NHS Greater Glasgow & Clyde

NHS Board Meeting

Chief Officer, Glasgow City HSCP and Nurse Director

17 October 2017

Paper No: 17/56

Mental Health Services - Delayed Discharges: Update

Recommendation:-

The NHS Board is asked to:-

1. Note the improvement in Mental Health services delayed discharges to date particularly within adult mental health.

2. Support the development of the Mental Health 5-Year Forward View strategy and improved scrutiny to further improve discharge performance from adult and Older Peoples Mental Health (OPMH) beds.

3. Support the connected development programmes that will transform learning disability services and address current delays.

Purpose of Paper:-

Following the discussion at the 27 June 2017 NHS Board meeting, to provide the NHS Board with an update on the volume of Mental Health services delayed discharges, an analysis of the reasons why patients experience delay on discharge and outline actions underway to improve discharge arrangements and patient outcomes

Key Issues to be considered:-

Proposed actions to improve hospital discharge arrangements and patient outcomes.

Any Patient Safety /Patient Experience Issues:-

NA

Any Financial Implications from this Paper:-

NA

Any Staffing Implications from this Paper:-

NA

Any Equality Implications from this Paper:-

NA

Any Health Inequalities Implications from this Paper:-

NA

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome:-

No

Highlight the Corporate Plan priorities to which your paper relates:-

Implementation of Hospital Based Complex Clinical Care

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Date – 12 October 2017

Mental Health Servcies - Delayed Discharges: Update

1. INTRODUCTION

1.1 The Health Board, in considering the NHS Greater Glasgow and Clyde Integrated Performance Report, requested an update in relation to Mental Health services delayed discharges to a future Health Board meeting. The following report summarises the numbers of mental health delays as recorded at the national monthly census point and provides further analysis on the main patient groups that are included in this overall number. The report also makes some comments on current arrangements for recording mental health delays. Finally, for each of the main groups of patients the report identifies improvement programmes underway to deliver timely and appropriate discharge arrangements for patients.

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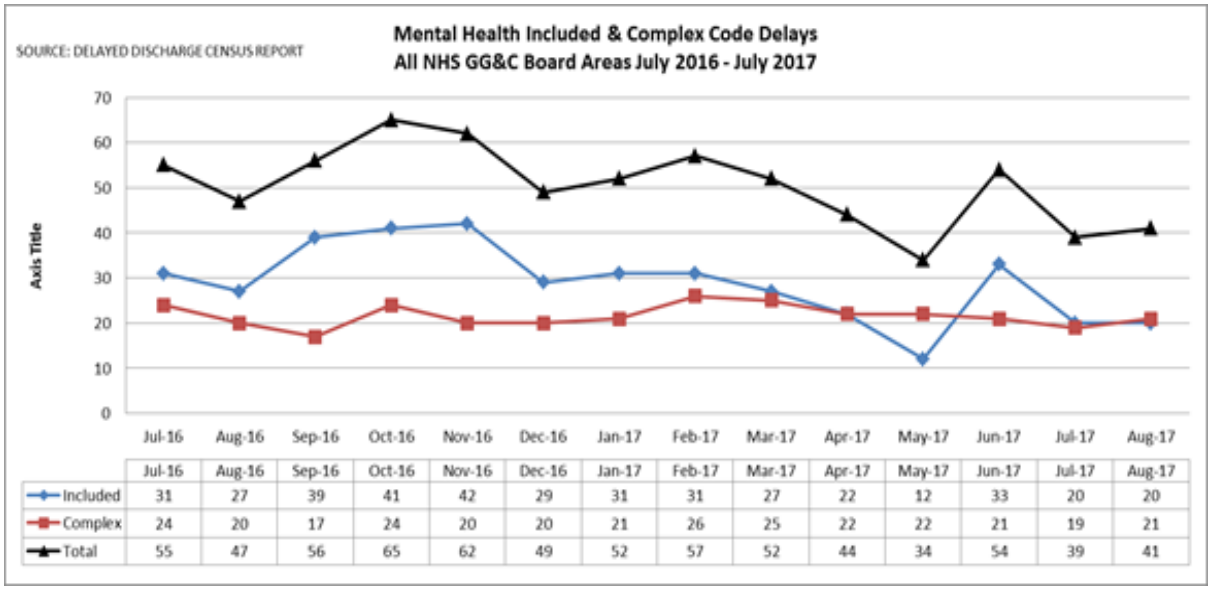


	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Included	31	27	39	41	42	29	31	31	27	22	12	33	20	20
Complex	24	20	17	24	20	20	21	26	25	22	22	21	19	21
Total	55	47	56	65	62	49	52	57	52	44	34	54	39	41

1.2 This summary table records the nationally reported NHSGG&C mental health delays for the period July 2016 – August 2017. Whilst there is monthly variation there has been a downward trend over the period with the majority of this improvement within the adult mental health cohort. At the end of September the total number of delays stood at 46 and this included 4 patients from Partnerships outside NHSGG&C.

1.3 There are a number of recording issues relating to mental health delays. Firstly, the volume of delays recorded as complex is significant. Complex codes, are used to identify patients that Partnerships find it difficult for external reasons to secure safe, timely and appropriate discharge from hospital. Complex codes include the following:

- Individuals who lack capacity and are going through a Guardianship process;
- Individuals who are delayed awaiting availability of a place in a specialist facility; where no facilities exist and an interim move would not be appropriate as no other suitable facility is available;
- Individuals awaiting completion of complex care arrangements – in order to live in their own home;
- Individuals exercising statutory right of choice where an interim move is not possible or reasonable (i.e. where long distances or limited transport infrastructures restrict

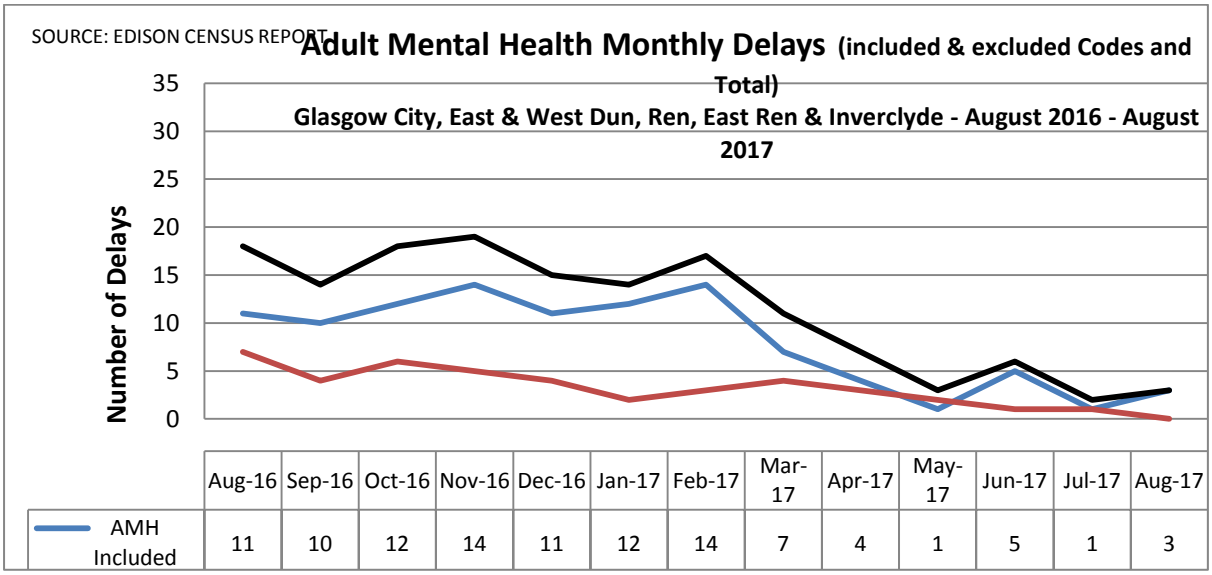
the ability of families and friends to visit and where the placement may isolate the individual from vital family and social network; and

- Individuals delayed due to the requirements of the Adults with Incapacity Act 2000.

1.4 Secondly, whilst Edison is a national reporting mechanism for delayed discharges it is not applied consistently across care groups and different hospital sites. The nature of mental health discharge arrangements mean that discharge arrangements can be extended and phased over a number of months. As noted in the following sections of this report a successful discharge may come after a number of failed attempts with a range of providers.

2. Adult Mental Health

SOURCE: EDISON CENSUS REPORT



	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
AMH Included	11	10	12	14	11	12	14	7	4	1	5	1	3

2.1 Individuals within adult mental health who experience delays prior to discharge do so for a variety of reasons. Historically the small number of patients who have significant delays are people who have had previously experienced several breakdowns in care arrangements resulting in multiple hospital admissions as a result of complex and challenging care needs that care providers in the community often struggle to meet. These patients, although no longer requiring hospital based complex care are at different stages in their "recovery" journey and often continue to experience symptoms of their ongoing severe and enduring mental ill health. Breakdown in care arrangements impacts significantly on the patients confidence, health and wellbeing and their own personal recovery. It is essential that discharges are well planned, care providers are well supported and understand the knowledge and skills required to provide the ongoing care needs. Currently there is a limited range of service models and other resources within our local communities to meet the needs of this small client group.

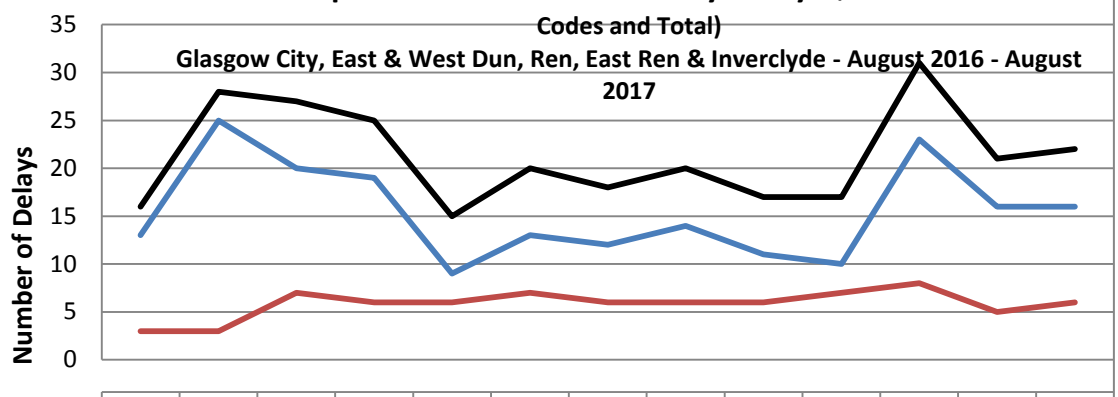
2.2 In response to this a key element of the Mental Health 5 Year Forward View Strategy, which is currently being developed by Partnerships, is to consider future commissioning and service provision. A specific strand of this work is to develop proposals for strong and robust alternatives to long term hospital care that will meet the complex needs of this small cohort of patients. It will additionally consider future models of care and support services that will work to reduce hospital length of stays and the risk of future recurring readmissions for all clients within mental health services.

Key elements will be to:-

- Develop an individual recovery plan (keep well and crisis management plan) early on in the individual's journey, in ways that will decrease the length of any possible treatment and care aspects and improve the quality and breadth of provision regards recovery orientated programmers;
- Ensure third sector are a key partner in this approach, working with allied services in and beyond mental health provision and providing appropriate recovery programmers with psycho-social, training, volunteering, and employment opportunities; and
- Developing recovery services that link closely to the community, and work alongside other systems to facilitate access to a broad range of reintegration and recovery support.

3. Older Peoples Mental Health (OPMH)

SOURCE: EDISON CENSUS REPORT



	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
OPMH Included	13	25	20	19	9	13	12	14	11	10	23	16	16

3.1 Over the last 1 – 2 years there has been an increase in the number of delayed discharges as a consequence of the increased complexity of the patient group being discharged from OPMH acute admission wards. This group of patients have generally been admitted from a care home setting and are exhibiting increased levels of stress and distressed behaviours which care homes are either struggling to manage or choose not to manage due to the level of risk.

3.2 Patients under 65 with dementia a diagnosis of ARBD are particularly difficult to place within a care home setting. There are only a small number of homes that are registered to take patients under 65. A number of patients can be refused by multiple homes due to a history of previous or current challenging behaviours.

3.3 In response to this challenge Partnerships have well established arrangements to consider the options for individual cases. The process requires commissioning leads to engage with individual private providers to agree how to support discharge with robust individual care planning, crisis intervention plans and follow up.

3.4 Although the current number of OPMH delays on Edison has remained fairly static, we are now seeing a drop in our average bed days lost. This has been achieved through scrutiny of cases and the individual work around complex cases.

3.5 There is a dedicated piece of work in progress by Glasgow City OPMH Delayed Discharge Working Group looking at the reasons for delays across the city and promoting a consistency of approach.

The purpose of the group is to

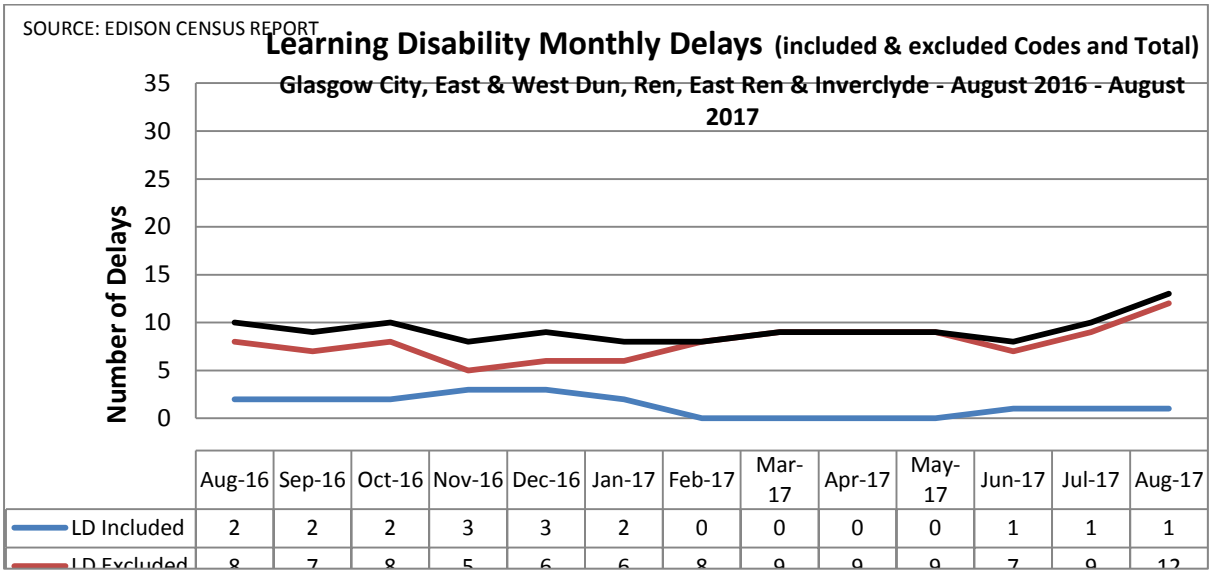
- Performance management of OPMH delayed discharges;
- Ensure consistency of use of Edison;
- Establish consistent pathway for delayed discharges;
- Establish a clear process of discharge from OPMH in-patient beds; and
- Ensure OPMH delays are included in the discussion at operational management groups.

3.6 As a result the performance in Glasgow has improved significantly from June of this year when 27 patients were recorded on Edison with an average bed days lost of 1564 and the average number of days individual patients remained on Edison was 53.7 days. The current number on Edison is 18, and has remained fairly consistent over recent weeks, and we have seen a drop in the average bed days lost to 778 with the average number of days patients remain on Edison at 39 days.

3.7 The commissioning programme identified above as an integral component of the Mental Health 5 Year Forward View will deliver an equivalent development program for OPMH. This coupled with the process developments identified will deliver further improvement in OPMH discharge performance and beds days lost.

4 Learning Disabilities

SOURCE: EDISON CENSUS REPORT



	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
LD Included	2	2	2	3	3	2	0	0	0	0	1	1	1
LD Excluded	8	7	8	5	6	6	8	9	9	9	7	9	12

4.1 Specialist Learning Disability in-patient services are hosted by East Renfrewshire HSCP on behalf of the other Partnerships. The service comprises a single continuing care unit – Nertherton House, which has eight patients. Waterloo Close, which accommodated 6 patients, closed in August as phase 1 of a planned retraction of long stay provision. There are two Assessment and Treatment facilities; Claythorn Ward on the Gartnavel Royal site and Blythswood House in Renfrew.

4.2 East Renfrewshire HSCP has embarked on a re-design of the Assessment and Treatment service, supported by the National Development Team for Inclusion, and involving all Partnerships, to ensure that there is an appropriate and sustainable service going forward.

4.3 The Specialist Learning Disability service provides a performance report to each Partnership and reports to the East Renfrewshire IJB Performance and Audit Committee. The Chief Officer and General Manager liaise with HSCPs within NHSGG&C and beyond to discuss delayed discharge performance. East Renfrewshire HSCP co-ordinates clinical governance arrangements for learning disability on behalf of the other Partnerships.

4.4 There is a cohort of clients who are currently experiencing extended delays within Claythorn and Blythswood House. Similar to mental health these clients have significant complex care needs and can present a huge challenge to care providers as a result of their challenging behaviours. They have several instances where their care package within the community has broken down resulting in admission to hospital care. There are limited examples of robust specialist care home provision of the type required to support adults with the most complex needs across Scotland. There are however some examples of successful residential and supported living services which seem able to support adults with profound learning disabilities and challenging behaviours.

4.5 Individual Partnerships have small numbers of delays within this group and Glasgow has around nine clients, at any one time, within Netherton House. These are long term patients and are ready to be considered for discharge with similar care needs. Glasgow City HSCP is working closely with East Renfrewshire HSCP to identify, develop and commission supported living models that will enable these clients to be cared for safely and with an improved chance of reduced future hospital admissions.

4.6 With the resource transfer that would follow with these patients, Glasgow City HSCP intends over the next 18 months, to develop supported living models that will accommodate both the long stay clients and the current clients delayed within Blythswood and Claythorn. In the interim, discussion with provider organisations will explore the potential for interim arrangements that could allow the patient cohort to be discharged to a social care arrangement within the current accommodation.

4.7 Early engagement with potential providers had identified a range of solutions including core and cluster supported living services, specialist residential care and specialist nursing home care.

4.8 As a result of the service redesign led by East Renfrewshire HSCP and the Glasgow City HSCP commissioning programme we will see a transformed service model delivering improved outcomes for service users and a significant reduction in patients experience delayed discharge.

Recommendation:-

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