Item No: 20

Meeting Date: **Wednesday 27th March 2019**

Glasgow City Integration Joint Board

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GLASGOW CITY HSCP'S DELAYED DISCHARGE PERFORMANCE IN THE ACUTE HOSPITAL SYSTEM

Purpose of Report:	This report outlines Glasgow City HSCP's delayed discharge performance; and actions being taken to optimise future performance.

Background/Engagement:	No specific engagement activity undertaken in preparation for this report.

Recommendations:	The Integration Joint Board is asked to: a) Note Glasgow City HSCP's delayed discharge performance; b) Note the deterioration in performance over the past year, following sustained improvement over a 6 year period; c) Note the risk factors in relation to future performance improvement; and d) Note the improvement activities being undertaken by the HSCP to drive future performance.

Relevance to Integration Joint Board Strategic Plan:

Minimising delayed discharges contributes to the efficient performance of the Acute sector and is a strategic priority within the IJB's Strategic Plan.

Implications for Health and Social Care Partnership:

Reference to National Health & Wellbeing Outcome:	Particularly relevant in relation to indicators 2, 3, 4 and 9.

Personnel:	No particular implications.

Carers:	No particular implications.

Provider Organisations:	No particular implications.

Equalities:	No particular implications.

Fairer Scotland Compliance:	Not applicable.

Financial:	Is material to the wider debate around set aside.

Legal:	No particular implications.

Economic Impact:	Not applicable.

Sustainability:	Not applicable.

Sustainable Procurement and Article 19:	Not applicable.

Risk Implications:	Delayed discharges present a risk to the efficient running of the Acute system.

Implications for Glasgow City Council:	High hospital discharge demand impacts on social care budgets, particularly home care and purchased care home budgets.

Implications for NHS Greater Glasgow & Clyde:	Improved delayed discharge performance is a strategic priority for NHSGGC.

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	✓
	2. Glasgow City Council	
	3. NHS Greater Glasgow & Clyde	
	4. Glasgow City Council and NHS Greater Glasgow & Clyde	

1. Purpose

1.1 This report outlines Glasgow City HSCP's delayed discharge performance and actions being taken to optimise future performance.

2. Definition and Description

2.1 The Scottish Government Information and Statistics Division (ISD) defines a delayed discharge as:

"when a patient, clinically ready for discharge, cannot leave hospital because the other necessary care, support or accommodation for them is not readily accessible and/or funding is not available, for example to purchase a care home place".

2.2 The Scottish Government's timescale target for a delayed discharged has significantly evolved over recent years, reducing from 6 weeks to 4 weeks to 2 weeks and ultimately to 72 hours. NHSGGC applies a more stringent definition of a delay than Scottish Government, namely, it logs patients on the system from the moment a person is declared fit for discharge from hospital.

2.3 The HSCPs' delayed discharge performance is generally taken to refer to discharges from the Acute hospital sector.

2.4 Delayed discharges also occur from the in-patient facilities managed by the HSCP sector, including adult mental health, older people's mental health and tier 4 learning disability. However, these delays are not a focus for this report as they have no impact on Acute sector performance. The Scottish Government's delayed discharge target is not applied to this population for that reason.

2.5 Assurance can be provided however, that delays in these sectors continue to be subject to their own scrutiny under the auspices of the 5 year mental health strategy, review of Older People's Mental Health (OPMH) and review of tier 4 beds.

2.6 The HSCPs' performance management arrangements focus on 3 distinct patient cohorts, each of which tend to be delayed for distinctive reasons:

i) Aged 65+ frailty – this is the highest volume patient cohort typically involving people aged 75+ with increasing frailty and multi-morbidities. This group accounts for the highest number of delays, but these are typically of a short duration, no more than 3-4 days. As a consequence there is a high turnover in this group; i.e. this is largely a completely different group of individual patients from week to week, even if the headline numbers remain largely unchanged.

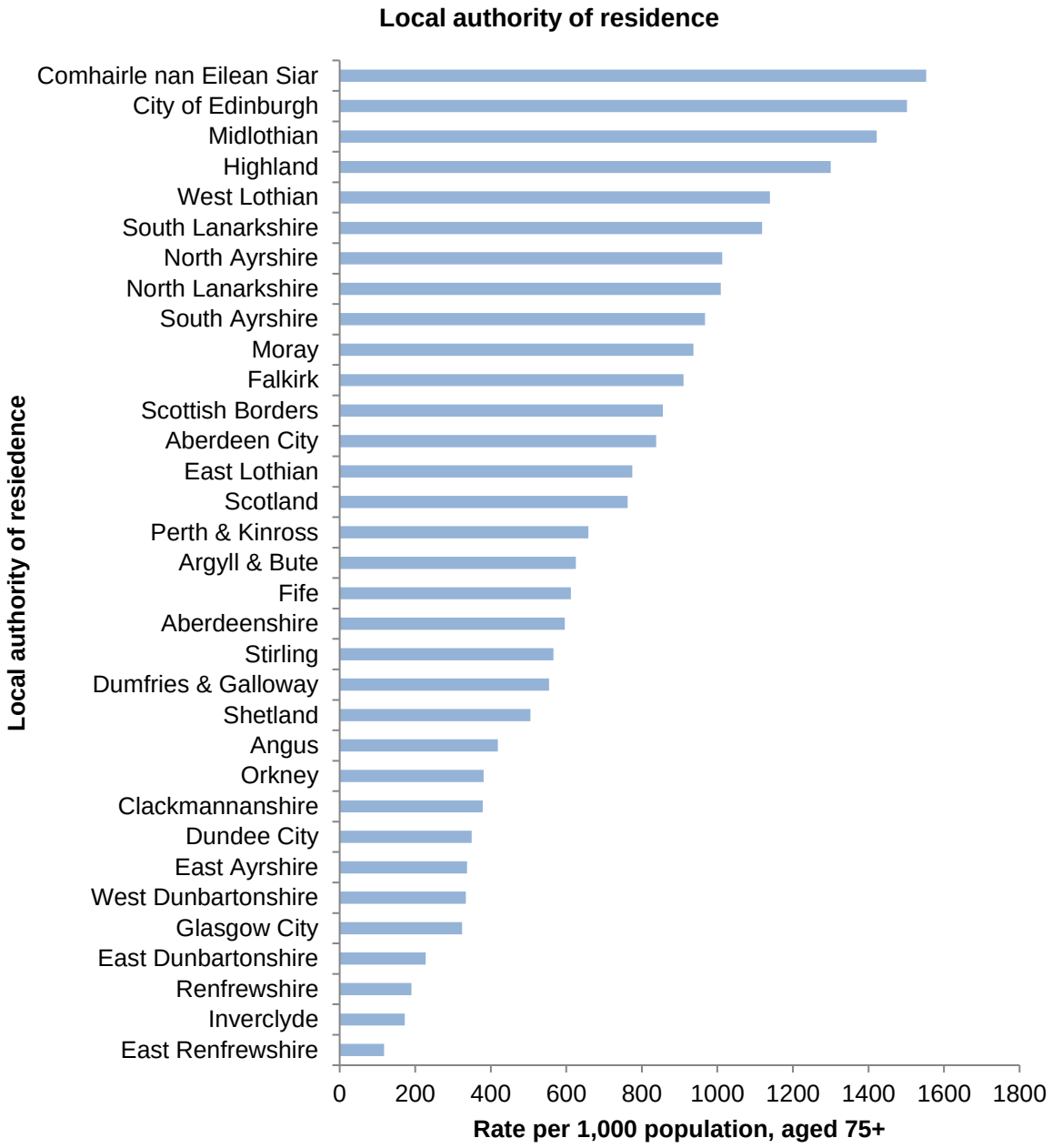
ii) Adults aged 18-64 – this is a much smaller cohort, characterised by a mixture of short (e.g. securing homeless accommodation) and longer-term delays (e.g. specialist community placements require to be commissioned due to unusually complex needs).

iii) Adults with Incapacity (AWI) – the numbers in this cohort are steadily increasing over recent months. Of the three patient cohorts AWI delays place the greatest strain on the Acute system as they typically involve delays of many months whilst guardianship powers are pursued to enable the patient to be moved to another location (invariably a care home) in line with legal requirements.

2.7 Appendix 1 details some typical case studies relating to each of these sub-groups.

2.8 Related to these differences, bed days lost to delayed discharges is a more meaningful measure of whole system performance than the number of individual patients delayed. For example, a single 65+ frailty delay will typically account for 3-4 bed days lost, whilst an AWI-related delay may result in 200-300 bed days lost. In that sense two delayed discharges can have quite fundamentally different implications for the running of the Acute system.

2.9 The charts below provide an illustration of the HSCPs' performance within Greater Glasgow and Clyde compared to all other HSCPs over time:



- In GGC, over the past year there has been a reversal in the downward trend experienced since 2011. This is consistent with the pattern across Scotland, with the Scottish Government indicating there has been a 13% deterioration nationwide during that time.
- NHSGGC is the best performing Health Board in Scotland in respect of delayed discharges. There is unlikely to be a better performing Health authority across the UK.

3. Issues for Consideration

3.1 No definitive explanation has been provided for the pattern of deterioration in performance in both GGC and across Scotland over the past year.

3.2 However, performance levels in the staple discharge services such as home care and intermediate care have remained consistent, so the explanation does not lie there.

3.3 Winter 2017/18 did generate high levels of demand across the entire health and care system, with flu levels the highest over recent years. Delayed discharge performance deterioration correlated directly with that additional period of demand and has yet to recover in Glasgow City in particular within GGC or across Scotland generally.

3.4 Over the past year we have also seen a steady increase in the number of AWI-related delayed discharges. This is considered symptomatic of the increasing complexity of need.

3.5 There are continuing future risks to performance, including:

- Continuing downward pressure on HSCP budgets.
- Increasing volume and complexity of demand from an ageing population.
- In the city, potential impacts on home care staffing levels from the equal pay settlement.
- Prospective legal challenges from the Equality and Human Rights Commission (EHRC) in relation to the specialist AWI beds commissioned by GCHSCP on behalf of the Health Board.

3.6 In the face of all these factors the question arises, what realistically is the optimum shared and agreed delayed discharge performance for Greater Glasgow and Clyde? Chief Officers would contend that it can't be zero, and that it is not solely an issue for determination by the Health Board, that it is also a matter that requires engagement with IJBs and the six local authorities.

4. Continuing Focus for Improvement

4.1 Having already exhausted the majority room for improvement over the period since 2011 the HSCPs have now entered the phase where the potential for further improvement is more marginal.

4.2 Activities being undertaken to deliver those further improvements include:

- In the city, a recent increase in the capacity of specialist AWI beds from 54 to 60. These will deliver a reduction in bed days lost of around 180 per month.
- A continuing programme of improvement in relation to Intermediate Care. This is being supported by a whole system group of relevant staff, including Acute consultants and a range of HSCP professional groups. There is a particular focus on average length of stay (ALOS) in Intermediate Care, as more efficient throughput creates greater capacity for discharge from hospital. The ALOS trend over time has been driven down by this improvement work, but this will continue to be a priority.
- A continuing programme of improvement in relation to AWI. Again the focus is on throughput from specialist AWI beds for the same reasons as Intermediate Care. HSCP staff do not control critical elements of the AWI system, such as the activities of families, private solicitors or the timing of courts. However, this

programme brings scrutiny to what the HSCP can improve; e.g. timeous completion of reports, local authority guardianship applications etc.

- A management focus on everyday activities, including:
  - A reduction in same day (as fit for discharge) referrals from Acute – which automatically generate delays.
  - More assiduous prioritisation of delays by HSCP community staff – these are marginal, as most cases are held by the hospital-facing Home Is Best team.
  - Improved communication arrangements between ward staff and the Home Is Best team around individual patients; i.e. single points of contact, more effective networks.
  - Improved performance around the ordering of transport, polypharmacy etc.
  - The national group of Chief Officers are also currently engaged in a joint piece of work with Scottish Government to analyse practice across Scotland with a view to learning about best practice and with the intention of implementing said best practice locally.
  - Within GGC, the MFT programme inevitably, is expected also to provide a framework for whole system transformation of the health and social care environment over the next ten years.

4.3 Whilst each of these areas is being actively pursued, expectations about their impact must be placed in context. Even allowing for the deterioration in performance experienced over the past year, delayed discharges in Glasgow City for instance, accounted for 1,196 bed days lost to the Acute system in December 2018. This equated to around 40 Acute beds or 1.3 wards or **c1%** of NHSGGC's total Acute capacity.

4.4 Therefore, whilst the deterioration in delayed discharge performance for the first time in 6 years remains a concern, and has undoubtedly added to the already significant pressures on hospitals, even substantial future improvement will not deliver major additional capacity to the Acute system.

4.5 It is the case that the biggest prize in relation to improving performance is to focus on the preventative side of the health and care system. It is without any doubt that the focus of attention and resource (both in monetary and staff time) remains at the reactive end of the business i.e. discharge from hospital. Arguably and perversely, such levels of attention and resource will be having a detrimental effect on the overall performance, potential to improve and actually achieve the expected shift in the balance of care.

5. Glasgow City HSCP - Discharge Pathways

5.1 A Glasgow City resident leaving hospital will typically be discharged through one of the following pathways:

- Home with no requirement for ongoing HSCP support.
- Home with HSCP home care support (reablement), directly ordered by Acute ward staff.
- To an Intermediate Care unit to enable a social work assessment to take place.
- To a specialist AWI bed (where they lack capacity).

- To a residential or nursing home, where the social work assessment has been concluded in hospital.

6. Glasgow City Performance Analysis

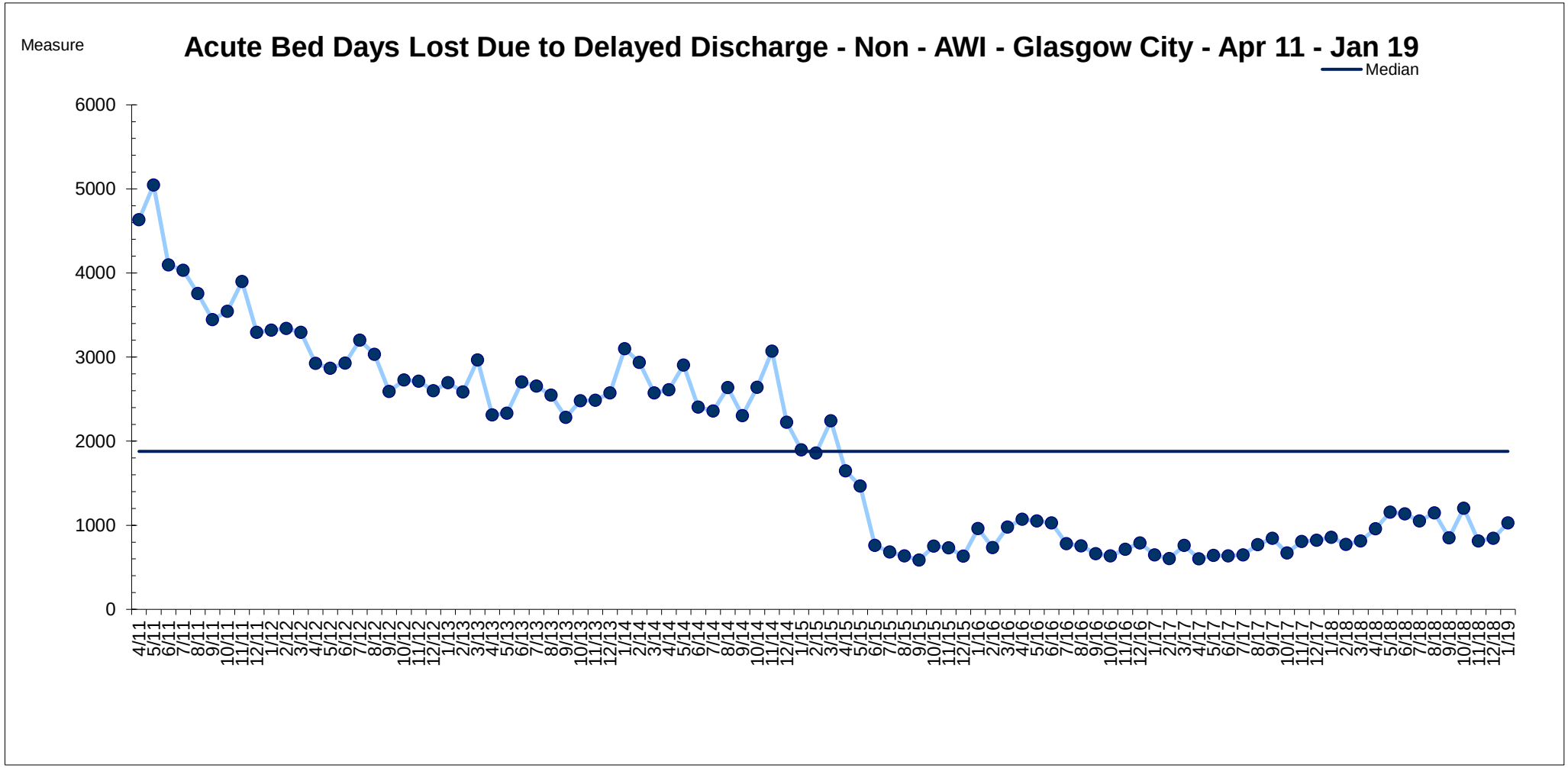
6.1 Glasgow City HSCP routinely monitors its performance against all of the above delays, with a breakdown by patient cohort.

6.2 The solutions for each group tend to be distinct, requiring this discrete performance focus; e.g. the majority of 65+ frailty delayed patients will be discharged to Intermediate Care, whilst AWI delayed patients will be discharged to specialist AWI beds commissioned by the HSCP.

6.3 Performance is vigilantly governed through a number of mechanisms. Core is the weekly Operations Meeting chaired by a Head of Older People's Services and involving all relevant operational leads from across the system, including the Acute Discharge Team. At these meetings each Friday afternoon every current delayed discharge is reviewed by the collective to ensure that all potential solutions have been exhausted. It should be noted that the Health Board's Nurse Director attended this meeting just prior to Christmas, and noted the process to be 'well structured and thorough'.

6.4 In addition, daily performance reports are circulated across all relevant managers detailing current delays by patient cohort.

6.5 There is further formal scrutiny via IJB committees, joint performance review mechanisms with the Council and Health Board chief executives and to the Scottish Government via national key performance indicators (KPIs). In fact, delayed discharge performance is the single most heavily scrutinised component of the older people's system.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Acute Bed Days Lost Due to Delayed Discharge - Non - AWI - Glasgow City - Apr 11 - Jan 19
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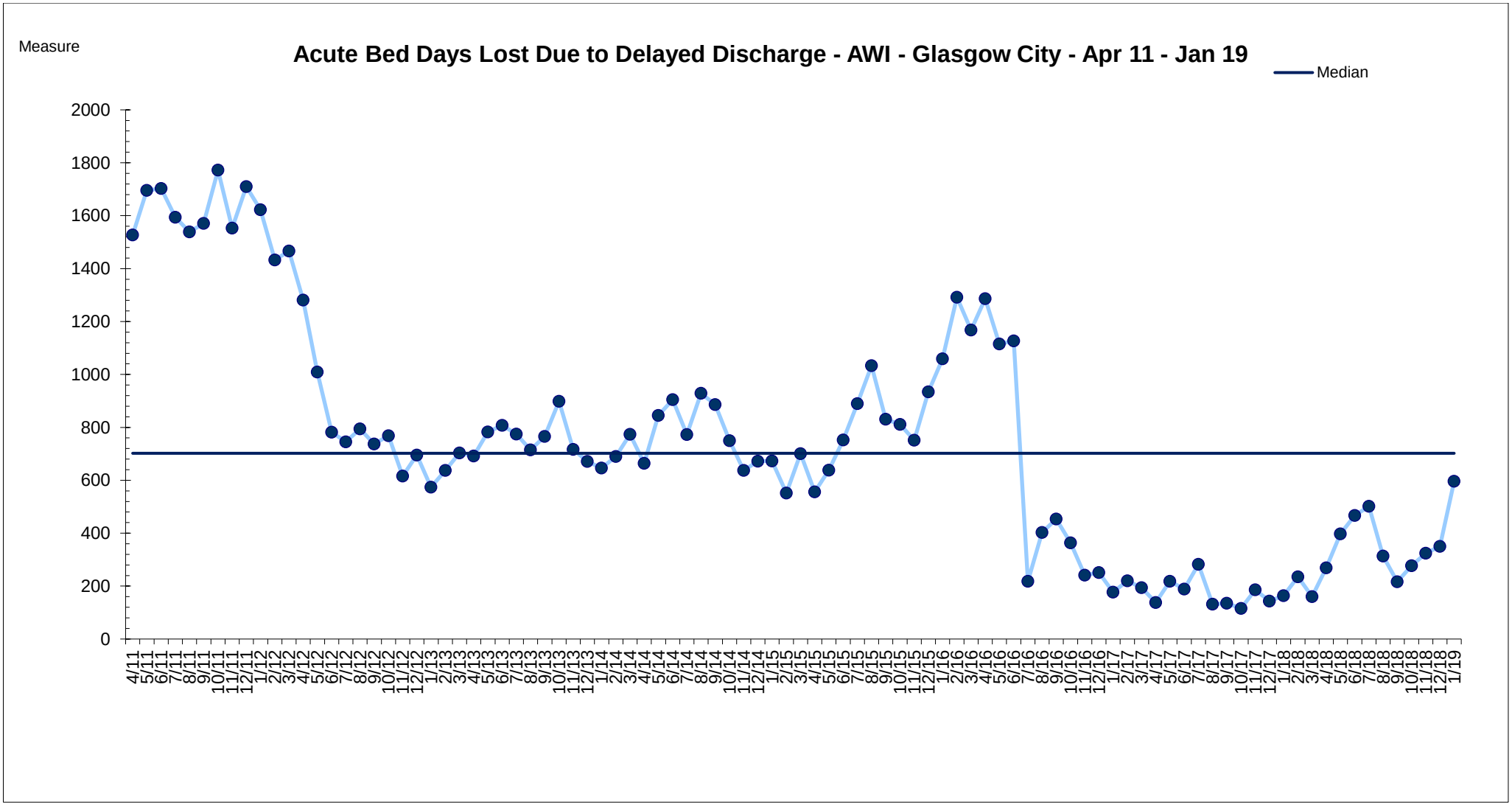
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Acute Bed Days Lost Due to Delayed Discharge - AWI - Glasgow City - Apr 11 - Jan 19
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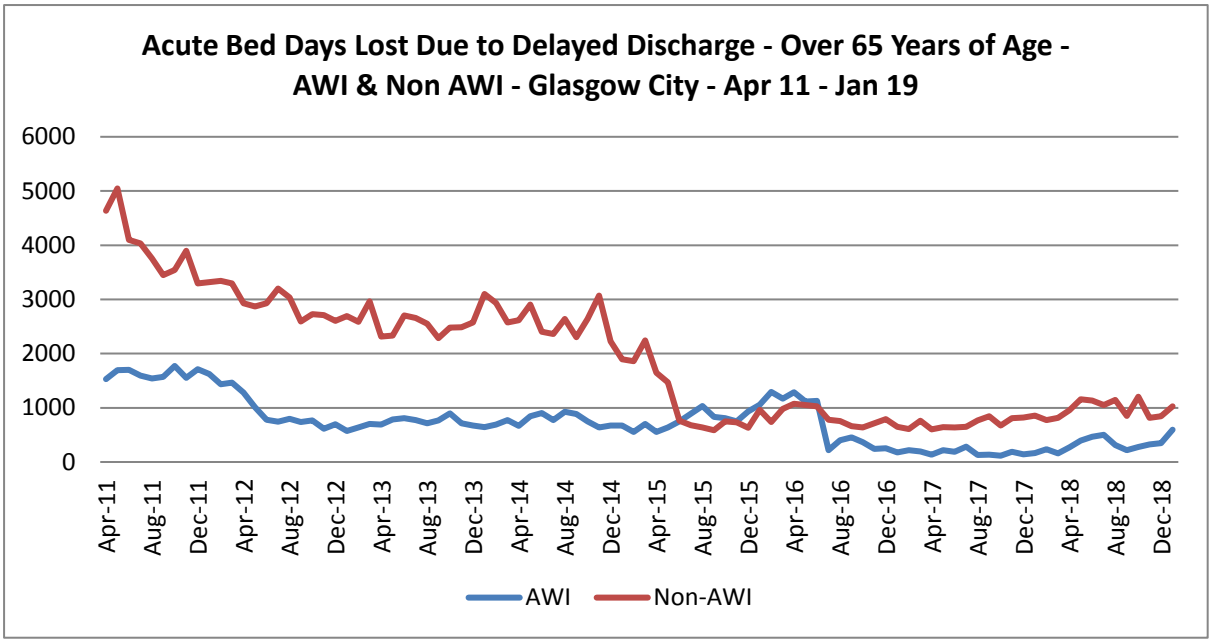

6.6 Some headlines from the data:

- Glasgow's performance has radically improved since 2011, delivering considerable benefit to the running of the Acute system.
- Performance had hit a plateau prior to the introduction of Intermediate Care in December 2014, which delivered a further sustained improvement.
- Glasgow City performs relatively well on delayed discharges. It was the 5th best performing of 31 HSCPs in Scotland during 2017/18, the last full year for which ISD figures are available.

7. Delayed Discharge March 2019: Acute Perspective

7.1 Bed Days Occupied by All Delayed Discharges: 2018/19 NHS Greater Glasgow & Clyde

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
Bed days occupied [5]	All delays	5,354	5,795	5,637	5,742	5,769	5,684	5,899	5,161	5,222	5,959
	Average number of beds per day[6]	178	187	188	185	186	189	190	172	168	192

7.2 The above table showing bed days occupied for all delays each calendar month and the average number of beds occupied by delayed discharge per day illustrates the extent of the delayed discharge issue.

7.3 Each hospital within the acute sector has a discharge team working with clinical teams to minimise delay to discharge, educate staff in discharge planning and ensure complex cases are managed, progressed and escalated to appropriate agencies. Discharge planning and process is consistent in all hospitals no matter what HSCP the patient is from.

7.4 The Discharge Team within acute are led by a Discharge Manager and a Discharge Team lead and are responsible for allocating beds within AWI units to ensure Length of stay in an acute bed for patients waiting on guardianship are minimised. They make sure that there is robust liaison with all HSCPs in relation to discharge and delays to discharge and are responsible for all daily, weekly and monthly delayed discharge reports and statistical reporting of NHS GG&C delayed discharge position.

7.5 All ward and clinical teams work as a multi-disciplinary team to ensure discharge home is the first option for all patients and only as a last resort will Home not be the preferred or appropriate option.

7.6 Referral to Social Work teams within each HSCP is generated when additional support is required to discharge the patient home or to explore alternative options to home. This is done in conjunction with the patient, family and carers and referral is generated as early as possible to allow time to assess and plan future care needs.

7.7 Daily Dynamic Discharge which incorporates Estimated Date of Discharge (EDD), Daily board rounds, Targeted ward rounds, is actively promoted and supported within each acute hospital and enables MDT's to prioritise care and promote effective discharge planning. This approach puts patients, families and carers at the centre of discharge planning and improves communication for all agencies as well as hospital staff as vital information is accessed to undertake a full and comprehensive assessment when required.

7.8 HSCP's out with the partnership area contribute significantly to delayed discharge performance within NHS GG&C and the consistent approach above to discharge planning and delayed discharge recording applies to all HSCP's within and out with partnership.

8. Recommendations

8.1 The Integration Joint Board is asked to:

a) Note Glasgow City's delayed discharge performance;
b) Note the deterioration in performance over the past year, following sustained improvement over a 6 year period;
c) Note the risk factors in relation to future performance improvement; and
d) Note the improvement activities being undertaken by the HSCP to drive future performance.

Appendix 1

CASE STUDY 1 – FRAIL 65+

Mrs A, aged 89 years, admitted to QEUH following a fall at home. Previously in receipt of homecare 4 times per day and good family support. Power of Attorney in place however Mrs A retained capacity. Broken hip requiring surgery and rehabilitation. During stay in hospital develops a UTI causing confusion. Early referral sent to Hospital team as it is deemed that Mrs A cannot be safely discharged home with just homecare/family supports. Family had also been concerned regarding Mrs A, who they deemed not to be coping prior to hospital admission. Hospital team complete risk assessment and identify Mrs A appropriate to transfer to Intermediate Care for period of assessment/ further rehabilitation. SMAT received on the Wednesday identifying that Mrs A as 'Fit for Discharge' and name is placed on TRAKCARE identifying her as a 'delay'. All Intermediate Care units are full in the area that family are requesting, first available vacancy is Saturday of the same week. On day of discharge Mrs A becomes unwell, unable to weight bear - suspected further fall / infection, discharge does not go ahead as planned. Hospital team follow up on Monday – and name removed from TRAKCARE nevertheless is recorded as 6 days delayed.

Alternate admission date to Intermediate Care arranged when well.

CASE STUDY 2 – AWI

Mrs B admitted to QEUH early Sept from a Nursing Home following a fall. Deemed FFD within 5 days. On constant 1:1 observation due to high falls risk and escalation in risk taking behaviours. Assessing social worker requested 1:1 support 24 hours per day (cost of £2,500 per week) for Mrs B to return to the original care home. However care home unwilling to progress due to difficulty recruiting and retaining staff to cover this longer term.

Discharge meeting held on early Oct. Nursing staff advised that Mrs B's behaviours had escalated. She had been continuously distressed, taking her clothes off in the corridor and climbing out of bed during the night. Medical/nursing staff advised that her behaviour remained unpredictable and difficult to manage.

Further ward meeting held in late Dec where it was confirmed that 15 Nursing homes had been contacted, 8 carried out assessments on the ward. Only 2 nursing homes considered offering a placement, on condition that 1:1 24 hour supervision was provided. Mrs B's family refused both of these placements due to location. This caused Mrs B to remain in hospital for a number of months until she passed away.

CASE STUDY 3 – ADULT <65

Mr C referred to the hospital SW team 9 days after admission. Referral information was scant and advised that he was both 'fit for discharge and requires a houseclean'. Upon investigation it became clear that Mr C had long history of homelessness and at the point of admission was residing in homeless accommodation, having lived in 17 tenancies in the previous 3 years. Diagnosis of Alcohol Related Brain Damage (ARBD). Known to Social Work services from childhood. In 2011, Mr C a victim of severe assault, suffering a severe subdural haemorrhage and multiple bone fractures resulting in neurosurgical intervention and a metal plate inserted into his skull.

On admission to hospital in February 2017 Mr C appeared to be suffering the effects of alcohol withdrawal with not much improvement after treatment. A head scan showed brain damage but no further investigation was possible through MRI due to the metal plate in his skull. He had withdrawal symptoms as he had seizures while he was in QEUH. When FFD Mr C could not return to homeless accommodation due to poly substance use and behavioural issues.

Consultant assessed Mr C as lacking capacity to make reasoned life decisions. He was considered to be a risk to others as he assaulted nursing staff, approached and threatened other patients, stole from patients and routinely left the ward to take drugs or alcohol. An AWI case conference confirmed that AWI powers were required to move Mr C to a suitable longer term placement.

Due the combination of medical features and behaviours it proved extremely difficult to find an alternative suitable placement. A range of alternatives (special units, rehab units, specially commissioned services and care homes) were exhausted as possible options. After lengthy discussion and planning Mr C was transferred to a specialist unit well outside Glasgow (psychiatric services) by hospital to hospital transfer on. He had been delayed for a total of 496 days. A Support Needs Assessment was completed with a view to seeking a placement in a community setting - care home/specialist unit as appropriate - when his guardianship is granted.