East Lothian Council

REPORT TO: Policy and Performance Review Committee

MEETING DATE: 20 June 2018

BY: Director of Health and Social Care Partnership

SUBJECT: Delayed Discharges

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1 PURPOSE

1.1 To update the Committee on delayed discharge performance in East Lothian.

2 RECOMMENDATIONS

The Committee is asked to:

2.1 Discuss the issues involved in performance on hospital delayed discharge.

3 BACKGROUND

3.1 There is a national target for hospital delayed discharge performance which is that no (non complex coded) patient should waiting more than 2 weeks for discharge following being declared medically fit to leave hospital.

3.2 The Integrated Joint Board (IJB) as one of its directions (no 11b) for 2017-18 agreed a local target to reduce the total number of occupied bed days for East Lothian residents arising from all episodes of unscheduled care by 10% compared to the previous year.

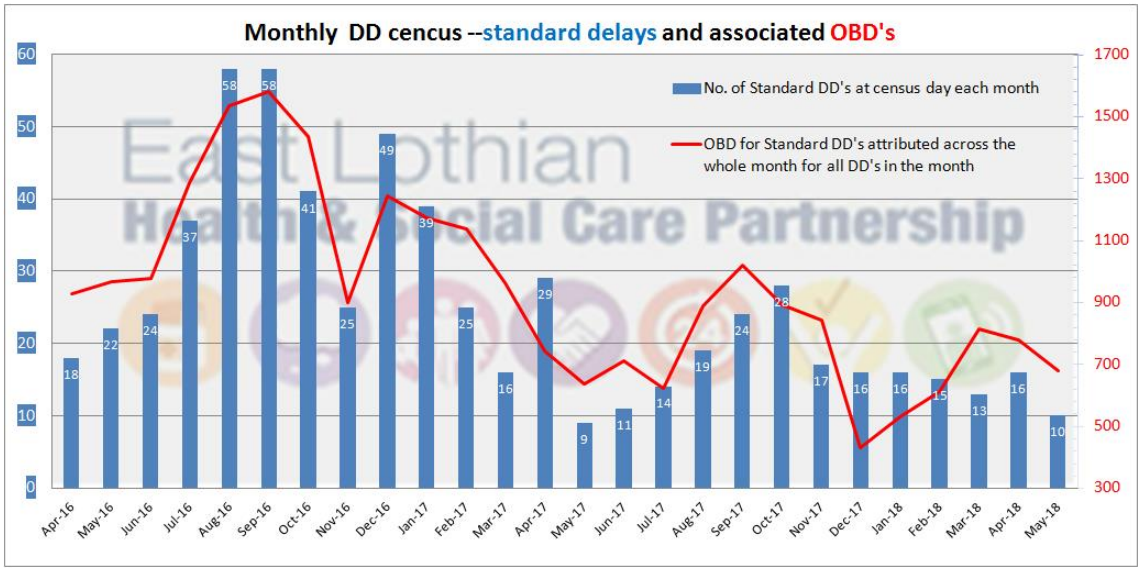
3.3 Scottish Government through its *Health and Social Care Delivery Plan (December 2016)*—states that by 2018 one of its Health and Social Care Integration actions is to reduce unscheduled bed days in hospital by 10% (National this is as much as 400,000 bed days), by reducing delayed discharges, avoidable admissions and inappropriately long stays in hospital.

3.4 Delayed discharge is essentially the situation where an individual's need for healthcare in their current location is completed and they are waiting transfer for provision of care in the community or from another non-NHS type of service.

3.5 The actual number of individual people reported as being delayed in hospital at a single point in each month has historically been the commonest expressed measure of performance. However, what can and is also measured is the Bed Days Occupied (BDO) across the whole month by all delayed discharge patents/clients. Not just those captured at 1 minute past midnight on the last Thursday of each monthly census snap shot.

3.6 East Lothian has performed well across the last two years in both reducing the number of individuals who experience a delay in their hospital discharge and the overall Occupied Beds Days.

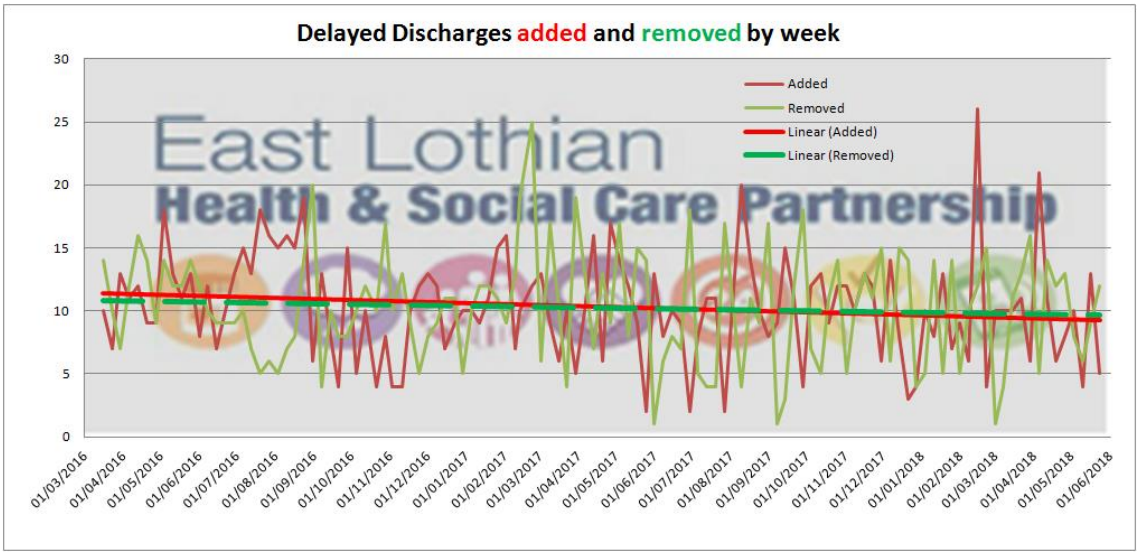
3.7 The graphic below shows both the Occupied Bed Days (OBD) (red line left hand axis) and the number of individuals recorded as a delayed discharge at the census point (blue columns right hand axis).



Data source NHS Lothian Trak patient administration system

There have been fluctuations but the direction of travel has been a steady and sustained reduction in East Lothian residents experiencing a delay in hospital discharge.

3.8 The numbers of patients becoming a delayed discharge is reducing and the speed at which the Health and Social Care Partnership reacts continues to improve. The Table below shows the number of people becoming a delayed discharge and those discharged weekly from May 2016 to May 2018. From circ. 12 people being added weekly this has been reduced to 8. The improvement is down to several interlinking factors detailed in paragraph 4. What this does is allow officers slightly more time to concentrate on some of the more complex cases and still find workable solutions expeditiously.



Data source NHS Lothian Trak patient administration system

3.9 From a Hospital delayed discharge perspective, the number of OBD has reduce by circa 30% from 2016 for standard delays within the county

3.10 When we take the standard delay discharges and the complex delayed discharges combined, we have reduced the OBDs by 25% over the last year. Complex delays are not included in the 'national standard' but are still reported monthly. East Lothian will have 3 or 4 at any one time, usually patients within the mental health or learning disability specialities. These patients will need additional support in the community, which may involve arranging adapted or supported housing, as well as some form of support package, or one of the more specialised care homes.

3.11 FACTORS CONTRIBUTING AND SUPPORTING THE IMPROVMENT

3.11.1 On referral by an East Lothian GP, The Hospital at Home service (H@H), a team based at East Lothian Community Hospital, assess and maintains a patient in their own home, thus avoiding a hospital admission. Whilst being of benefit to the patient this also avoids an unscheduled admittance into Hospital and a potential delay in discharge further down the line.

3.11.2 The Hospital to Home service (H2H) takes people from hospital and gives them care in their own home with the ability to do rehabilitation work. The client will then be taken on by a care provider, often with a reduced care need.

3.11.3 The retention of care packages for a client who goes into hospital for up to 7 days has helped hugely in both giving a discharge goal and getting the client home with continuity of care.

3.11.4 Weekly collaborative meetings across health, social work, care brokers and care providers has greatly improved understanding and ability to offer joint working and shared solutions. This has enabled clients to return home quicker than would have historically been the situation.

3.11.5 The continued commitment to weekly meetings with senior management and operational staff from Health and Social Work ensures every client is discussed and resolutions sought. The discussion is not only around 'hospital delayed discharges' but other clients in need of care whether they are in hospital or in the community.

3.11.6 Work continues in looking at the outstanding Care at Home hours. This has been reduced from 1500hrs in the 1st week of May 2017 to 1000hrs in the 1st week of May 2018.

3.11.7 The daily 8am health teleconference looks at bed capacity, expected discharges, admissions, as well as H@H, H2H workloads and what capacity there may be in order to avoid an acute admission or pull patients from the acute hospitals. There are also twice daily teleconferences involving all NHS Lothian Health acute and community sites, reviewing capacity and discharge options.

3.12 CONTINUED CHALLENGES

3.12.1 The key issues in East Lothian that need to be taken into consideration are:

- The vulnerability of the care at home market where providers have faced real challenges in recruitment and retention of staff which has restricted their ability to respond timeously to packages of care for people in hospital.
- Care at Home packages is the single biggest reason for clients remaining in hospital. The situation is County wide and is more acutely felt where two carers are required for each visit. All of the contracted care providers find this a challenge to manage within their capacity.
- The short term issue of access to nursing home places has eased, with all homes in the County capable of taking new admittances.
- However, there is a growing need for Care Homes with Dementia places.
- We continue to have growth in our over 65 population, which will brings greater demand on health and social care services.
- In addition, the service has to balance the needs of people who are delayed in hospital with people in the community.

4 POLICY IMPLICATIONS

4.1 The achievement of the national standards is set out in the Single Outcome Agreement and the IJB strategic plan.

5 INTEGRATED IMPACT ASSESSMENT

5.1 There is no requirement to carry out an impact assessment on this issue.

6 RESOURCE IMPLICATIONS

6.1 Financial – the resolution of the delayed discharge situation may have a financial impact. The costs of the living wage and the additionality required in home care are assumed to be covered through the social care fund.

6.2 Personnel - there are no direct implications of this paper.

6.3 Other – none.

7 BACKGROUND PAPERS

7.1 None

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