PERTH & KINROSS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

13 MAY 2016

DELAYED DISCHARGE PLAN 2016/17

Report by Chief Officer

PURPOSE OF THE REPORT

This report is to inform the Board on the significant challenges facing the Perth & Kinross Health & Social Care Partnership in relation to delayed discharges and provide an outline of the improvement activities already undertaken in 2015/16 with proposals for urgent actions in 2016/17.

1. BACKGROUND

1.1 A Perth & Kinross Joint Delayed Discharge report and action plan was developed in 2015/16 identifying the resources required to tackle delays of people moving from Acute Services to more appropriate care settings and to build increased capacity in communities to receive patients from acute settings and reduce unnecessary admissions to acute care.

1.2 Whilst the above plan has made inroads to support people in a delayed discharge situation, the Partnership continues to see an increase in the levels of delayed discharge from hospital with services and funding struggling to keep up with the demand.

2. PROGRESS UPDATE

2.1 The Delayed Discharge Action Plan has now been updated for 2016/17 and includes key learning from other areas that have previously experienced similar challenges but have successfully managed to improve their performance as a Partnership. In addition the plan lays out the future improvement activities and new governance and assurance procedures being put in place

3. NEW DELAYED DISCHARGE DEFINITIONS MANUAL

3.1 National Services Scotland has produced an updated Delayed Discharge Definitions Manual and National Data Requirements Manual which is effective from 1 July 2016 (supersedes May 2012 version) to ensure quality assurance and verification. From July 2016 NHS Boards will be required to submit one national data return to ISD containing details of ALL patients delayed for one or more days within the calendar month to support the measurement of the 72 hour health and social care outcome indicator.

4. RECOMMENDATIONS

4.1 Acknowledge the challenges facing the Partnership.

4.2 Note the progress to date.

4.3 Acknowledge and support future improvement activities contained with the Delayed Discharge Action Plan for 2016/17.

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May 2016

PERTH & KINROSS HEALTH & SOCIAL CARE PARTNERSHIP

DRAFT DELAYED DISCHARGE ACTION PLAN

2016/17

1. Introduction

Perth and Kinross Health and Social Care partnership has seen a continuing increase in levels of delayed discharge from hospital with services and funding struggling to keep up with the demand. Delayed discharge levels are running at high levels and these have reached national attention. Addressing the delayed discharge area has become the number one focus of the Health and Social Care partnership. A number of urgent learning events and actions have been initiated as part of a major reorientation towards improvement.

1.1 What the Data are telling us

While numbers vary from day-to-day, over recent years more people are experiencing hospital discharge delays. Furthermore, delays are generally longer. For example, since the financial year 2012/13, the median delay has increased from 10 to 14 days.

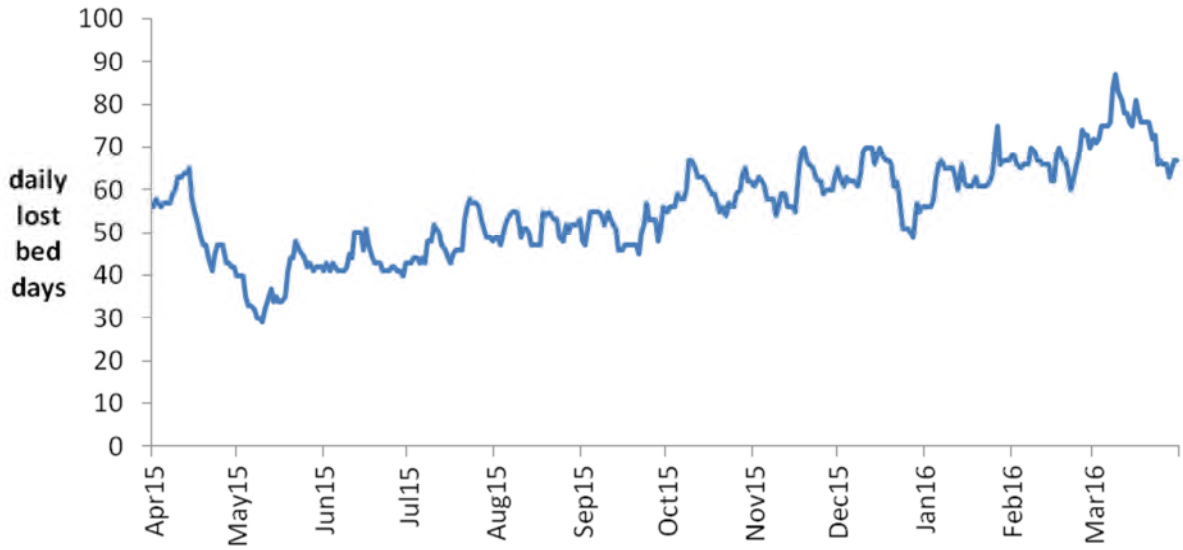
On the 1st of April 2015, the Scottish Government introduced a target for no people to wait more than 14 days to be discharged from hospital into a more appropriate care setting.

In the year before the national target was set, 371 delayed discharges exceeded 14 days in duration. In the year since its introduction, the target was breeched on 416 occasions. This represents an increase in the number of delays over 14 days of 12%.

2. Key Pressure Areas

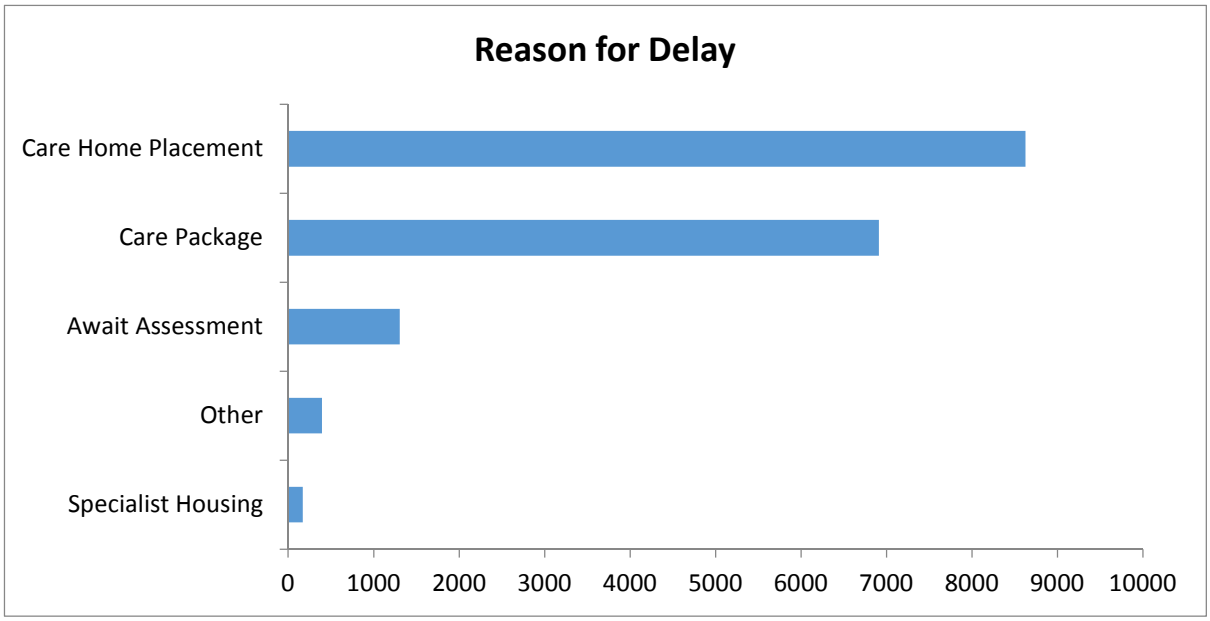
Graph 1 below illustrates the continually rising number of lost bed days due to delayed discharge, with March this year reaching a peak of 90 bed days lost per day. The total number of lost bed days is around 17,500 for the financial year 2015/16.

Graph 1



Graph 2 illustrates the reasons for delay and length of delay for each of the reasons for financial year 2015/16. 90% of lost bed days are resulting from either awaiting a care home placement (303 people with an average age of 84 years) or a care package (438 people with an average age of 81 years).

Graph 2



2.1 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 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

Section 7 in this report gives details of our commissioning plans in relation to improving our Care at Home performance.

2.2 Care Home Placements

There has been significant pressure on the Care Home placement budget due to increasing numbers of service users requiring care home placements, whether those in hospital or those moving straight from the community. Our annual care home numbers (for those aged 65 over) have increased from 802 in 2013 to 868 in March this year. The pressure on the budget means that patients can be delayed in hospital while authorisation for funding is sought. In March this year, funding for 24 additional care home placements for those delayed in hospital, while additional funding for 36 clients waiting in care homes for Free Personal Care payments was also agreed. Such

is the pressures that even with these additional monies, at time of writing, there are still 46 clients waiting for Care Home funding, 27 of which are delayed in hospital. In addition, residential care homes across Perth and Kinross but particularly in Perth City are at capacity, with some long waits for patients in hospital waiting for a placement.

3. Current Services Supporting Capacity & Flow

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.

3.1 Front Door Model

This Early Intervention and Assessment team is based within the admission unit at Perth Royal Infirmary. This MDT approach has input from Occupational Therapy, Physiotherapy, Nursing, CPN, Social Work, Geriatrician and Pharmacist. The service aims to provide multi-disciplinary triage, assessments, diagnostics and employs a fast track Comprehensive Geriatric Assessment approach to frail elderly patients. The patient will be see assessed, treated on presentation and where possible, return home the same day using Rapid Response carers. The model is promoting an 'assess to admit model' approach and looking to develop a dedicated triage area around the Acute Admission Unit.

3.2 Psychiatry of Old Age Transitional Care

The POA Liaison Team has been enhanced by 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. The staff support patients during their stay in hospital and augment the capacity on wards to support people with dementia/delirium. At the point of discharge, they assist patients to return home and support that post discharge period and resettlement in the community

3.3 Immediate Discharge Service

15 Social Care Officers 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 need for further assessment input by hospital based social work services. "

3.4 Rapid Response

The Rapid Response Service in Perth & Kinross delivers a crisis response service to prevent unplanned admissions to hospital or a care home. 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, palliative care support, physiotherapy, occupational therapy and direct step-up to an Intermediate Care environment when necessary.

3.5 Enhanced Community Support Model

GP Practice-based Enhanced Community Support (ECS) aims to ensure that healthcare professionals provide prompt identification and timely response to, helping to avoid unnecessary hospital or care home admissions. 6 GP practices are now delivering the service. A total of 13 sites will be 'live' by late summer 2016.
3 early pilot sites have provided evidence to support further rollout. The main patient reasons for involvement with the service were Falls, Reduced Mobility and Post-discharge Support. The professions in highest demand were Pharmacy, Physiotherapy and Occupational Therapy. A roll out plan has been developed to provide ECS across all 24 practices in Perth & Kinross over a two year period.

4 Improvement Activities

4.1 Core Group Delayed Discharge

The Chief Officer Group (COG) requested that a more in-depth reporting and assurance mechanism that allows for the management of risks and system flow be developed in relation to delays in discharge and placement setting. The need for this grew out of the need to secure additional funding for Care Home placements in March this year with the wish that more regular reporting of risks would help prevent another recurrence of this. To progress this, weekly meetings will provide the Chief Officer Group (COG) with regular status updates into performance, financial pressures and risk in relation to delayed discharge to enable the COG to make informed decisions. The group provides the COG with a performance reporting template, a continually updated risk profile and an SBAR summarising risks and offering options to COG to ameliorate risk and improve performance.

To support the Core Group, Perth & Kinross Partnership are currently developing a whole system capacity and flow model which will be populated by key performance data to inform the Group on the demand, capacity, queues and activity (DCQA) for all services. This will pull together the information on key services, for example:

- Emergency Department admissions and discharges
- Front of Door assessment and discharge
- Assessment / Admission area and discharge (triage)
- Immediate Discharge Services
- Enhanced Community Support (prevention of admission in community and pull out from hospital)
- Reablement / Rehabilitation (discharge to assess, releasing capacity)

- Nursing Home (admission / availability of beds / delays on return from hospital, dependency score on admission (eg IoRN) and age)
- Care at Home (Demand in hours)
- Secondary care inpatient activity (LOS, bed days lost, boarding)

4.2 Commissioning Care at Home

Along with Reablement, care at home is the key lynch pin to supporting people out of hospital and back into the community and to reducing our delayed discharge figures. We currently spend in excess of £6.6 million on external care at home which equates to over 90% of home care provision. In the last 6 months, there has been a significant increase in hours for care at home but despite this we are still struggling to cope with the demand. Over the last year, the lack of capacity has been identified as the critical issue to resolve and has been the subject of ongoing dialogue with the sector. The persistence of the capacity problem in Perth & Kinross means that there can be up to 300 hours of homecare not picked up at a time and there is a pressing need to review our approach.

4.2.1 Short term Commissioning plan

In the short term we are focusing on the development of a pilot in order to test out a new model, improve capacity in the system and manage risks associated with the Council's transformation programme. We have completed consultation with care providers and are ready to start a new programme that will mean care at home providers will not stop the care package when the person has an admission to hospital.

4.2.2 Long Term Commissioning plan

A long term plan to commission a new framework for care at home has been approved and the aim of this is a) to develop an outcomes based approach, b) streamline our current provision, and c) to develop a more collaborative approach with providers to ensure we are working towards shared goals. The timetable for this has to be agreed and is contingent on the implementation of transformation plans within the council for care at home.

4.3 Reducing waits due to Welfare Guardianship

Patients waiting for private Welfare Guardianships has contributed to delayed discharges, with some patients waiting up to 200 days and over in the in the past. The delays are often caused by families understanding of the system, the natural time delay while families agree roles as well as procedural issues in the system itself. In order to improve this, we have aligned a Mental Health Officer (MHO) to the Hospital Discharge Team, in order to oversee and give advice to staff and families on securing a Welfare Guardianship. We have also introduced a new procedure whereby the Council will take over the Welfare Guardianship if the family are not making reasonable steps to complete the process quickly. We have also secured funding for an MHO to be based full time at the Hospital Discharge Team to fast-track this work. The learning visit to Renfrewshire Health and Social Care partnership highlighted that they had managed to reduce the level of those delayed waiting from private Welfare Guardianships from 30 to 6 over the course of 8 months by implementation of a raft of measures that we will replicate.

4.4 Learning from Success

A number of learning events have been organised to give the Health and Social Care partnership the best starting point for the changes we will have to implement to reduce the numbers of people delayed in hospital. The learning from the areas below will be added to the delayed discharge improvement plan.

4.4.1 Visits to Other Partnerships

We are visiting a range of Health and Social Care partnerships that have been identified by the Scottish Government as being high performing in relation to delayed discharges. Renfrewshire Health and Social Care partnership was visited on 19 April and Midlothian is being visited on 19 May. It was obvious from the Renfrewshire visit that the Health and Social Care team had implemented changes across all systems to radically improve their delayed discharge statistics. Key to this was a shared approach across all levels of the organisations and leadership from senior management to drive change.

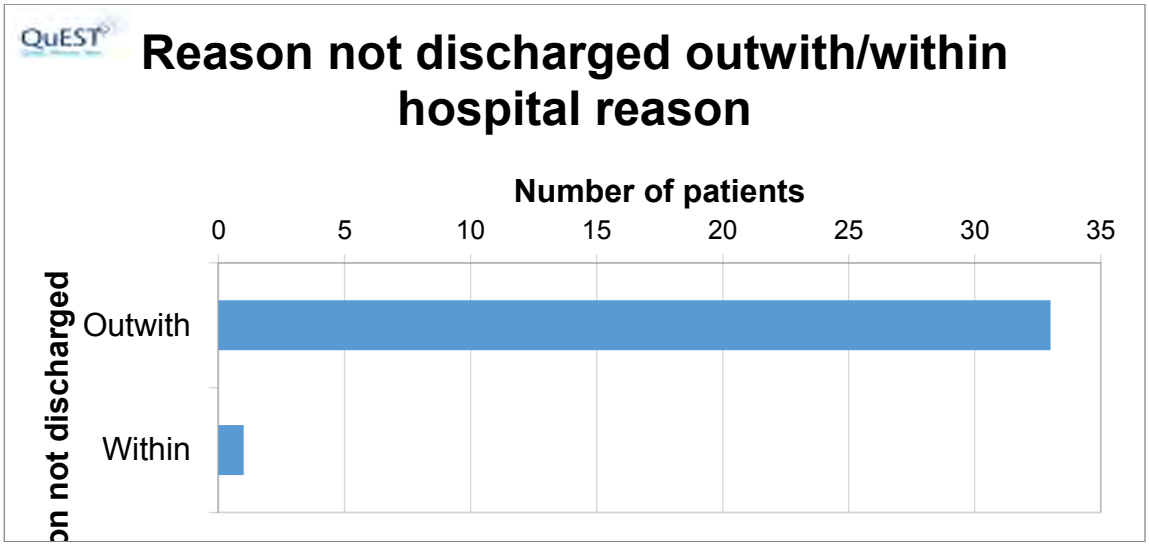
Outcome

We have initiated weekly senior level meetings that focus solely on our delayed discharge performance and report to the Chief Officer Group.

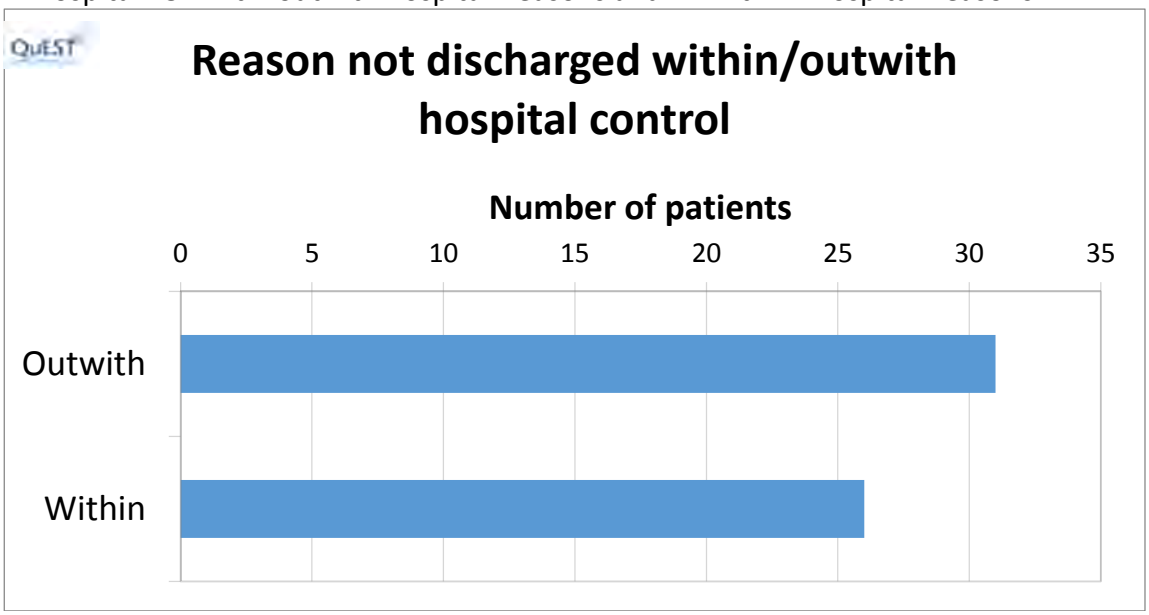
4.4.2 Day of Care Survey

A 'Day of Care' survey was completed in acute and non acute Perth & Kinross hospitals on 21 April, 2016. Findings from the Day of Care Survey revealed that, for community hospitals and Medicine for the Elderly (Tay Ward), 48.6% of patients should not have been in hospital at the point of the survey. This represented 34 out of 71 patients. Only one patient was identified as being in hospital when they should not have been due to 'in hospital reasons' (for example, waiting on discharge papers, transport and so forth), with 33 patients 'outwith hospital reasons', for example, waiting on care package, social work assessment and so forth. For Acute areas, 198 patients were surveyed, with 59 not meeting the criteria to remain in hospital. Of these, 32 patients were delayed 'outwith hospital' reasons and 27 were delayed with 'in hospital' reasons. This audit will contribute to shaping the Rapid Improvement Event below.

Findings from the Day of Care Audit (April 2016) related to community hospitals and MFTE, showed that 48.6% of patients should not have been in hospital at the point of the audit. This represented 34 out of 71 patients – the reasons shown were 33 'outwith hospital reasons' and 1 with 'in hospital reasons'.



For acute areas, the figures were - 198 patients surveyed, with 59 not meeting the criteria to remain in hospital - 32 with 'outwith hospital' reasons and 27 with 'in hospital' reasons.



4.4.3 Rapid Improvement Event (R*IE*), Perth Royal Infirmary 25-29 April

The scope of the RIE will focus on patient pathways and processes that support safe, timely and effective assessment, admission and discharge following unscheduled referral to PRI. Capacity and Flow at PRI is a strategic risk for NHS Tayside and the Delayed Discharge position in PRI has been identified as a Red risk for the Perth & Kinross Integrated Partnership. The desired outcomes are aligned with the Perth & Kinross Health and Social Care Joint Strategic Commissioning Plan, NHS Tayside's Local Unscheduled Care Action Plan and the risk measures outlined in the NHS Tayside's strategic risk related to PRI Capacity and Flow. Clear models of care supported by agreed standards ways of working will be a key outcome from the RIE and Patients receiving care and treatment in the right setting.

The overarching aim of the REI is to reduce delays across the hospital system to improve the patient, carer and staff experience. It is also an opportunity for staff to challenge accepted views and norms and we expect this event to improve multi-disciplinary working at all levels. The REI has had leadership support from across the Health and Social Care partnership.

4.4.4 Deep Dive into assessments for Care Home placements

An in-depth exploration was conducted by a multi-agency panel into the assessments of people waiting in hospital for care home placements. The aim was to find out if alternative routes could have been sought for people waiting for care homes. There was a concern social workers were being too indiscriminate in assessing for care home placements. The results showed that in a majority of cases, a care home was the most appropriate destination. However, for a significant minority, many people may have been able to return to their homes were it not for the delay, which ended up eroding their confidence.

Outcome
A two weekly Delayed Discharge panel has been convened to ensure continued scrutiny of assessments for care homes.

4.5 Extending Enhanced Community Support

Perth &Kinross have developed a roll out plan for Enhanced Community Support initially over Perth City and Strathmore areas (13 practices) in 2016/17 and onwards onto North & South Perthshire in 2016/17.

4.6 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.

4.7 Redesign Community Hospitals

A review of community hospital activity is scoping enhanced support requirements 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 integrated 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 would only be admitted to acute care when they require specialist input and more complex diagnostics, and transferred back to their communities at the earliest opportunity, with support from the local integrated team. Our new investment in a community geriatrician model is supporting more complex patients locally to home.

4.8 Community Care Management Restructure

The learning visit to Renfrewshire Health and Social Care partnership highlighted the importance of improving the resources as close to as possible people's entry and exit from hospital. People need support to return home immediately that they are deemed ready for discharge before they lose confidence. The Community Care restructure review has now completed and steps are being taken to implement this, with a new arrangement of teams in autumn. The restructure will move resources from longer term work to enhance our preventative work, with a new Early Intervention and Prevention service.

Outcome

New managers will be recruited to posts by the end of May and from then until September, we will work on implementing the new structure, moving resources to early interventionist ways of working.

5. Conclusion

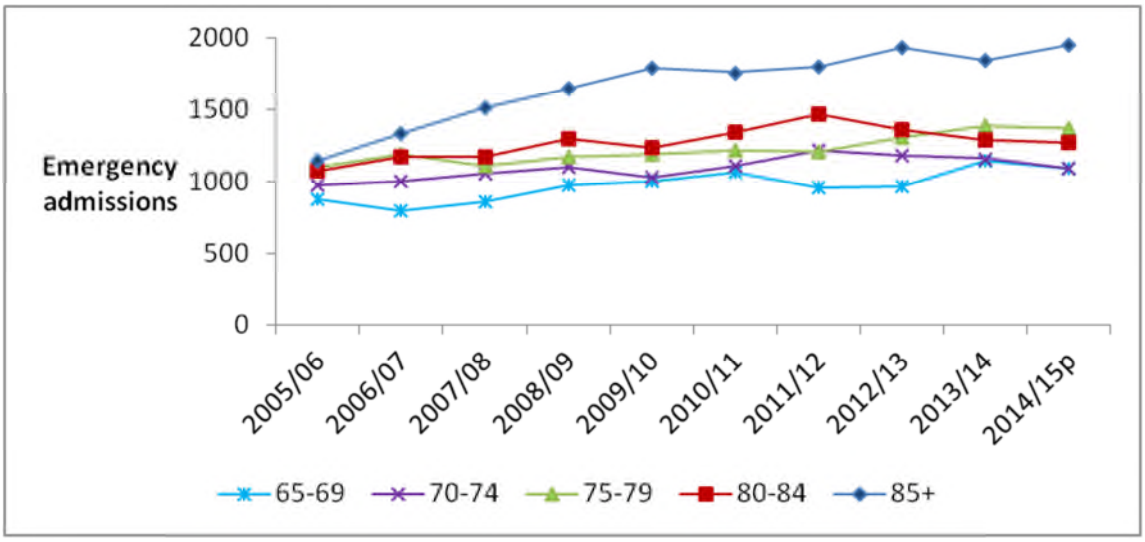
This report highlights the significant challenges the Health and Social Care partnership faces in relation to delayed discharge. Despite the investment of the Delayed Discharge monies and the ingenuity and effort of staff, we continue to experience unacceptable levels of delayed discharges across our hospitals.

The pace of learning activity underway demonstrates that we own the problem as a Health and Social Care partnership. The range of improvement actions detailed in this report illustrate that we are already urgently changing our services, reorienting them to an early intervention and preventative model.

Appendix 1 – Additional Performance Information

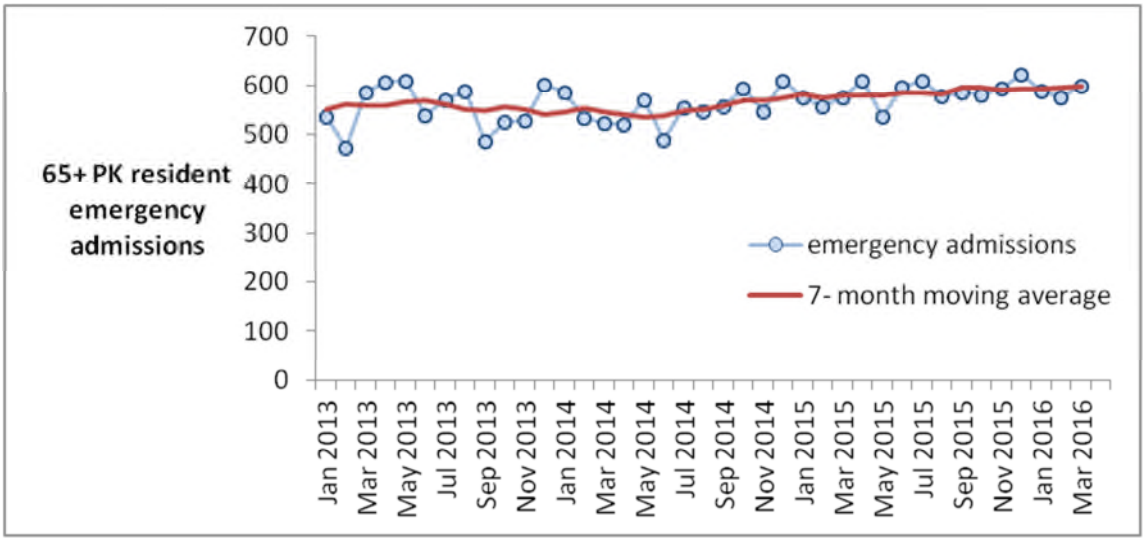
Figure 1 below illustrates that from 2004 to 2013 there has been a 38% increase in the number of people with a Perth & Kinross postcode over 65 being admitted to hospital as an emergency admission with a relatively larger increase in emergency admissions for people aged over 85 - 82%.

Figure 1 – Emergency Admissions for 65+ population by age group – Source ISD



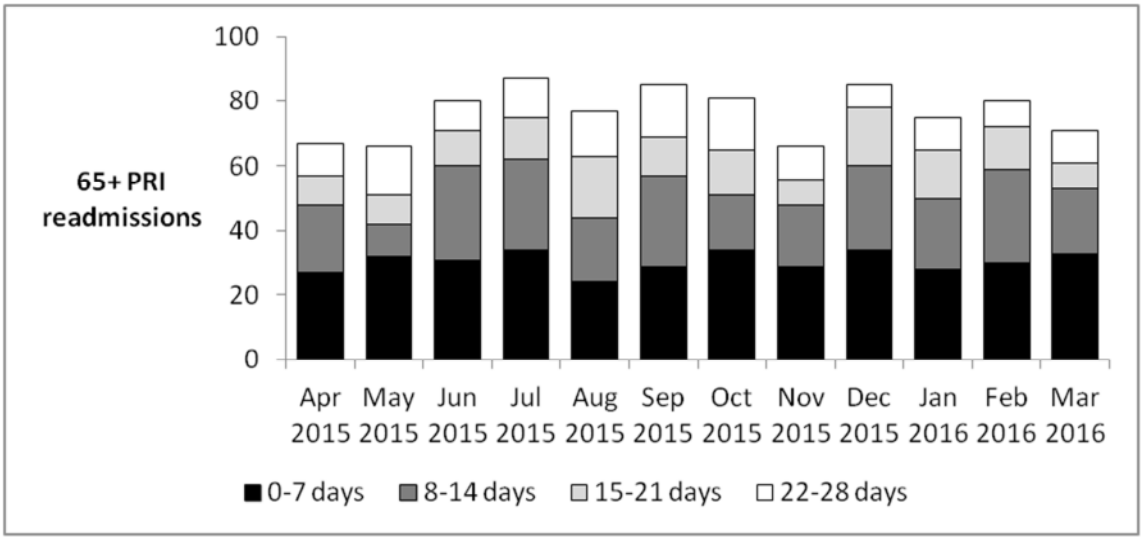
However, since early 2013 there appears to be a levelling in the number of people aged 65+ being admitted as an emergency. The rolling average for 65+ emergency admissions for P&K residents (Figure 2) indicates a reduced rate of increase compared with previous years. Between 2004 and 2012, the rate of 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.

Figure 2 – Monthly Emergency Admissions for 65+ PK residents (Source Qlikview)



In addition, Perth & Kinross have been experiencing a slight increase in the number of people being readmitted to hospital within 28 days of discharge, with no specific reason as to why (Figure 3)

Figure 3 – Emergency Readmissions to PRI – April 2015 to March 2016 (65+)



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. Analysis of Scottish data has confirmed that over 90% of patients experiencing delayed discharge were initially admitted as an emergency.

figure 4- Delayed Episodes by Discharge Month and Age Group, Perth & Kinross CHP, Source EDISON (archived only)

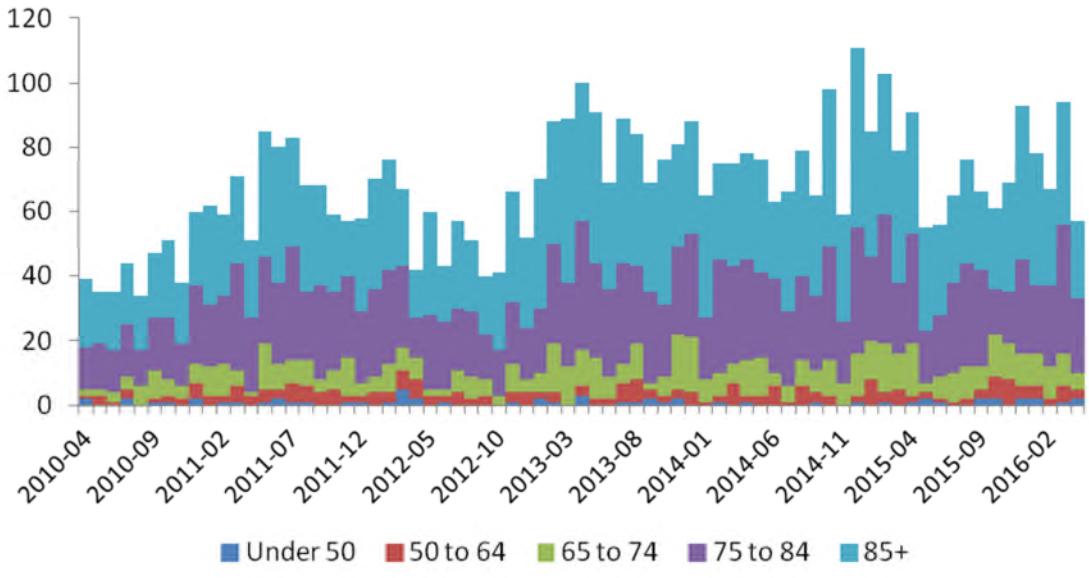


Figure 4 shows the number of delayed episodes in each month, by the month in which the person was discharged, by their age group. It demonstrates that in Perth & Kinross, people aged over 85 are the group most likely to be delayed in hospital, with people in this age group making up the largest number of delayed episodes over this time period.

Figure 5- Median delay and total delayed episodes by month of discharge, Perth & Kinross CHP, Source EDISON (archived only)

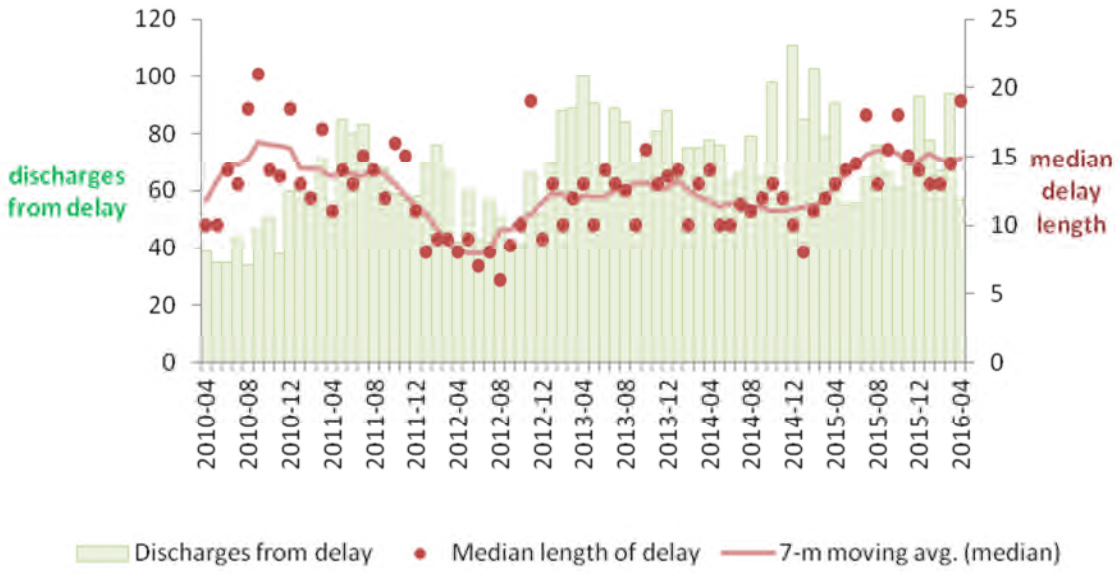


Figure 5 above shows the median length of delay between 10/11 and 15/16 compared with the total number of delayed episodes. It shows that in August 2011 the median length of delay started to decrease significantly started to increase again at the end of 2012 against an increasing number of delayed episodes.

Figure 6- Delayed episodes by last recorded reason for delay (includes archived and current at extract date) Source, EDISON

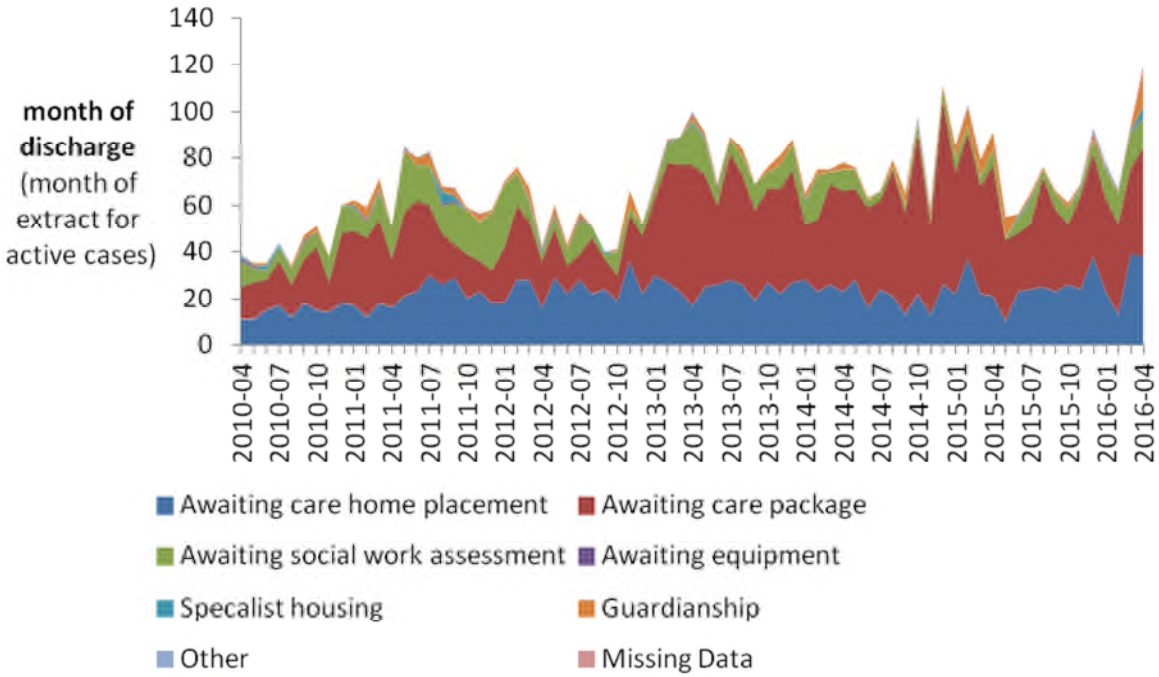


Figure 6 above shows that the distribution of the last reason for delay on discharge, between 2010 and 2015. Overall, waits for care home placements and waits for care packages account for the largest proportion of delayed episodes. Delays due to waits for care packages have increased the most significantly between 2010 and 2015, in particular since January 2013.