Midlothian Integration Joint Board

Thursday 3 May 2018 at 2.00pm

Delayed Discharge

Item number: **5.4**

Executive summary

Midlothian Health and Social Care Partnership has consistently been a good performer in addressing delayed discharge and ensuring that patients are discharged in a timely manner to an appropriate setting. A paper was presented to the IJB earlier this year providing members with an overview of performance in this area.

In summary over the previous 12 months, this performance has deteriorated as a result of a number of factors that have been previously presented to the IJB.

This paper describes a range of actions that are place or being implemented to improve our performance in relation to timely support for our patients being discharged from hospital.

Board members are asked to:

1. *Note the current admission profile and corresponding delayed discharge performance in Midlothian*

2. *Support the detailed actions in place to address and reduce the number of patients who are delayed in hospital*

Report

Delayed Discharge

1. Purpose

1.1 The purpose of this report is to highlight the continuing challenges within Midlothian in addressing delayed discharge, setting out the actions that are being taken to ensure patients are discharged at the earliest opportunity in their care pathway, as well as ongoing work on admission avoidance. This follows a Delayed Discharge report presented to the IJB in March which described performance.

2. Recommendations

2.1 Note the current admission profile and corresponding delayed discharge performance in Midlothian.

2.2 Note the significant amount of work teams are putting into managing this, and support the detailed actions in place to address and reduce the number of patients who are delayed in hospital.

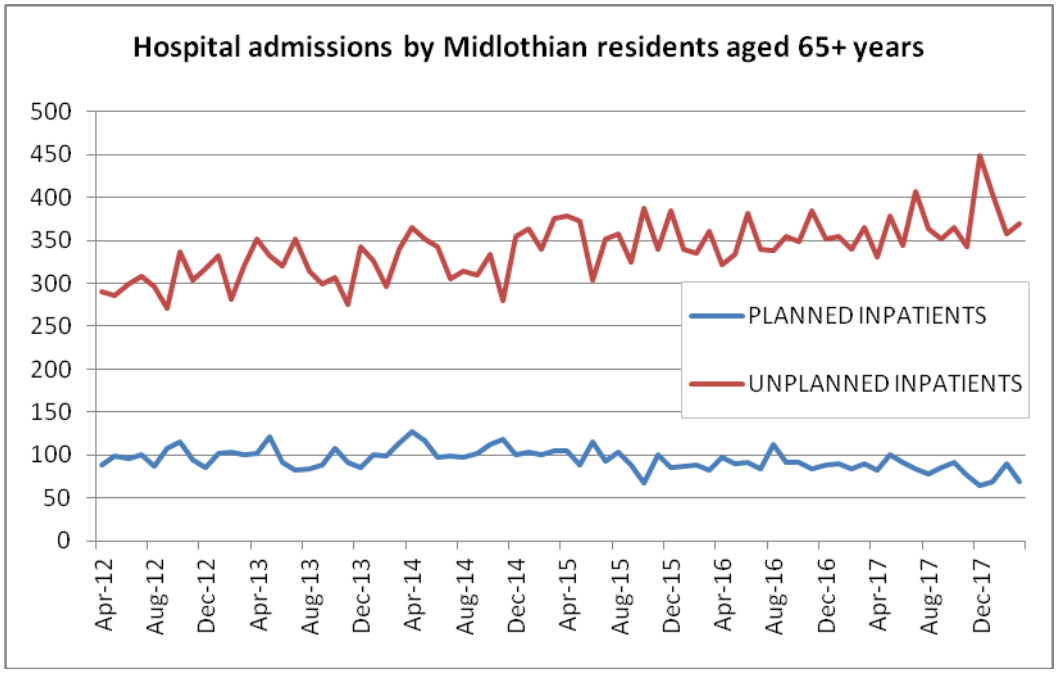
3. Background and main report

3.1 Reducing and eliminating the number of patients whose discharge is delayed has been, and continues to be, a key priority within Midlothian. It is well evidenced there is a negative impact on patients as a result of an extended stay in hospital, with significant loss of mobility, confidence and function, as well as increased risk of hospital acquired infection.

3.2 The number of patients delayed is representative of how well the overall health and social care system is operating, demonstrating effective or ineffective patient flow. As expected, there is a direct relationship between hospital admissions and the number of patients who are delayed. There is a corresponding impact on the capacity for elective activity, with beds being unavailable across the hospital sites, result in delayed admissions and cancelled operations.

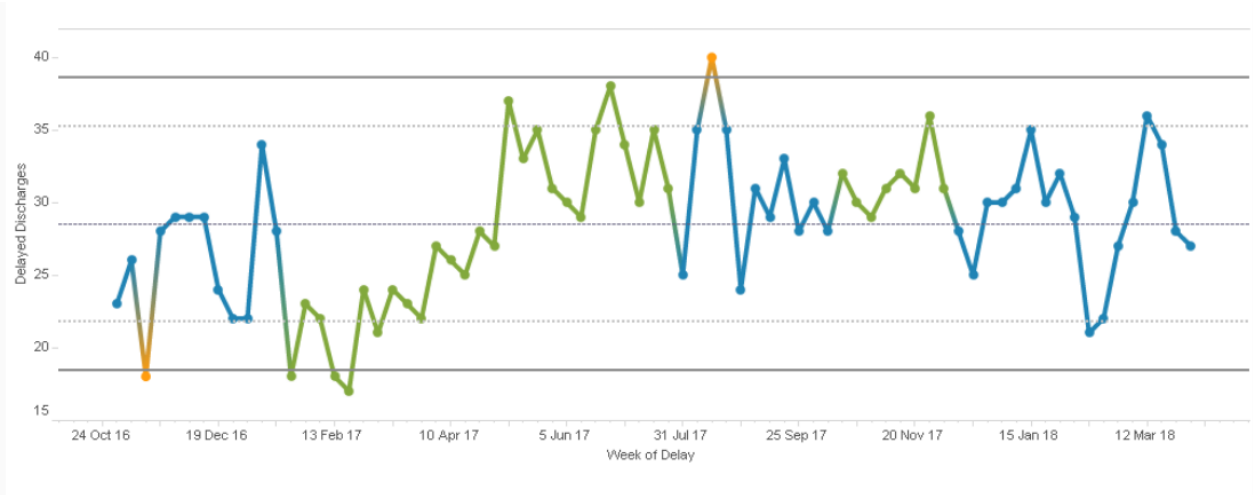
3.3 There has been an increase in the number of Midlothian admissions over the last few years, demonstrated in the graph below.

3.4



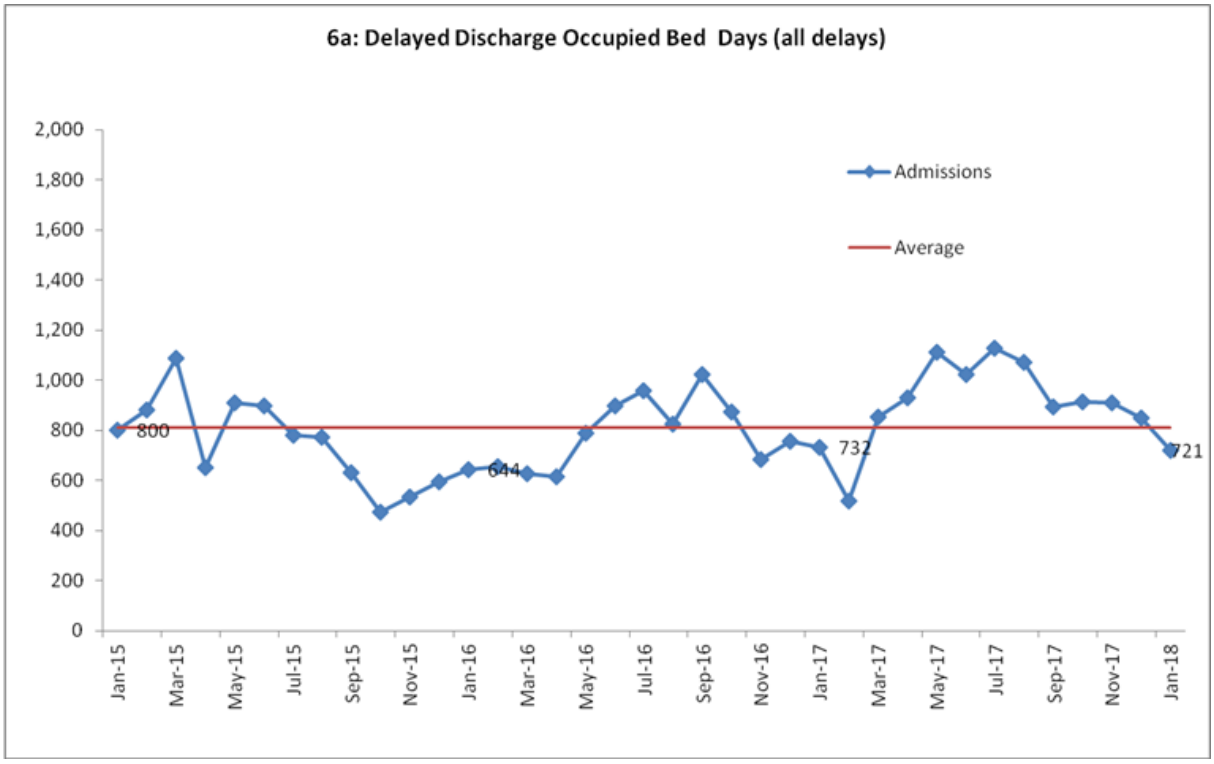
3.5 There continues to be a range of actions to support admission avoidance through MERRIT (Midlothian Enhanced Rapid Respond & Intervention Team), as well as the continuation of a virtual ward model of 15 beds within Hospital at Home. Due to Consultant absence, there has been a restriction in Hospital beds from 15 to 10 at present.

3.6 The table below sets out the current delayed discharge position within Midlothian.

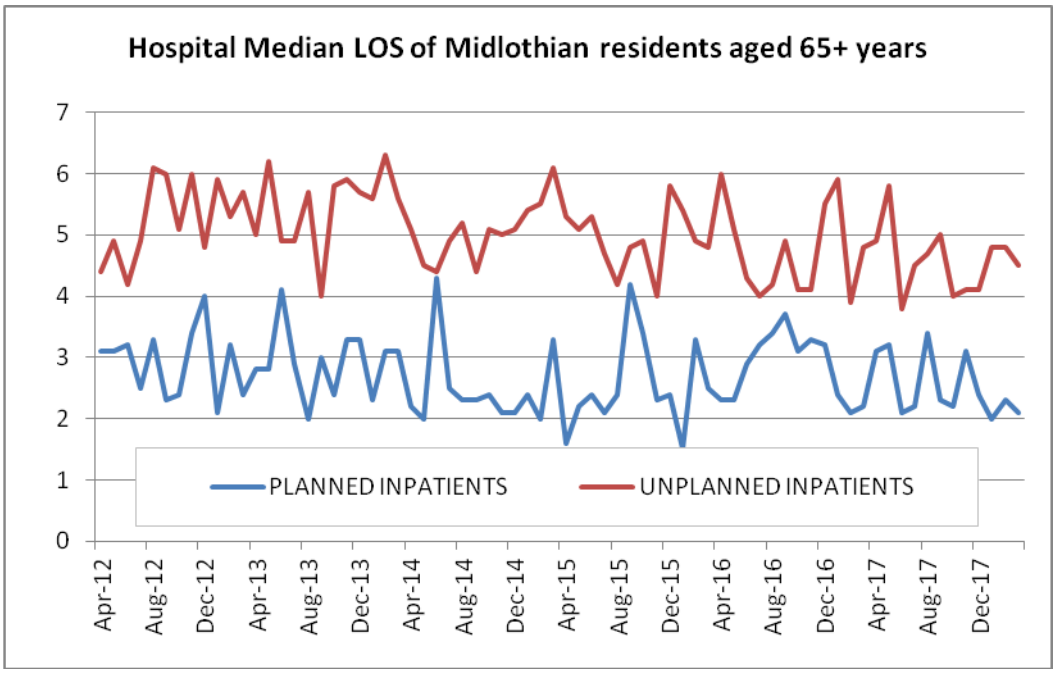


3.7 This increased activity is being experienced system wide, with ongoing pressures at the front door of the main hospital sites. Admission rates remain high, with acute services remaining under pressure.

3.8 Since February 2017 there has been a steady rise in the number of patients with a delayed discharge. This peaked in August 2017 with 40 people in hospital with a delayed discharge. Despite the number of patients with a delayed discharge remaining higher in January 2018 compared with previous Januarys. The total occupied bed days in January 2018, is lower than January 2017.



It should also be noted that despite delays increasing, median length of stay is showing a downward trend.



Current bed based care capacity in Midlothian is as below:

Midlothian Community Hospital	Edenview ward (rehab)	20 beds
	Loanesk ward (HBCCC)	20 beds
Highbank (Intermediate care)	Rehabilitation	6 beds
	Step-up/step-down	24 beds
	Respite	6 beds
	Emergency	1 bed
	Long term residential care	3 beds
Newbyres care home	Respite	1 bed
	Total	81 beds

External contributors:

- External provider capacity has always varied depending on demand and carer availability within geographical areas. Business models will only support additional recruitment when a "run" is financially viable for these providers. This has left significant gaps in capacity across the county at times, which is challenging to address real-time.

- External care providers are unable to attract new recruits meaning in-house teams are providing care services additional to the specialist purpose they were designed for.

- As a result of an ageing population, and an increase in co-morbidities, clinical presentations are becoming more complex. This is complicated further by pressures on acute care beds, with more patients requiring more complex support at home. Many care requests now ask for 2 carers, 4 times a day, which can be challenging to provide, particularly in outlying areas.

- Winter 2017/18 saw a period of cold weather which presented an increase in falls and fractures prior to Christmas. At the same time we experienced high levels of Flu-like presentations, resulting in additional demand for care.

- Traditional 4 day closures over the festive period presented the expected challenges for unscheduled care and unplanned admissions. In February, we experienced a red Met office warning for snow, and experienced significant issues to maintain safe care across all sites, as a result on limitations of transport, and subsequent workforce limitations. This resulted in elective surgery being cancelled, delays to discharge patients home, and a growing need within primary care for patients who could not access care services.

- Springfield Bank Care home has a Care Inspectorate Improvement Notice active at present, limiting bed usage capacity for the partnership for circa 20 beds. Health and Social Care support has also been allocated to work with Care homes to improve key elements of care provided.

- Midlothian currently have 6 GP practices with restricted lists.

Internal contributors:

- Care at Home capacity is not at its optimum. A recent Care Inspectorate report requested improvement to many aspects of the Care at Home service. An action plan was developed and is being worked though.

- Community waiting list with 80 people waiting for package of care.

- Rising demand for packages of care in general, in line with desire to support more people to live at home. The charts below demonstrate an increase in activity by in house teams in the first quarter of this year.

Chart A - No. of clients supported each week

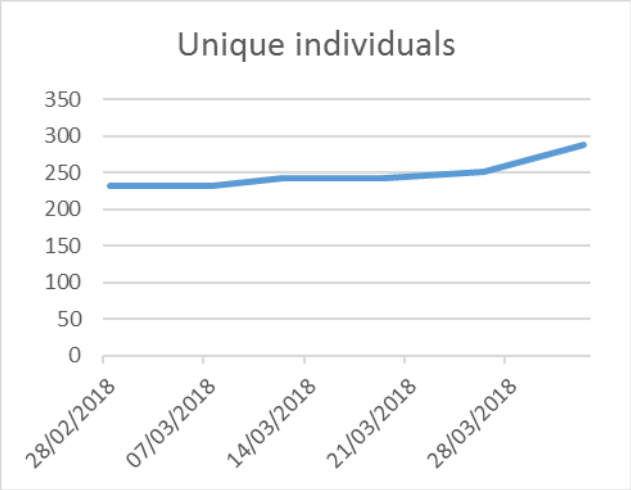
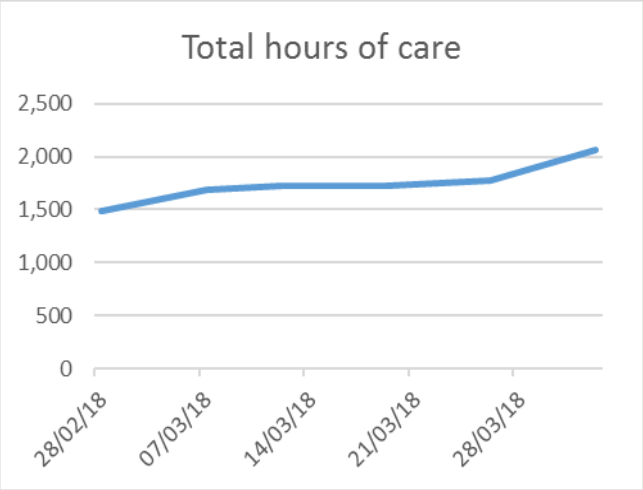


Chart B - No. of hours of care provided weekly



- Significant progress has been made. However, work is still ongoing to review all carer "runs" to eliminate waste. Complex Care and Reablement remain separate, and work independently of each other. Single points of failure exist within these services, such that processes are person dependant, rather than process adherence.

- Sickness absence within Care at Home services is at an unacceptable level. Currently this sits at 10%. This has not been managed as well as would have been expected, and is being addressed by the new management team.

- Changes to management and working practice have resulted in some instability for the team. Re-engaging with staff is key to improve morale, and rebuilding a cohesive, flexible care model.

- Implementation of management review has not fully taken place, resulting in a gap in senior leadership within intermediate care teams.

- There are significant examples of innovative care currently in the intermediate care spectrum within Midlothian. Increasing pressure of services has resulted in silo working at times, with limited real-time communications for care planning. Service creep has also taken place over time, where demand for care or beds, has resulted in reactive placements, outwith service remit. This has resulted in blockages within our flow systems.

- Weekly MDT/MA Delay meetings were in place. However, as demand increased, there was no overall flow management/ownership outwith this meeting. On occasion, delays were impacted by internal ways of working that require to be refocused to support the patient journey.

- Currently there is a complex eco-system of reports sent into the partnership from acute sources. There is no single overall flow document that tracks admission through to discharge that would provide professionals with a real-time, accurate position.

- Operational processes are developed, but systems in place on a daily basis, can be person dependant. Experience and corporate memory are relied upon, where a process base should be augmented.

- Ways of working have been reactive not proactive, due to system pressures and staff wanting to provide good care as soon as possible. Service creep is a good example where decisions to place a patient in a particular bed to support discharge form an inappropriate acute bed, may not be the most appropriate placement/service to support realistic care.

- As with most areas, specialist vs generalist flexibility is not always evident, or as flexible as it could be. Specialist culture where inappropriate, is detrimental to patient care, and the various delivery plans are seeking to address this from a strategic perspective. Further work requires to be done on this operationally at a local level.

- Performance is measured as activity not outcome based.

- Family expectations are changing. Many will not support any other option for discharge than their preferred option. Whilst this is appropriate in principle, acute care beds are being blocked through "boarding". A renewed focus on "moving on", and a family first discussion process is required at point of admission.

Actions to address

Coordinated Multi agency planning and care

- Daily discharge hub meetings to review and manage all delayed patients
- Establishment of Flow Coordinator/Bed Manager role to keep visibility of all flow
- Centralised coordinating hub, not person dependant
- Single performance report from admission to home
- Single point of referral for Midlothian for all beds
- Request RIE Discharge Hub Coordinator to attend meetings
- Review and management of care at home community waiting list to avoid conversion to emergency admission
- Weekly meetings with external providers
- Third sector partners involved with care planning

Maximise available capacity

- Whole carer run review to maximise efficiency
- Sheltered Housing cover review to maximise efficiency
- Appropriate review process in place

- Create one Care at Home team, bringing together Complex and Reablement
- CM 2000: mobile technology real-time call monitoring system (CM2000). This technology uses mobile phones to digitally scan when a carer attends and leaves a care visit. This allows improved management and scheduling of care workers, which promotes improved quality of care, a safer workforce that can flex to respond to episodic changes in care needs, by understanding in real-time where our workforce are
- Robust sickness management: HR support in place.
- Recruit to locum bank to provide resiliency
- Continued H&SCP support to Springfield Bank Care have to support removal of improvement notice and access to beds within Bonnyrigg

Operational data to inform practice and performance

- Weekly activity reports to understand levels of activity and team capacity
- Care worker scheduling
- Cost and value analysis
- Weekly care worker geo-mapping scheduling report (Plots, care visits on map)
- Weekly sheltered housing report to minimise multiple providers to single location
- External care provider capacity reporting
- Community care waiting list management report
- Sickness absence reporting
- Finance reporting (per accounting period)

Visible leadership

- Appointment of Service Manager for Community (Management Structure review implementation), with recruitment to Service Manager for Intermediate care due for summer 2018
- Interim Care at Home Manager to be recruited
- Manager desk base to be within team office area
- Link to regional/national forums

Development of Care model

- Review Discharge to Home Clinical Support Worker model to focus on delayed patients
- Incorporate activity based performance with outcomes based performance
- Deliver model within financial envelope, releasing identified savings.(£900k)
- Scope out seasonal contingency planning (Locum, Private Home care)
- Avoid service model creep: right patient, right bed, and right time
- Review respite bed usage over 52 weeks
- Review HBCCC ward, with view to convert beds to step down for LTC care patients awaiting care home availability
- Development of COPD/Respiratory model to prevent admission

4. Policy Implications

4.1 The establishment of the Integrated Joint Boards was to implement and accelerate change to shift the balance of care from institutional to community settings. A key performance metric for the IJB is to reduce the delayed discharge occupied bed days by 30% April 2018.

5. Equalities Implications

5.1 The majority of delays are older people, therefore, there is a need to ensure timely discharge to support independent living and to prevent loss of function.

6. Resource Implications

6.1 There is both a financial and broader clinical costs associated with delayed discharge. The occupied bed results in waste within the hospital environment, preventing the bed being used by another patient, which may include elective activity. Furthermore, there are evidenced clinical impacts on patients who have an extended stay in hospital as a result of being delayed. This includes potential reduction in overall function, ongoing exposure to hospital acquired infection and loss of confidence when returning home.

7 Risks

7.1 There is a risk that patients will have their discharge delayed because there is insufficient community supports to enable timely discharge leading to deterioration in their health, beds being blocked and elective operations potentially being cancelled.

7.2 The actions as set out above will attempt to address these risks. However, there is a need to ensure effective monitoring to provide assurance around implementation and impact.

7.3 Delayed discharges are a symptom of system health. There is a risk that too much of a focus is reacting to these, rather than a focus on admission prevention.

8 Involving People

8.1 The wider issue of shifting the balance of care from institutional to home or homely settings has been discussed widely within the Midlothian Older People's Assembly and Hot Topics, with overwhelming support for this approach.

9 Background Papers

None

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