**This paper relates to**
**Agenda Item 7**

**Title/Subject:** **Delayed Discharge**

**Meeting:** **Integration Joint Board**

**Date:** **5 th February 2016**

**Submitted By:** **CHP General Manager and Head of Adult Social Care Services**

**Action:** **For Noting**

## 1. INTRODUCTION

1.1 The purpose of this paper is to update Integration Joint Board members on progress with meeting the national target that no-one who is ready for discharge should be delayed by more than 2 weeks.

## 2. RECOMMENDATION

2.1 The Integration Joint Board is asked to note current performance.

## 3. BACKGROUND

3.1 As of 15th January census date, there were 27 people delayed in their discharge, 20 of whom were delayed for more than 2 weeks. These relate to delays which count towards the national, published delayed discharge target (standard delays).

3.2 Trend analysis from April 2015 shows a modest improvement in the overall position from November 2015 and in the number of people waiting over 2 weeks, compared with November and December census position.

**Table 1** (excluding Code 9 & Code 100)

| | Apr 15 | May 15 | Jun15 | Jul 15 | Aug 15 | Sept 15 | Oct 15 | Nov 15 | Dec 15 | Jan 16 |
|---|---|---|---|---|---|---|---|---|---|---|
| Total delays at census point | 6 | 19 | 24 | 23 | 25 | 36 | 23 | 37 | 35 | 27 |
| Total number of delays over 2 weeks | 1 | 9 | 11 | 11 | 16 | 25 | 19 | 20 | 24 | 20 |

3.3 Table 2 shows the total picture of delays in Falkirk Partnership across all categories expressed as occupied bed days. These figures are for full months to the end of December.

**Table 2 total occupied bed days**

| | September | October | November | December | Equivalent Beds (December) |
|---|---|---|---|---|---|
| Standard Delays | 1097 | 802 | 1001 | 1085 | 35 |
| Complex Delays/ Guardianships (Code 9) | 268 | 248 | 231 | 248 | 8 |
| Code 100 Delays | 210 | 248 | 279 | 279 | 9 |

3.4 **Table 3** shows the **weekly** position for the last four weeks in Falkirk Partnership.

Ta**ble 3**

| | Total Delays (excl. Code 9 ) | Delays Over 2 Weeks | Delays Under 2 Weeks | Longest Wait (days) | Code 9 (Only guardianship 51x) | Total (Standard + Code 9,51x) |
|---|---|---|---|---|---|---|
| 23rd Dec | 37 | 22 | 15 | 63 | 17 | 54 |
| 30th Dec | 38 | 29 | 9 | 72 | 17 | 55 |
| 7th Jan | 33 | 28 | 5 | 80 | 16 | 49 |
| 14th Jan | 30 | 21 | 9 | 87 | 15 | 45 |

3.5 The availability of care homes in Falkirk to support patient's first choice remains very limited. In addition, there has been limited availability of interim places across Forth Valley in the last 2 months. The number and length of delays continue to be challenging with **5** patients delayed for more than **4** weeks and **12** delayed for more than 6 weeks.

3.6 The discharge of **5** patients is currently been taken forward under the policy on choice.

3.7 The availability of care at home services remains a challenge due to difficulties in recruitment. Services are working hard to recruit appropriate staff and will use short term and interim placements at Oakbank and Summerford should delays for this reason increase. Work on jointly agreeing the criteria for the use of short term placements is underway and should result in better use of these placements.

3.8 Some nursing homes are now refusing to take people on an interim basis. Work continues through the Development Worker from Scottish care to address this issue.

## 4. ACTION PLAN

4.1 The Delayed Discharge Sub Group of the Joint Management Group has been working on the development of an action plan covering the following 5 key areas:

- Re-model services to deliver a broader range of community based services available over 7 days. This would encompass Closer to Home and Alfy, Frailty, short stay assessment, and community rehabilitation services.

- Identify the population who have the biggest need for health and social care services and plan services which reduce that need and support them to live well at home.

- Analyse the discharge pathway, identify blockages, and improve the process of discharge with a focus on 72 hour discharge.

- Promote power of attorney both with staff and with the public through staff awareness and public awareness campaign.

- Embed a home first ethos across acute hospital and community services. Review model of intermediate care including short stay assessment and intermediate care beds.

A summary action plan is attached at Appendix 1.

## 5. CONCLUSIONS

5.1 The delayed discharge position has seen modest improvement last 2 months and the delayed discharge position continues to be a significant challenge for the Partnership.

5.2 Ongoing actions are required to improve current performance in the short term together with the implementation of the plans contained in the Action Plan to build sustainability for the medium to long term.

5.3 There are no additional resource implications arising from this report.

5.4 This report identifies the current position in relation to the National Target for Delayed Discharges.

5.5 There are no additional Legal and Risk implications associated with this report.

5.6 No additional consultation has been undertaken for the purpose of this report and no equalities implications have been identified.

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Approved for Submission by: Title and Organisation

**Author – Kathy O'Neill**
**Date: 21/01/16**
**List of Background Paper**

**Key Issue 1:** There are a number of services which are currently being delivered which are having an impact on small numbers in the population but are not having the impact required across the area to reduce ED attendances or acute admissions.

**Measures of Success/Impact**

- **Process measures** : Evidence of coordination across services e.g. single points of access/awareness of services and how they work.
- **System Impact measures** : Linked data showing impact on admission/discharge/length of stay and readmission.
  : Positive impact on high cost care.
- **Person centred measures** : Evidence of person experience/story/audits of individual case studies linked to strategic plan person centred outcomes.

| Action | Lead Officer | Timescales | Key Milestones | Reporting |
|---|---|---|---|---|
| **Systematic review of current service provision. Re-model and implement changes where necessary to meet the needs of the total population in a planned and sustained way. Services will include closer to home/Alfy/Frailty/Short Stay Assessment provision/OOH 24/7 services.** | • Kathy O'Neill | • 6 month interim evaluation of closer to home model June 2016 | By the end of 2016:-<br>• Closer to home will be fully implemented across all 3 pathways.<br>• All services will be better connected with single points of contact/access where appropriate.<br>• There will be linked data showing the impact on individuals and the wider health and social system of more coordinated and intensive interventions. | Integration Joint Board |
| **Linked Actions:** | | | | |
| • Implement closer to home. | • Marlyn Gardner | • December 2015 | | Joint Management Team |
| • Recruitment of community physicians/development of closer to home acute pathway. | • Leslie Cruickshank | • During 2016 | | Joint Management Group |
| • Recruitment to ARBD Team and evaluation of impact on high resource patient group. | • Kathy O'Neill | • 6 month interim evaluation of ARBD Team – July 2016 | | Integration Joint Board |
| • Use of LIST data analysts to identify population who require most intensive input across health and social care. | • Patricia Cassidy | • February 2016 | | Joint Management Team |

**Key Issue 2:** There are patients in hospital whose pathway is delayed for a variety of reasons and, while not formally delayed in their discharge, their length of stay in hospital could have been shorter.

**Measures of Success/Impact**

- **Process measures** : Increase in proportion of discharges within 72 hours. Staff awareness of admission/transfer/discharge policy.
- **System Impact measures** : Improved length of stay measured through day of care audits.
- **Person centred measures** : Patient stories/audit of individual pathways.

| Action | Lead Officer | Timescales | Key Milestones | Reporting |
|---|---|---|---|---|
| **Analyse current patient pathways from home to home. Analyse key points in pathway through hospital, indentify blockages and streamline pathway.**<br><br>**Linked Actions:** | • Chris Beech | • March 2016 | During 2016:-<br>• Key points in the process of admission and discharge will be measured.<br>• Blockages affecting timely discharge will be proactively identified and addressed.<br>• Potential to discharge to assess at home or in short stay assessment will be proactively pursued. | Joint Management Group |
| • Develop patient tracking system and measure key points in admission and discharge pathway | • Chris Beech | February 2016 | | |
| • Review model of intermediate care in Falkirk including pathway for use of short stay assessment beds. | • Susan Nixon | • March 2016 | | Joint Management Group |
| • Implement agreed changes to skill mix and utilisation of the Integrated Discharge Team to support timely discharge from acute hospital. | • Lorna Henry | • January 2015 | | Joint Management Group |
| • Use planned dates of discharge on admission proactively. | • Ian Aitken | • December 2015 (linked to Winter Plan) | | Delayed Discharge Sub Group |

**Key Issue 3:** There are a number of patients whose discharge becomes delayed as they fall within the scope of the Adult with Incapacity Act.

**Measures of Success/Impact**

- **Process measures** : All ACPs have evidence of discussion regarding power of attorney.
  : Close measurement of AWI pathway and evidence of review at key points in guardianship process.
- **System Impact measures** : Reducing trend in overall number of people delayed for AWI reasons.
  : Reducing trend in occupied bed days.
- **Person centred measures** : More patients and carers aware of benefits of power of attorney.

| Action | Lead Officer | Timescales | Key Milestones | Reporting |
|---|---|---|---|---|
| **Promote power of attorney through proactive awareness with GPs, Acute hospital and health & social care staff. Educate general public that this is positive step for future.**<br><br>**Establish Project Team to undertake this work.**<br><br>**Linked Actions:** | • Kathy O'Neill & Project Team | • Spring 2016 | By summer 2016:-<br><br>• There will be a step change in the awareness and understanding of staff of the importance of power of attorney.<br>• A public campaign raising awareness of the benefits of power of attorney will have happened.<br>• Where guardianship applications are necessary, the process will be proactively managed. | Joint Management Group & IJB. |
| • Identify patients early in hospital stay who are likely to fall within remit of AWI Act. Take steps to have early conversations with families. | • Ian Aitken | • Immediate | | |
| • Involve MHO staff early in the inpatient journey. | • Susan Nixon | • Immediate | | |
| • Meet with Sheriff Principals and local Solicitors to streamline legal process. | • Project Team | • Spring 2016 | | |
| • Plan and undertake local public campaign (radio/press/leaflets/TSI). | • Project Team | • Spring 2016 | | |
| • Ensure every ACP has evidence of discussion of power of attorney. | • Marlyn Gardner | • Immediate | | |

**Key Issue 4:** The right balance and range of care options is now available in Falkirk to support early discharge and avoid admission.

**Measures of Success/Impact**

- **Process measures** : Improved information on need and required capacity for range of care options.
- **System Impact measures** : Proportion of Falkirk population going into long term care.
  : Increase in numbers of patients discharged home from FVRH.
- **Person centred measures** : Patient stories/individual case audits.

| Action | Lead Officer | Timescales | Key Milestones | Reporting |
|---|---|---|---|---|
| **Embed ethos of "home first", 72 hours discharge to assess. Following admission, ongoing care needs should be considered in a non acute environment.**<br><br>**Linked Actions:** | • Ian Aitken | • Immediate and ongoing | By the end of 2016:-<br><br>• There will be a greater understanding of the utilisation of long term care options in Falkirk to inform future planning and commissioning. | |
| • Identify care home admission rate per head of population. Use this to identify required capacity in short and medium term. | • Susan Nixon | • February 2016 | • The benefits of and need for short stay assessment care options will be better understood and more embedded as a clear pathway from hospital. | |
| • Review use and availability of short stay assessment beds as an alternative to admission to care home. | • Susan Nixon | • March 2016 | | |
| • Consider options for "step up" to short stay assessment as part of a pathway including closer to home/frailty unit etc. | • Chris Beech/Marlyn Gardner | • March 2016 | | |