This paper relates to
Agenda Item 11

Title/Subject:	**Delayed Discharge Progress Report**
Meeting:	**Integration Joint Board**
Date:	**5 August 2016**
Submitted By:	**Community Services Directorate 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

The Integration Joint Board is asked to:

2.1 note current performance and the work underway to develop a strategic change programme.

3. BACKGROUND

3.1 Delayed Discharge is a standing agenda item at Integration Joint Board meetings acknowledging the impact that delays to discharge have on outcomes for individual patients and on the health and social care system.

4. PROGRESS UPDATE

4.1 As of 15th June census date, there were **32** people delayed in their discharge, **18** of who were delayed for more than 2 weeks. These relate to delays which count towards the national, published delayed discharge target (standard delays).

4.2 There has been an increase in the position since the last Report to the IJB as can be seen in table 1.

Table 1 (excluding Code 9 & Code 100)

	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
Total delays at census point	24	23	25	36	23	37	35	27	23	29	27	23	32
Total number of delays over 2 weeks	11	11	16	25	19	20	24	20	14	18	18	12	18

4.3 At the June census point, there were **1** patients identified as a complex discharge (code 9) and **5** proceeding through the guardianship process.

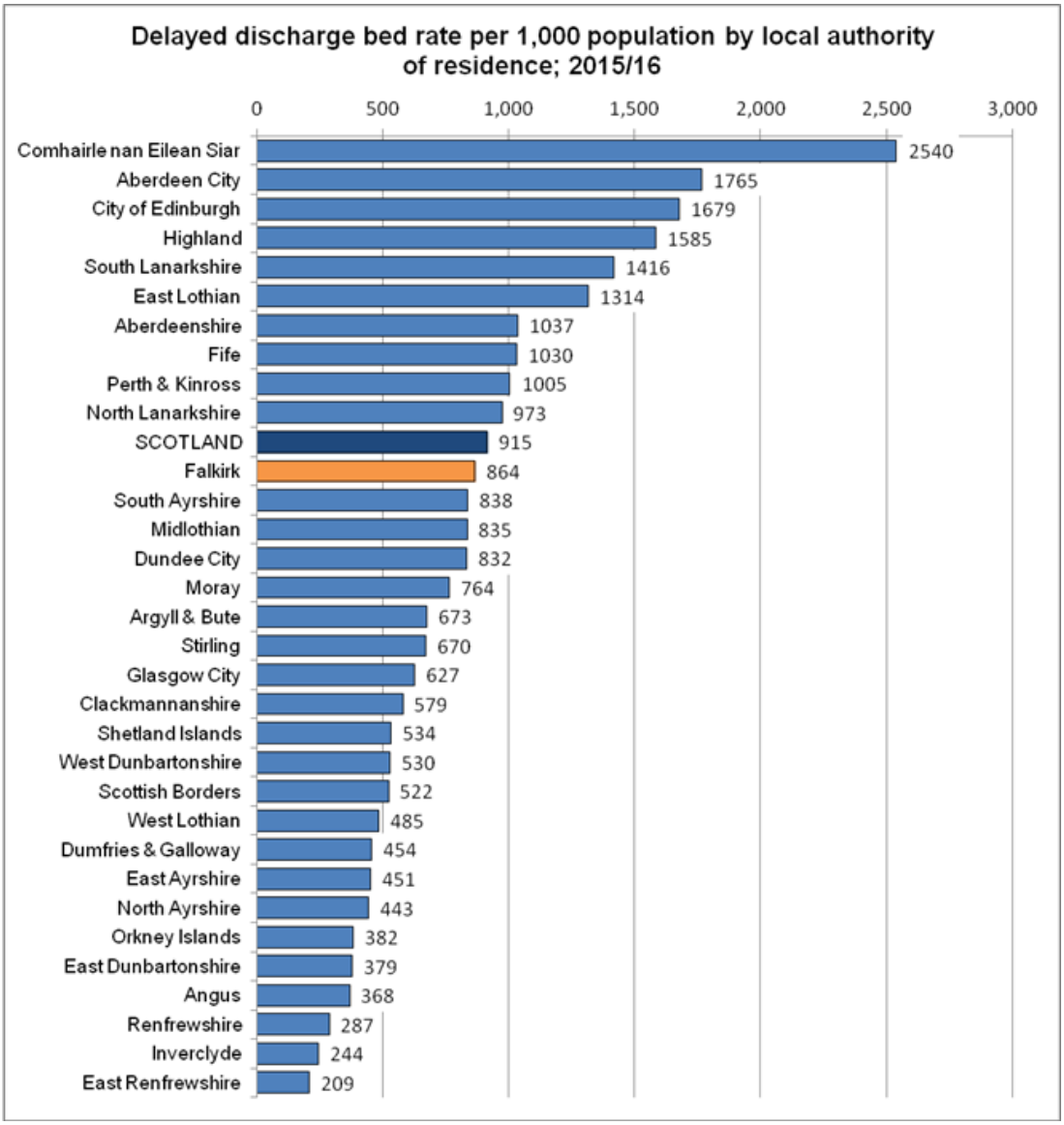
4.4 At the June census point, there were **6** patients identified as a Code 100 delay. These are predominately patients with a learning disability.

4.5 **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 June and show reducing pressure on bed days compared with March.

Table 2 total occupied bed days

	February	March	April	May	June	Equivalent Beds (Jun)
Standard Delays	797	990	975	875	854	28
Complex Delays/ Guardianships (Code 9)	217	265	277	186	158	5

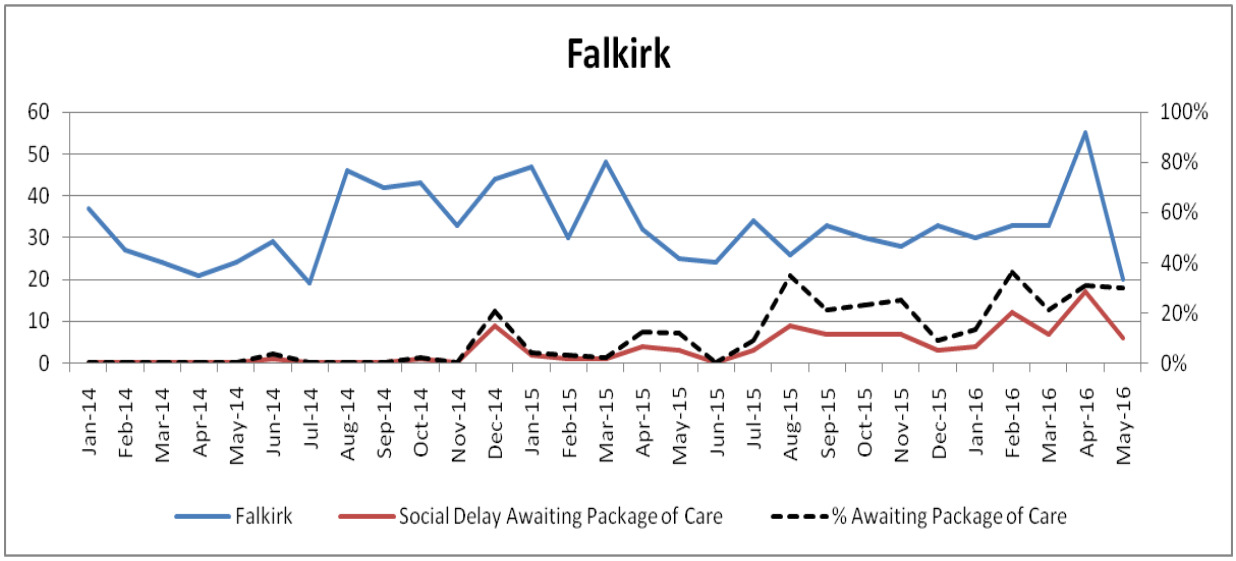
4.6 **Table 3:** below shows Scotland delayed discharge bed day rate per 1,000 population aged 75+ years for 2015/16.



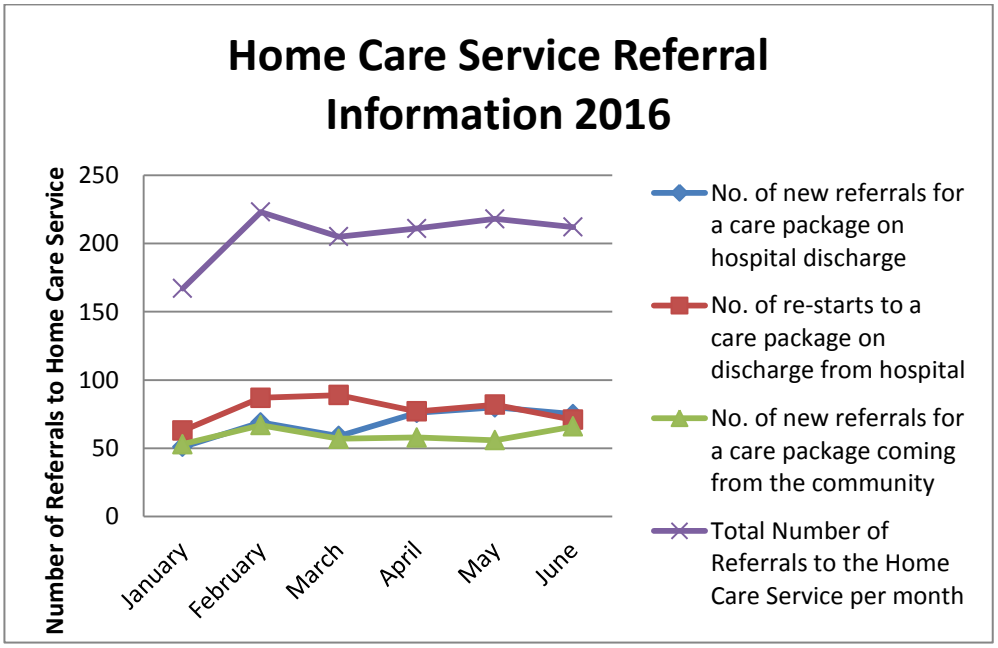
The delayed discharge bed day rate for 15/16 showed a decrease from 14/15 as explained later in the report [paragraph 4.9]. Although the rate is below the Scottish average, this measure highlights the imperative of achieving further improvement relative to comparator partnership areas.

4.7 **Table 4:** Delays in discharge from Acute Hospital 2014/16

The table below shows trend information 2014/16



4.8 **Table 5:** The number and trend of referrals to the home care service source of referral for 2016 is below



An increasing number of referrals come from the hospital both as new referrals (those not previously in receipt of care before their admission to hospital) and those who have been in receipt of care previous to their hospital admission and need their service re-started, sometimes increased. In addition the service also receives referrals for those people who have been identified as requiring care who are currently living at home.

The number of people requiring care packages who are living at home has remained fairly stable however this year, as evidenced, the number of people being discharged from hospital whether requiring a re-start to their service or a complete new care package has risen.

This provides significant challenges to the service in being able to ensure packages of care are not only available against the background of difficulties in recruiting staff to care posts but also to the increased volume of work required to ensure packages of care meet individuals care needs in a safe way for both them and the staff who are providing the care.

The service also has a programme of reviews to undertake in respect of all those in receipt of care which is run alongside this adding of new service users to the service.

4.9 ISD has published the first annual report of delayed discharge information covering the period until March 2015. This publication is attached at Appendix 1 for information. To note is the total number of bed days occupied by delayed discharge has decreased in Scotland by 9%, with Falkirk decreasing by 18%.

4.10 The breakdown of the local ISD data is attached at Appendix 2 to enable a comparison of local performance against national data.

4.11 Members of the IJB will note key differences

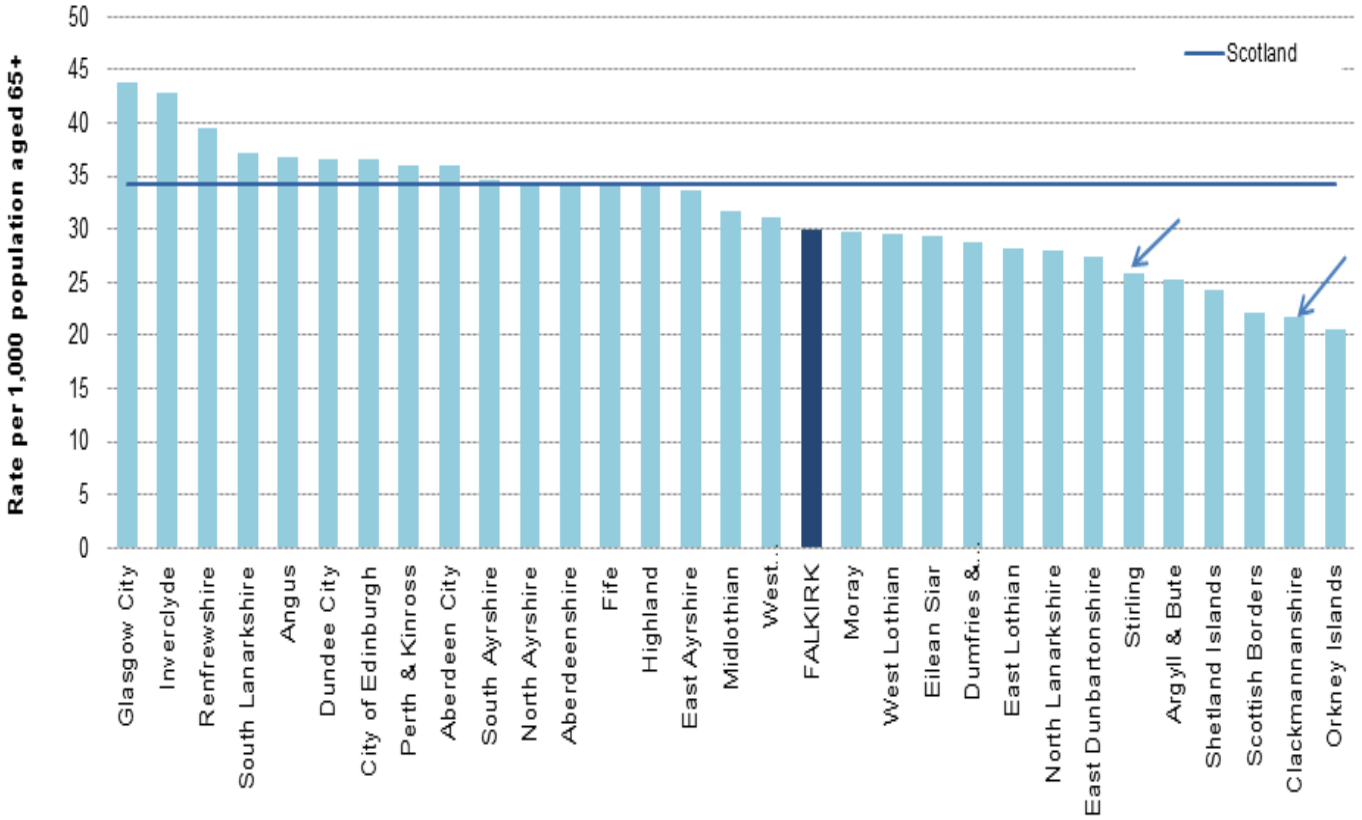
- 47% of delayed discharges are awaiting care home availability in Falkirk compared to 22% nationally

- 5% of delayed discharges in Falkirk are waiting for care arrangements in order to go home compared to 24% nationally

This highlights that Falkirk has a greater percentage of people awaiting care home placements.

4.12 Table 6 below shows older people aged 65+ supported in care homes as a rate per 1,000 population. Falkirk sits at 30 per thousand, below the national average but greater than Stirling or Clackmannanshire. The average social care budget is historically overspent in regard to care home placements.

Table 6: - Older people supported in care homes, Mar 14 [last nationally published data] Source: Care Homes Census



4.13 This information indicates the need for a more strategic approach to address the underlying issues contributing to both the delays in discharge and the rate of care home admissions in Falkirk. The plan to address this is outlined in the Chief Officers report on this agenda.

5. PROGRESS WITH ACTIONS

5.1 Work is ongoing to progress the actions included in the Delayed Discharge Action Plan Integration Joint Board members supported a focus on addressing four key issues that were impacting on delayed discharge performance and these remain a focus for the Joint Management Group and Delayed Discharge Sub Group.

5.2 **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***

The Closer to Home Service commenced as planned in December and continues to build. Over the winter months, the enhanced community team also supported early discharge from hospital in addition to its core role of

prevention of admission. To date, 455 people from the Falkirk area have called the AFLY line and 158 people have accessed the enhanced community team. Discussions are taking place, encompassing the full range of services working to prevent admission to hospital, to see how they can connect better and to consider the potential for a single point of access to these services.

5.3 A "Wicked Issues" workshop, led by the Chief Officer, was held on 28 June 2016. The recommended actions are outlined in the Chief Officers report on this agenda and will encompass short term actions outlined below.

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

A delayed discharge patient tracking system has been developed which is assisting in identifying key points in the pathway through hospital and addressing blockages. The Partnership is undertaking work to collate process flow maps and volume charts which should be concluded by September 2016.

Work has commenced to review reablement services through the Reablement Steering Group and two reablement workshops are planned for August flowing the IJB approval in June to a recommendation to *"develop a strategic approach to intermediate care pathways, including frailty and reablement".* The intention is to develop and enable a strategic approach to be taken to service provision, service re-design and future targeting of partnership funding, to achieve improved outcomes for service users, based on re-shaping or developing current initiatives. It is anticipated that the outcome of this work will be reported to the IJB as part f the proposed Change Programme.

The workshop sessions will:

- collectively agree a definition for intermediate care and reablement
- define what these services should look like in Falkirk
- consider the evidence on what's currently working well,
- agree what change may be required to existing provision,
- develop actions to take forward change.

5.5 **Key Issue 3:** ***There are a number of patients whose discharge becomes delayed as they fall within the scope of the Adults with Incapacity (AWI) Act***

A Planning Group has been meeting to consider how to increase awareness of AWI issues generally and specifically, how to increase the numbers of people in Falkirk with power of attorney.

Falkirk Community Voluntary Service (CVS) are supporting the Partnership to undertake a public awareness campaign commencing in May. This is being supported by other community organisations in Falkirk such as the Making it

Happen Group and by solicitors for older people. The campaign will focus on some key messages:

- it can be very difficult for families coping with situations where there is no power of attorney
- many older people can access legal aid
- family members cannot make decisions for another family member without power of attorney.
- Power of Attorney in not just about dementia

5.6 **Key Issue 4: The right balance and range of care options is not available in Falkirk to support early discharge and avoid admission**

Work has commenced to look at bed modelling requirements across the Partnership. This will focus initially on the short-term impact of the closure of Oakbank and identification of any mitigation actions required. This work will include a review of short-term; intermediate rehab; community hospital and residential and nursing care home beds. In the longer-term this will also need to take account of accommodation and housing support opportunities arising from discussions with housing colleagues through the Housing Contribution group.

6. CONCLUSIONS

6.1 The delayed discharge position remains under significant pressure due to the reliance on care home places which continue to be limited.

Further work is required to improve outcomes and to support people to remain in their homes with appropriate care packages.

It is critical that these issues are addressed through a strategic whole system approach as outlined within the Chief Officer report on this agenda.

6.2 **Resource implications –** Current investment is being reviewed through the Partnership Funding review as detailed in a separate report on this agenda.

A further report will be brought to the next IJB meeting in October to outline the patient flow, financial and bed modelling for the Change Programme.

6.3 **Impact on IJB Outcomes and Priorities -** this report identifies the current position in relation to the National Target for Delayed Discharges.

6.4 **Legal & Risk Implications -** there are no additional Legal and Risk implications associated with this report.

6.5 **Consultation & Equalities Assessment -** no additional consultation has been undertaken for the purpose of this report and no equalities implications have been identified.

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Date: 27 July 2016

List of Background Papers