East Lothian
Integration Joint Board

**REPORT TO:** East Lothian Integration Joint Board

**MEETING DATE:** 27th February 2020

**BY:** Chief Officer

**SUBJECT:** Hospital Delayed Discharges

---

## 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 following being declared medically fit to leave hospital no (non-complex coded) patient should waiting more than 2 weeks for discharge.

3.2 An East Lothian IJB Direction (no. 11c) for 2019-20 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. This has been achieved.

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.

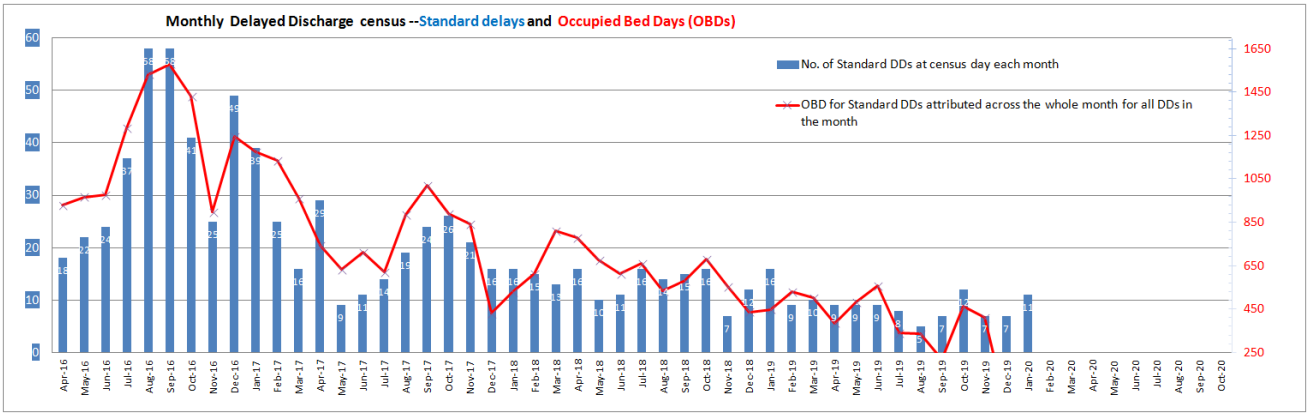
3.4 Delayed discharge is essentially the situation where an individual's need for healthcare in the acute hospital setting is complete and they await transfer for provision of care in a community setting, or from another non-NHS type of service.

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 most common expressed measure of performance. However, what can also be measured is the Occupied Bed Days (OBD) 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 three years in both reducing the number of individuals who experience a delay in their hospital discharge and in overall OBDs.

3.7 The Health and Social Care Partnership's OBDs from a high of 1,400 days per months are now down to circa 400 in each of the last twelve months. Actual numbers of individuals being recorded as a delayed discharge on the census day has been 10 or below for the last 12 months –although January 2020 saw us with 11, which was still below our planned maximum of sixteen for the 1st month of 2020.

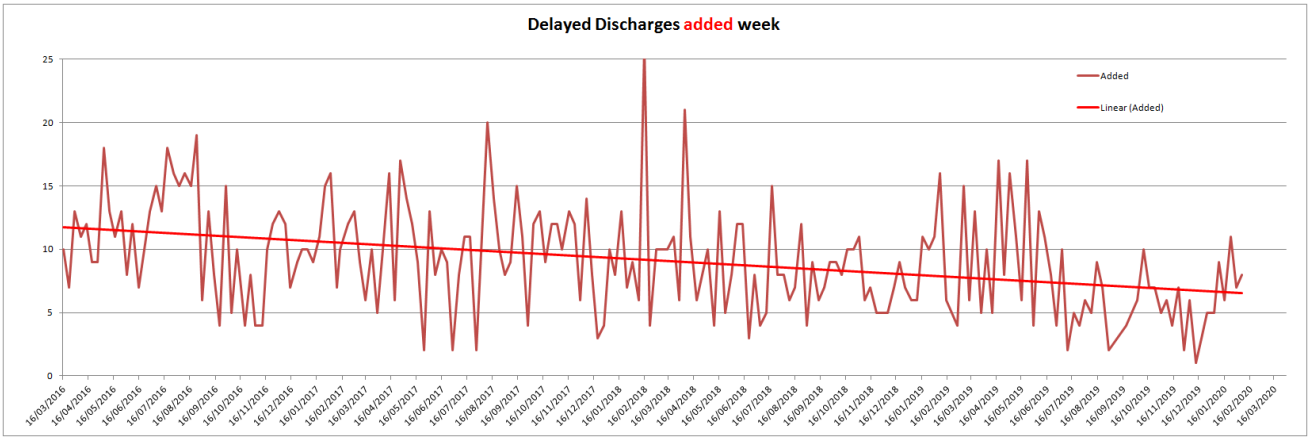
3.8 The graphic below shows both the OBDs (the red line, right hand axis) and the number of individuals recorded as a delayed discharge at the census point (blue columns, left hand axis).




Data source NHS Lothian live Trak

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

3.10 The table below shows the number of people becoming a delayed discharge weekly from April 2016 to January 2020. From circa 12 people being added weekly this has been reduced to 6. To date the winter spike across December to March has been far less than in previous years. The improvement is down to several interlinking factors detailed in section 3.12




Data source NHS Lothian Trak patient administration system

3.11 Within the county, from a hospital delayed discharge perspective, the number of OBDs has reduced circa 70% from 2016 for standard delays.

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 Assess Team in-reach to secondary care to support discharge at an earlier stage in journey. This team works closely with core services to co-ordinate care, if required.

3.12.3 The East Lothian Community Hospital (ELCH) 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. Health and social work colleagues now sit together with in the ELCH HUB.

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
- 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.
- Circ. 9000 hours of home care are supported by the Partnership for the >65's weekly—currently in Hospital we have patients who cumulatively require 300 hours weekly—this equates to between 8 and 9 WTE care at home workers.
- There continues to be a need for care homes with dementia places.
- In addition, the service provision has to balance the needs of people who are delayed in hospital with people in the community.
- We continue to operate 12 beds in ward five at ELCH – primarily in support of pressures being experienced within the wider NHS Acute care system this winter

## 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



| | |
|---|---|
| **AUTHOR'S NAME** | Gordon Gray |
| **DESIGNATION** | Operational Business Manager ELHSCP/ Service Manager: Day Services ELCH |
| **CONTACT INFO** | gordon.gray@nhslothian.scot.nhs.uk |
| **DATE** | 14th February 2020 |