staff recruitment in this area.

6.8 Long Term Improvements Care at Home 2017
A new Home Care strategy is under development that will see the re-commissioning of services within the private sector taking effect in 2016. New contractual arrangements will look to a more flexible approach to care delivery that provides best value. The strategy will take account of locality variation, supply and demand… This should include a review of the reablement strategy and its relevance to the growing number of people with multi-morbidities who do not fit with the current concept of service delivery.

7. Proposed Delayed Discharge Investment

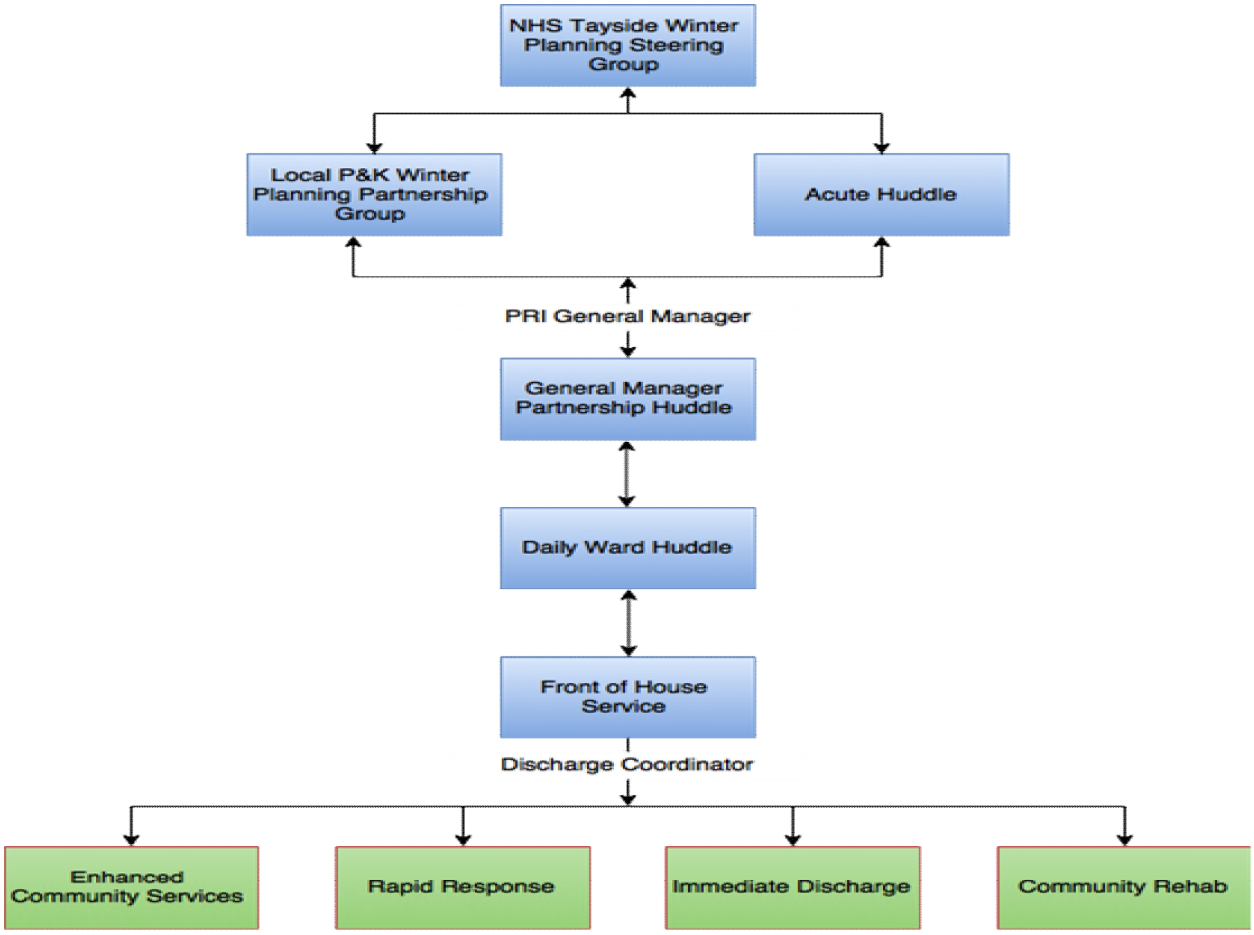
Service improvement	Resource Required	Investment
Extended Hours	2 x Band 6 Nurses 1.5 x Band 6 Physiotherapists	£11,000 £68,000
Winter Planning Structures	1 x B7 Discharge Co-ordinator	£52,000
MIIU / OOHrs Review	1 x B7 Clinical Improvement Lead	£52,000
Discharge to Assess	1 x B7 Occupational Therapist	£52,000
Beechgrove Enhanced Residential Care Model	Interim Placements This would support an additional 3 patients per week.	£100,000
Care at Home	Unblock Reablement to improve capacity and flow. This would provide an additional 631 hours.	£455,000
	TOTAL	£790,000

8. Trajectory



In order for Perth & Kinross Partnership to achieve the 14 day trajectory, there will be a need to focus a targeted case management approach for those patients who may potentially become delayed for over 14 days. This will involve our Front Door model linked to Rapid Response, Immediate Discharge Service, Enhanced Community Support and Community Rehabilitation. This integrated team will support expedited discharge on to reablement and into the community.

Appendix 1


NHS Tayside Winter Planning Steering Group
Local P&K Winter Planning Partnership Group
Acute Huddle
PRI General Manager
General Manager Partnership Huddle
Daily Ward Huddle
Front of House Service
Discharge Coordinator
Enhanced Community Services
Rapid Response
Immediate Discharge
Community Rehab