HEALTH SOCIAL CARE AND WELLBEING SCRUTINY COMMITTEE - 24TH MARCH 2015

SUBJECT: HOSPITAL DISCHARGE

REPORT BY: CORPORATE DIRECTOR SOCIAL SERVICES

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1. PURPOSE OF REPORT

1.1 To provide members with information on the Joint Hospital Discharge Team (JHDT) particularly in relation to winter pressures.

2. SUMMARY

2.1 The report will provide information in relation to performance measures for delayed transfers of care (DToC).

2.2 The report will outline the use of the Intermediate Care Fund to change practice and demonstrated the good work between the JHDT and the Community Resource Team (CRT).

3. LINKS TO STRATEGY

3.1 The Welsh Government is very clear that Health and Social Care must work together to minimise lengths of stay in hospital for people.

4. THE REPORT

4.1 Members will be aware that DToC has been an area of concern for the authority for sometime, and one in which we have committed to improve .

4.2 The national performance indicator for DToC during 2013/14 placed the authority 22 out of 22 in terms of delays recorded, which impact on the whole system.

4.3 DToC are collated on the third Wednesday of every month, known as census day. This looks to capture the number of people whom health boards declare as medically stable and ready to be discharged, however, are not able to transfer from hospital due to a wide range of reasons.

4.4 The lists of declared people are jointly validated and the delay reasons are coded to indicate if the reason for delay is attributable to health or social. Examples of delay codes for social care reasons: assessment not started, awaiting arrangement of package of care or reablement, awaiting placement in long term care. Examples for health are awaiting specialist equipment, Continuing Health Care (CHC).

4.5 The data is collated monthly by Health on the HOWIS database, which cannot be updated by Local Authorities. Joint validation has been introduced to ensure both LHB's and LA's work together to report as one team.

4.6 The JHDT manager validates the lists for ABUHB hospital patients, however, as Caerphilly residents access a number of out of area hospitals, such as The University Hospital and Prince Charles, these health boards also declare delays on HOWIS with limited/no joint validation.

4.7 The JHDT manager has been proactive in working with all health boards and Assessment and Care Management Teams to reduce the number of delays for social care reasons and improve the experience for people and their carers.

4.8 Several initiatives have been undertaken, including proactive meetings with health board managers, redeployment of human resources to different hospitals on a needs/demand basis which changes regularly, attendance at daily meetings and working with CRT particularly the home care arm to provide temporary packages of care to facilitate discharge as an interim arrangement. As a result the CRT delivered 1,000 extra hours in December to prevent unnecessary admissions or facilitate discharge from hospital for people.

4.9 The Welsh Government's repatriation policy has proved a challenge to the team, as all Caerphilly residents who are admitted to hospitals outside the borough should be repatriated within 48 hours. This clearly has an impact on bed availability for people who need to be transferred to rehabilitation beds verses those that need to be returned to the borough under the policy guidelines.

4.10 The authorities have worked with ABUHB and the four other local authorities to develop winter pressures plans to assist with the management of the perceived increase in demand for this period of the year.

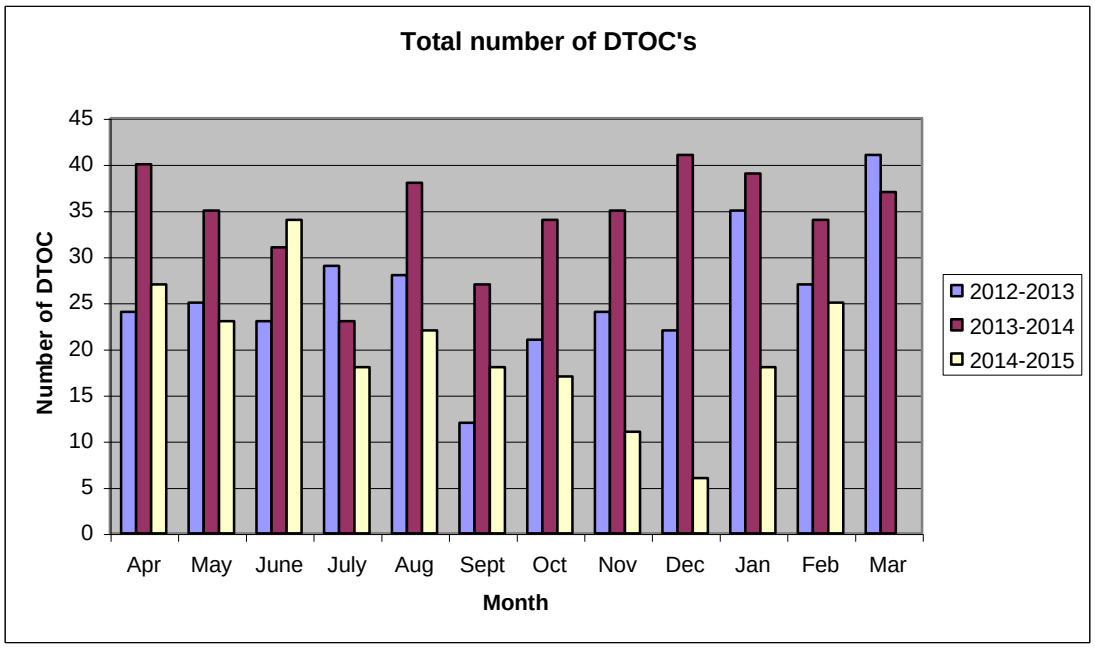
4.11 On a weekly basis each of the 22 local authorities has to submit a return to the Welsh Government to inform a weekly conference call regarding the position in each health board region in respect of DToC and impact on what is termed patient flow.

4.12 This weekly report has to give information on current pressures, perceived pressures within the next 7 days, action being taken locally to address the issues and any other information deemed appropriate. In addition to this WG has now requested monthly information on the number of current open cases for social services, number of hours of domiciliary care and reablement being provided and number of long term care beds funded in an attempt to illustrate the wider picture in terms of how many people that are being supported in the community by Local Authorities and secondary health care.

4.13 The focus of the current performance indicators is very much on discharge and not prevention of admission something that is looking to be addressed in the future.

4.14 The table below illustrates the significant improvements that have been made since April 2014 on the number of people classed as DToC.

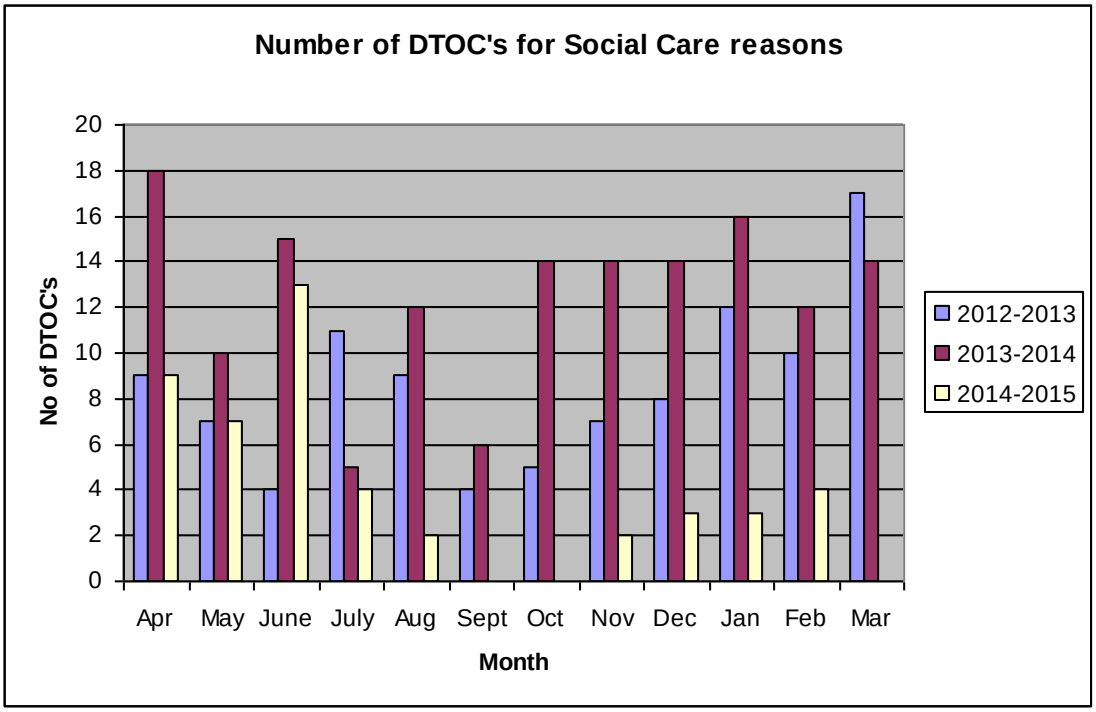
Total Number of DTOC's for Caerphilly



	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2012-2013	24	25	23	29	28	12	21	24	22	35	27	41
2013-2014	40	35	31	23	38	27	34	35	41	39	34	37
2014-2015	27	23	34	18	22	18	17	11	6	18	25	

4.15 The table below illustrates the significant reduction in the numbers of delays that are classified as delaying for social care reasons, now the higher percentage of delays are for health reasons.

Number of DTOC's for Social Care reasons



	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2012-2013	9	7	4	11	9	4	5	7	8	12	10	17
2013-2014	18	10	15	5	12	6	14	14	14	16	12	14
2014-2015	9	7	13	4	2	0	0	2	3	3	4	

4.16 The Intermediate Care Fund (ICF) has been used to develop a number of assessment beds across the borough with associated staffing levels. These beds can be used for step up or step down and enable an accurate assessment of an individuals needs to be undertaken.

4.17 The assessment beds can be accessed by the JHDT and community staff as they are managed and resourced from the CRT.

4.18 Location of beds is as follows:

- Ty Clyd - 7 beds for residential step up/step down
- Ty Iscoed - 3 beds for residential EMI step up/step down
- Integrated North Resource Centre - 6 beds for nursing step up/step down beds

4.19 Integrated Care Fund (ICF) monies were obtained to support five full time posts; a (NHS) Band 7 Nurse Assessor, a (Social Services) Grade 9 Occupational Therapist post, a (SS) Grade 9 Social Worker post, a Band 5 Registered Nurse and a Band 3 Healthcare Support Worker (HCSW) plus additional care hours at Ty Iscoed.

Each post holder is notionally attached to one of three inter-related schemes spanning health and social care services in the Caerphilly borough, however work as a multi-disciplinary team supporting all three schemes.

4.20 Service Aims

The goal of the services provided by this multi-disciplinary team and the three associated schemes are to:

- Prevent unnecessary admission to hospital or long-term care;
- Achieve a reduction in length of stay in an acute hospital setting;
- Facilitate timely discharge from hospitals;
- Ensure a multi-disciplinary team completes appropriate assessments to facilitate targeting of the correct interventions and maximise potential for independence;
- Share good practice;
- Allows patients, professionals and families to make informed decisions regarding their future care needs.

4.21 Usage of the beds has been very good and will be subject to a separate evaluation process as part of the ICF. Some early findings are very positive in terms of reducing length of stay, reducing DToCs, supporting people returning home and feedback from individual and their carers/family.

5. EQUALITIES IMPLICATIONS

5.1 An equalities impact assessment is not required report is for information only.

6. FINANCIAL IMPLICATIONS

6.1 The additional 1,000 hours provided in December cost circa £15K.

6.2 Approximately £210K of ICF money has been used in 2014/15 to support the assessment beds.

7. PERSONNEL IMPLICATIONS

7.1 The are no direct personnel implications associated with this report.

8. CONSULTATIONS

8.1 All comments received have been incorporated into the report.

9. RECOMMENDATIONS

9.1 Members note the significant improvement in the number of delayed transfers of care for social care reasons.

10. REASONS FOR THE RECOMMENDATIONS

10.1 Delayed Transfers of Care (DToC) is a key performance indicator for adult services.

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