REPORT TO: East Lothian Integration Joint Board

MEETING DATE: 25 October 2018

BY: Interim Chief Officer

SUBJECT: Hospital Delayed Discharges

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1 PURPOSE

1.1 This report updates the Integration Joint Board (IJB) on performance for delayed discharges in East Lothian and asks the IJB to agree further actions to maintain progress.

2 RECOMMENDATIONS

2.1 The IJB is asked to:

(i) Note the improving trend on performance and recent actions.

(ii) Discuss the issues involved in performance on hospital delayed discharge.

3 BACKGROUND

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

3.2 An East Lothian Integration Joint Board Direction (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.

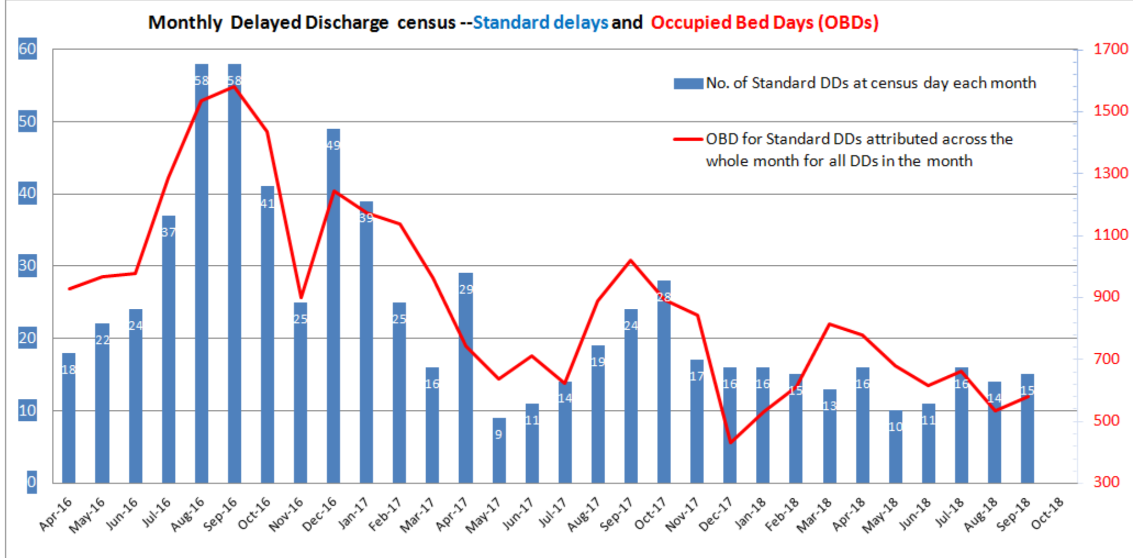
3.3 The Scottish Government, through its *Health and Social Care Delivery Plan* (December 2016) states that one of its Health and Social Care Integration actions is to reduce unscheduled bed days in hospital by 10% by 2018 (Nationally this is as much as 400,000 bed days) by reducing delayed discharges,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

3.4 Delayed discharge is essentially the situation where an individual's need for healthcare in the acute hospital setting is complete and they await transfer for provision of care in a community setting, or from another non-NHS type of service.

3.5 The actual number of individual people reported as being delayed in their discharge from hospital at a single point in each month, has historically been the commonest expressed measure of performance. However what can also be measured is the Bed Days Occupied (BDO), across the whole month by all delayed discharge patents. This extends beyond the simple data capture 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 in overall Occupied Beds Days.

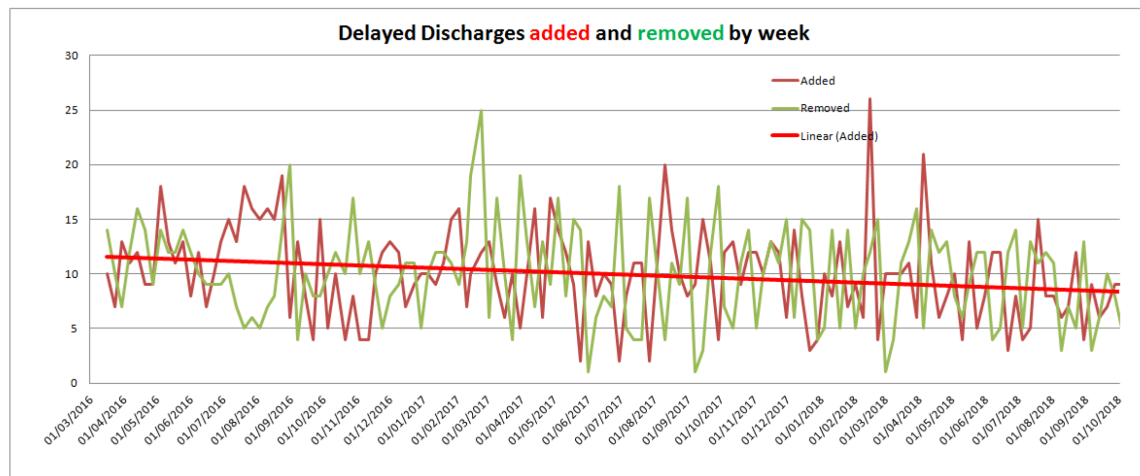
3.7 The graphic below shows both the Bed Days Occupied ((BDO on the red line, right hand axis) and the number of individuals recorded as a delayed discharge at the census point (blue columns, left hand axis).



Data source NHS Lothian Trak patient administration system

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

3.9 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 April 2016 to September 2018. From circa 12 people being added weekly this has been reduced to 8. The improvement is down to several interlinking factors detailed in section 4. What this does is allow officers slightly more time to concentrate on some of the more complex cases and to find workable solutions expeditiously.



Data source NHS Lothian Trak patient administration system

3.10 Within the county, from a hospital delayed discharge perspective, the number of OBD has reduced circa 30% from 2016 for standard delays.

3.11 Combining the standard delayed discharges and the complex delayed discharges, East Lothian has 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 a place in one of the more specialised care homes.

3.12 Factors contributing to the improvement:

3.12.1 Core Health and Social Care services continue to work with discharge hubs on all acute hospital sites

3.12.2 The Hospital to Home service (H2H) takes people from hospital and gives them care in their own home and rehabilitation input. The client can then be taken on by a care provider, often with a reduced care need.

Discharge to Asses Team inreach to secondary care to support discharge at an earlier stage in journey. This team works closely with core services to coordinate care if required.

3.12.3 The East Lothian Community Hospital based Hospital at Home service (H@H) team which accepts East Lothian GP referrals, to assess and maintains a patient in their own home, thus avoiding a hospital admission. This is not just of benefit to the patient, but also avoids an unscheduled admission and a potential delay in discharge further down the

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

3.12.5 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 be they in hospital or community settings.

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

Continued Challenges

3.13 The key issues in East Lothian regarding delayed discharges are:

- The vulnerability of the care at home market where providers continue to face real challenges in recruitment and retention of staff
- Wait for 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. The short term issue affecting access to nursing home places has eased, with all homes in the county capable of taking new clients.
- There is a growing need for care homes with dementia places.
- Growth in the over 65 population continues, which brings ever greater demand on health and social care services
- In addition, the service provision 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 Other – none.

7. BACKGROUND PAPERS

7.1 None

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