ABERDEENSHIRE COMMUNITY PLANNING BOARD – 10 JUNE 2015

DELAYED DISCHARGE ACTION PLAN

Copy of report presented to:

Aberdeenshire Health and Social Care Partnership
Transitional Leadership Group 13th May 2015

1 Recommendations

1. **Agree to the three year spend profile (section 4).**
2. **Agree to the 1st year plan and its associated costs with the identified "ranges of spend" to be delegated to the Chief Officer (section 5).**
3. **Agree to the plan (section 6) which identifies the medium and long term projects / approaches.**
4. **Agree to receive further reports (alternate months written and verbal) updating on**
    a. **Progress against the short term actions identified in this plan**
    b. **The number of people who are delayed**
    c. **The actual spend within the identified ranges**
    d. **More detailed spending profile for the medium and long term actions.**

2 Background

A person is considered to be a delayed discharge if they remain in hospital but are deemed medically fit to leave hospital. A delayed discharge is less than ideal for the individual who is in hospital; there is a risk that the individual's condition will deteriorate while in hospital because they are not undertaking their normal activities. Remaining in hospital has a very rapid "institutionalizing" effect on individuals, which contributes to challenges in regaining and maximizing independence. On a wider "system" basis, if people who do not need to be in hospital are utilizing a bed then that bed is not available for someone who does need it for their medical requirements.

The issue of delayed discharge has been of Political interest for considerable time with the Scottish Government setting progressively more challenging targets over the past few years. The National target has dropped from six weeks some five years ago to a target of zero delays for any patient for any time longer than three days being proposed for later in the current year. The current Cabinet Secretary for Health Wellbeing and Sport has set out her desire to see no patients delayed by September of this year. On the back of these Ministerial statements the Government has made additional funding available to Health and Social Care Partnerships across the country to support work to reduce the number of people who are delayed in hospital.

Within Aberdeenshire we have set out an ambitious plan for the redesign of services through our investments of the Integrated Care Fund. At the heart of these plans is a desire

to switch as much emphasis as possible to anticipatory planning and schemes which support preventative measures. These are clear examples of longer term redesign which we believe will support the migration of our system to one which is more sustainable within the resources available to us as a Health and Social Care partnership.

The Transitional Leadership Group (TLG) identified delayed discharge as one of its priorities for the new Health and Social Care Partnership in the autumn of 2014. The TLG has used two of its recent seminar sessions (January 2015 – "Journey of a delayed discharge patient" & April 2015 – "20 Things you always wanted to know about delayed discharge but never dared ask") to explore the issues which surround delayed discharge. These two sessions have aimed to ensure that all members of the TLG are aware of the challenges and potential solutions, on a system basis, to reduce the number of individual patients who are delayed within a hospital setting.

This paper sets out a series of actions which have been developed by both the TLG and the Aberdeenshire Strategic Group for Delayed Discharge.

3 Resources to support the plan

The Government has provided funding, over the next three years, to support work on delayed discharges. The Aberdeenshire Health and Social Care Partnership has received the allocations shown in Table1.

Table 1. Allocation of resource received from Scottish Government

Financial Year	Funding (£) in Millions
15/16	1.134
16/17	1.323
17/18	1.323
TOTAL	**3.78**

4 Approach to reduce delayed discharges – developing a spend profile

There are two obvious approaches to reduce the number of people who are delayed;

1. Short term solutions. Most of the short term solutions simply do more of what we currently do and will utilise the additional money to, for example, make more placements or increase the number of care staff. The challenge with this approach is that once the money is spent then the number of people delayed will simply increase again.
2. Redesign of services. The longer term approach is to redesign services so that we can manage the number of people within the health and care system within the available resource envelope. This longer term redesign of services is consistent with the approach we have taken for the Integrated Care Fund Plan. One example of this longer term redesign is to develop a community based geriatric service which supports a 'hospital at home' approach. Substantial redesign of the services offers

the opportunity to have a sustainable solution where the demand is met by the available resource.

Although it is essential to pursue the redesign of services it also logical to invest, at this early stage, some resource in reducing the immediate and significant number of delayed discharges within the system; each and every delayed discharge is a person who is presently in a less than ideal environment for their own best outcomes.

The suggested approach for the spend profile is shown in Table 2.

Table 2. Suggested proportion of spend on short term and long term approaches.

Financial year	Short Term Investment % (£ in Millions)	Longer Term Investment % (£ in Million)
15/16	90% (1.021)	10% (0.113)
16/17	40% (0.529)	60% (0.794)
17/18	10% (0.13)	90% (1.19)

5 Detailed spend and action plan for year 1

Table 2 identifies that we will spend £1.021M on short term measures in our first year.

Table 3 identifies the actions (and associated costs) which will be taken in the first year. A significant number of the actions have little or no cost and identify areas where improved work, both within our partnership but also with other parts of the wider system (for example, Aberdeen Royal Infirmary), can be undertaken. Many of these actions will improve the "flow" of patients through the system thus improving the patient experience and releasing capacity for alternative use. Such improvements will not typically reduce the current number of people delayed but will be crucially important in supporting less people becoming delayed in the future.

Table 3 also identifies the increased activity for an identified number of people. These are included in areas where we believe there will be a direct change in the number of people who are delayed. This is contrary to the example above where some issues will improve flow for new patients only.

Finally, Table 3 has identified costs presented as a "range" of costs. It is requested that the TLG delegate the more detailed on-going spend to the Chief Officer. This is requested as, at this stage we are not certain of the effects of the investment or indeed our ability to invest in the short term measures (for example, number of existing care staff prepared to work additional hours to enable us to get more people home; the ability of some care homes to open more beds to accelerate people moving to residential care; the ability to open more beds for a step down facility etc.). The TLG will receive a monthly report (alternating verbal and written) and so will be kept fully informed of how the money is committed and its effectiveness in action.

Table 3. Short term actions and costs for year 1

Action	Cost (£) in 000	Outcome / Number of people
Additional care home placements. The figures are worked out on the typical cost of a placement in a care home of £27k/annum	Up to 300	11 additional people
Additional care assessment (up to FIVE additional care managers for one year – costs based on a typical full cost of £50k)	150 - 250	Typically 6 people per month fully worked through. Whole year expect 60 people per practitioner. Total – additional 180 (up to 300) people receiving care assessment (or some of the same number more quickly)
Additional care at home This will be achieved by paying our current staff, on part time contracts, to work more hours (internal services cost £27/hour)	200 - 400	Additional 3700 hours per £100K spent. For the whole year that is an additional 70 hours per week for each £100k invested in these services. A common used test is people needing more and less than 10 hours per week. If someone needs ten hours per week then we would accommodate an additional 7 people per £100k spent. [Our current spend is for some 11,500 hours per week so a £200k investment would increase our hours by about 1.5%.]

Commission a number of 'step down' beds to ensure people have an appropriate amount of time to make potentially life changing decisions whilst not in a hospital bed. (This may be slower to implement with changes required to care homes registration.)	Up to 350	This would provide us about 12 additional beds over the year. We are currently exploring with providers their interest in providing such a service. Ideally we would commission 2 or 3 beds in a number of establishments to achieve an appropriate geographical spread within Aberdeenshire.
KAIZEN Event with ARI, Aberdeen City and whole Aberdeenshire process. Planned for late May 2015. This event will aim to identify a number of issues some of which will become individual bits of work to improve. The rows below give a number of examples of the types of things that staff have expressed they hope will be achieved by the Kaizen event.	5-20	Ensure that the processes associated with the 'journey' of a patent through the system is re-designed to be as efficient as possible. (We have attributed a small sum of money for this event and some follow on actions – likely to be used to support release of people for the improvement work.)
• Assessment process		
• Use of SBAR with every patient decant. Completed fully and accurately to support planned process and person centred approach		
• Discharge process led by Senior Charge Nurse and Hospital Medical Director in each community hospital		
• Improve information available to support the discharge planning process on care home capacity and home care capacity.		
• Support clinicians to be able to accept the risk to discharge a patient before they have been assessed for care (*imposing the "can't stay" rule if clinical treatment has finished and the patient does not need to be in hospital.)*		
• enforce Multi-disciplinary team guidance that any decision taken at a meeting stands (e.g. Irrespective of whether someone was not in attendance at the meeting		
From April, teams will be moving towards an integrated team approach/ways of working - will promote single focus shared responsibility for these patients.		

Preventative/Anticipatory care approach through rapid response (stop the flow in to hospital, keep people at home and prevent admission.)	Up to 50	Build on the work of the Change Fund projects which initiated these approaches. Support the spread of the techniques identified as most successful. Utilise the money to support some significant additional work in this area (protected time for a number of professionals to promote this approach.)
Commission the Third Sector to develop some work streams to support the reduction in delayed patients.	50	Wish to demonstrate the desire to support co-production, led by Third Sector Partners with our communities.
Adaptations to the home. Work with Housing to explore how to improve this.	Up to 20	Maybe some work that can be achieved to accelerate this work whilst maintaining the right approach to costs.

6 Medium and longer term actions

The plan for the medium and longer term actions (Table 4 – next page) start to describe the more significant re-design agenda. The management team will oversee the further development of these schemes and will revert to the TLG as these plans emerge.

7 Conclusion

This plan presents two key things:

- firstly, some short term investment options which will help to make a rapid, but unsustainable, reduction in the number of people delayed in hospital and
- secondly, some longer term redesign options which will provide a sustainable change and allow people to be placed in the right place, without delay, whilst staying within the identified resource envelope (this may require more money than currently identified in the long term).

Adam Coldwells
Chief Officer, Aberdeenshire Health and Social Care Partnership
May 2015

Table 4. Medium and longer term actions

Medium Term		
Purchase some geriatrician time to develop the model of redesign that would, potentially, be sustainable from within existing resources.	50k from year 1 money	
investigate options to open up closed/disused wards within the community to provide additional capacity over the next 2-3 years (while a longer term redesign/solution is worked on) to house patients currently in hospital who do not need to be, staffed by band2/3 Health Care Support Workers.		
Create ARI discharge ward next to discharge lounge staffed by voluntary support workers (based on successful model in England)		
Enhance very sheltered housing and care home capacity through additional multi-disciplinary support (supplementing existing resource available) to try and facilitate patients to be discharged earlier where appropriate		
invest in more administrative support to absorb some of the administrative workload of Care Managers and other professionals with a key aim of addressing some of the current gaps in information/data that exist.		
Utilise third sector support (e.g. Cornerstone) whenever this could potentially support aid/ add capacity.		
Longer term		
Continue to implement our 'Position Statement' on the opportunities to influence availability of care home capacity. This would potentially increase our control over this part of the system. (Within this there is potential opportunities presented by the new care home proposal for Peterhead - much greater capacity, integrated facility – take learning from the Stonehaven and Inverurie facilities.)		
Fulfil the vision that we have around significant services being delivered in the community rather than in the hospital sector. The Aberdeenshire approach of the past decade has made great inroads in to this approach but needs to be continued and delivered in all locations. Develop, at scale, a number of the approaches demonstrated through the older people's change fund which maximise short stay in hospital when needed but maintain more people in their own home.		