WEST DUNBARTONSHIRE COUNCIL

Report by the Acting Director of Social Work Services

Health Improvement and Social Justice Partnership:

9 August 2006

Subject: Delayed Discharge Action Plans

1. Purpose

1.1 This report updates the Partnership on the July 2006 Delayed Discharge Census figures and the draft action plans that have been jointly developed by officers of NHS Greater Glasgow and Clyde and West Dunbartonshire Council.

1.2 The draft action plans are in the format stipulated by the Scottish Executive Health Department template, and aim to identify the key actions and resources required to address the issues that cause delayed discharges.

2. Background

2.1 Delayed hospital discharge performance has been reported to the Partnership on a regular basis since the Partnership was formed, and remains an important issue for patients and relatives, NHS systems and West Dunbartonshire Council.

2.2 In February 2006 the Scottish Executive Health Department announced new, even more challenging targets for local partnerships, as reported at the May 2006 meeting of the Health Improvement and Social Justice Partnership.

2.3 The appended draft action plans attempt to identify key actions that will help us meet these targets, thereby improving the quality of care for those people who are at risk of having their hospital discharges delayed.

2.4 Appendix 1 outlines the NHS Greater Glasgow and Clyde overarching plan, and has been presented in very broad, strategic terms.

2.5 Appendix 2 contains more specific proposals, and relates solely to West Dunbartonshire. This plan is in draft form, and is subject to agreement by the Partnership and confirmation of the final financial allocation. The draft plan has been developed based on financial assumptions that we will receive an equivalent allocation from the new NHS Greater Glasgow and Clyde, as the combined figure previously received from NHS Greater Glasgow and NHS Argyll & Clyde.

3. Main Issues

3.1 At 15 July 2006, there were 39 people whose hospital discharge had been delayed. Of these, 28 had been delayed for six weeks or more. At that census point there were 10 people delayed whilst accommodated in a short stay bed. Table 1 below shows how these figures compare with the April 2006 census. Our targets for April 2007 on these indices are 20, 16 and 9 respectively.

	April 2006	**July 2006**	**April 2007 Targets**
Overall Delayed Hospital Discharge	33	39	20
Delayed 6 weeks or more	31	28	16
Delayed in short-stay bed	18	10	9

3.2 Please note that the July figures are provisional subject to final verification.

3.3 While the delayed discharge position is very serious, it should also be considered in the context of other service activity. For example, during June 2006, 171 people were provided with social work support to enable them to leave hospital as soon as they were pronounced ready for discharge (Rapid Response = 48; Clydebank Hospital Discharge Team = 83; Dumbarton Hospital Discharge Team = 40). Since the April 2006 census, 17 of the 33 people who had been recorded as having their hospital discharge delayed have been discharged. However, during that same period a further 23 people came on to the list leading to a net increase of 6.

3.4 The majority of those whose discharge has been delayed at the July 2006 census point are awaiting a care home place (25). While there are vacancies in care homes in West Dunbartonshire, West Glasgow and Helensburgh, choice remains a serious issue in moving people out of hospital and on to a more appropriate and comfortable setting.

3.5 The Scottish Executive directive on choice of accommodation on discharge from hospital states that " … *indefinite occupation of a hospital bed by a patient who is ready for discharge, while awaiting his/her choice of care home, is not appropriate. … patients should be asked to make choices of care homes, and interim accommodation should be secured if none of these choices becomes available within the discharge planning period*." (Circular No. CD 8/2003, paragraph 5). Given that the issue of choice is the biggest single factor affecting the number of delayed discharges in West Dunbartonshire, our Partnership must consider proactive implementation of interim placements. Most of our delayed discharges are due to people awaiting their choice of care home whilst remaining in a hospital bed. This means that unless we tackle this issue, we are unlikely to meet our targets. Current moves to address the issue of choice, and to help prevent future problems around this issue include:

- Re-instatement of the Area Resource Group (ARG), which now meets on a weekly basis, and considers new applications for care home places. The ARG works with fieldwork staff to help identify alternative support packages, or if this is not possible, alerts fieldwork staff if a home with a long waiting list has been requested. This is in line with the Scottish Executive guidance which states that if a particular home is unlikely to have an available place once the assessment is completed, an alternative or interim place should be secured as early as possible.
- For those people who are ready for discharge but are still awaiting placement from a hospital bed, case reviews take place each week to try to identify possible solutions. Interim places are offered, but the guidance is clear that choice does not apply to interim places. It is therefore important that we begin to implement interim placements within the parameters of the statutory guidance.
- The Scottish Executive Joint Improvement Team (JIT) are working with us to help identify the complex factors that have led to a higher than average rate of unplanned and multiple unplanned hospital admissions in our over 65 population. The JIT will host a workshop seminar on 18 September 2006, aimed at helping NHS and local authority officers in West Dunbartonshire understand the causes and identify solutions. This approach is in response to the documented evidence from ISD Scotland that older people who are admitted to hospital as an emergency are significantly more likely to have their discharge delayed. The risks increase further if the person is subject to multiple unplanned admissions.

3.6 Our Partnership Discharge Planning Agreement (September 2005) supports the use of interim placements and details our agreed policy to protect waiting list places for the home of first choice should an interim placement be required. The policies to implement interim placements are therefore agreed and in place, but have not been fully implemented. The action plan at appendix 2 states a number of proposals designed to sustain areas of good performance, and are explained more fully within this section (paragraphs 3.6 to 3.12).

3.7 The West Dunbartonshire Action Plan proposes that we continue to fund the additional assessment capacity that was implemented in 2003. Since assessment capacity was increased we have maintained a position of preventing delays due to non-completion of community care assessments. On the rare occasions when this has been recorded as cause of delay, it has been due to either a significant change in circumstances or a wide variety of options being feasible and therefore more time has been needed for the service user or carers to make an informed choice of care plan.

3.8 We also propose to continue our current investment from these funds in respect of care home places. Inevitably some older people will have to move from hospital to care homes, and if we are to implement the use of interim placements, the financial resources required will increase. Overall spend on care home placements will be monitored as part of the performance management framework for the action plan.

3.9 The Lomond Care Team is a joint development which takes an integrated approach to ensuring that people who are at risk of a hospital admission because of insufficient health and/or social support at home can have increased inputs and therefore remain at home. In cases where hospital admission has been unavoidable, the team works to ensure that a fully supported discharge home can take place when the patient is ready for discharge. This team has been partially funded through the delayed discharge monies since 2002, and the action plan proposes that funding should continue.

3.10 Homecare services have long been regarded as key to maintaining people in their own homes for as long as possible. Augmented Homecare provides a high level of care, such that would have traditionally been expected in residential care home settings. The plan proposes that we should continue to support Augmented Homecare and also intensive homecare (in cases where no nursing inputs are required but the person needs a high level of personal care support to remain at home).

3.11 The Step up – Step down service is designed to help build confidence in people to return home after a hospital care, or to give people high levels of additional support to prevent them from having to be admitted to hospital. Places are based in West Dunbartonshire Council sheltered housing complexes, and can also provide crisis support during a carer emergency. The service is continually developing and is becoming very popular with clinicians as its successes become more widely known and understood. The plan proposes continued support of this service.

3.12 Carers and clinical colleagues have expressed some anxiety about the prospect of some older people who live alone being discharged and left on their own overnight. This can lead at times to either a reluctance to discharge or pressure from relatives to keep the person in hospital longer. In response to this the draft plan proposes that we support short-term overnight homecare and district nursing services.

Appendices

3.13 The NHS Greater Glasgow and Clyde overarching plan is attached as Appendix 1, and the West Dunbartonshire plan is at Appendix 2. The Scottish Executive letter of 30 May 2006, requesting Action Plans is attached at Appendix 3. The templates in appendices 1 and 2 have a column headed “Anticipated Outcome”, against which reference numbers have been matched. For clarity the outcomes to which these refer are as follows:

1. Reduce delays over 6 weeks to zero by April 2008
2. Reduce the number of delays in short-stay beds to zero by April 2008
3. Prevent unnecessary emergency admissions
4. Speed up assessment process and discharge planning
5. Ensure resources are available to fund care home and domiciliary care
6. Ensure quarterly sustainable reductions are made

4. Personnel Issues

4.1 There are no personnel issues.

5. Financial Implications

5.1 The monies identified within the plan may not be sufficient to fund the required activities and care packages that will enable us to achieve our targets, in particular the additional care home costs if we implement interim placements. The Head of Social Work Resources is currently assessing the overall resources currently being used to address delayed discharges, in an attempt to clarify any potential shortfall, and the impact of this on our performance against targets.

6. Conclusions

6.1 The Partnership has consistently shown its commitment to reducing the incidence of delayed hospital discharge, and supported the joint working agenda to address the issues which cause these delays.

6.2 There is a shared acknowledgement across the Partnership that delayed discharge has a negative impact on patients who are already in hospital, as well as those awaiting admission for elective procedures. On that basis, safe and timely discharge remains a priority. The action plans, once agreed, will therefore be closely monitored by the Joint Strategy Group which will in turn report progress to the Health Improvement and Social Justice Partnership. Monitoring will take account of the overall activity required to ensure timely discharge, to provide a clearer context of successful hospital discharge as well as delayed hospital discharge.

6.3 The issue of choice of care home needs to be proactively managed through the use of interim placements.

6.4 The action plans will help to ensure that appropriate actions are taken to address this issue, but we must be alert to the risk that the resources identified may not be sufficient to enable us to meet our targets.

6.5 In the longer term, our local capacity plan lays out proposals by which to tackle some of the underlying structural issues that can contribute to the problem of delayed discharge. However, we must also be alert to the potential risk that the drive to meet targets may undermine the proposed redesign of older people's services as pressure increases to effect hospital discharge into existing models of care as opposed to new, more appropriate options. That scenario would lock resources into current service configurations rather than freeing them up to develop new services that keep more people at home.

7. Recommendations

7.1 The Partnership is asked to note the content of this report and appendices.

7.2 The Partnership is asked to make comment to the Director of Social Work Services.

7.3 The Partnership is asked to support the full implementation of our agreed Discharge Policy, including interim placements.

7.4 The Partnership is asked to agree the West Dunbartonshire draft action plan, subject to comments by members and confirmation of the financial allocation.

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Background Papers: Scottish Executive Letter: Patients Ready for Discharge – Future Target Setting, 23 February 2006.
Scottish Executive Circular No. CD 8/2003: Choice of Accommodation – Discharge from Hospital, 13 January 2004.
NHS Greater Glasgow Partnership Discharge Protocol [produced in association with local authorities, including West Dunbartonshire Council], September 2005

Wards Affected: All council Wards.