Borders NHS Board

DELAYED DISCHARGES

Aim

This paper aims to provide the Board with an update on the performance for patients in relation to delayed discharges.

Background

Patients should not have to wait unnecessarily for the most appropriate care to be provided after treatment in hospital. Waiting unnecessarily in hospital is a poor outcome for the individual, is an ineffective use of resources and potentially denies an NHS bed for someone else who might need it.

A delayed discharge is experienced by a hospital inpatient who is clinically ready to move on to a more appropriate care setting but is prevented from doing so for various reasons, for example, awaiting place availability in a residential or nursing care facility or indeed awaiting care at home to be provided.

National Targets Associated with Delayed Discharges

In October 2011, two new targets were announced by the Scottish Government. These stated that by April 2013, no patient should wait more than 4 weeks from when they are clinically ready for discharge and thereafter by April 2015 no patient should wait more than 2 weeks for their discharge to take place.

Performance Overview

Over the last three years, considerable effort by Scottish Borders Council and NHS Borders has elicited a positive impact on the total number of delayed discharges for patients in NHS Borders. The total number of delayed discharge cases has reduced from 747 in 2010/11, of which 189 were delayed over the national target of 4 weeks, to 600 in 2013/14, of which 15 were delayed over 4 weeks. The percentage of associated occupied bed days has also reduced from 11.9% in April 2010 to 6.0% to the end of March 2014.

This is demonstrated in the tables, in **appendix 1.**

Current Position

It is still the case however that whilst the situation has improved, this performance has flat-lined and a number of NHS Borders beds have remained unavailable for their most appropriate use.

The 2013/14 year started on a positive note. Since August however maintaining the improvements has been more challenging. At the end of March 2014 the total number of delayed discharge cases recorded was 600 for the year to date, of whom 15 were delayed over 4 weeks. The associated occupied beds days recorded, for that same period, was 7553. This represents a 6% loss in occupied bed days and a continuation of the level achieved in 2012/13.

Whilst performing well against this target to achieve the new 2 week target due to be implemented in 2015 further improvement is required in the year ahead in order to achieve and sustain this level of performance.

A number of challenges remain to the partnership with regard to improving performance. These are detailed below.

- The importance of continued transparency in relation to budget pressures between partners so that the impact of decisions can be predicted, managed and where necessary escalated appropriately.

- The necessity to communicate with the public to ensure expectations in regard to timely discharge and the importance of this are clear.

- MDT and wider staff training in order to ensure teams have a robust working knowledge of best practice discharge planning processes and management of delayed discharges.

- Further improve real time data collection and reporting from TRAK and EDISON. Further developing standardized weekly and monthly reports detailing for example the number of cases by reasons, duration, and location and age band in order to better support operational management.

Operational Response

The Implementation of CEL 23 (2013) *Guidance on choosing a care home on discharge from hospital.* (Of particular note under Guiding Principals it is explained that a patient does not have the right to “choose” to stay in hospital where this goes against best clinical practice). This is a helpful document which can be used to develop communication for the public and patients and helps manage expectation with regard staying in hospital. The NHS General Manager and the SBC Group Manager will be using this guidance as a means of informing and advising the public and managing expectations.

The previous Board report indicated issues with the provision for complex mental health needs, particularly for people with dementia. We are able to report that work to develop specialist services within the community is now progressing. The tender process for the specialist service will be completed this year.

Issues with 24 hour care service provision and care at home continue to cause concern. An independent development officer has been funded through the Change Fund to support the development of innovative services with the independent sector to help address some of these concerns;

Care Homes -The Care Home Quality Partnership Group has recently been established. This group meets bi-monthly to consider issues with practice and quality in care homes

and is in the process of developing a work plan for 2014/15. A training needs analysis is underway to determine the skills deficit / need for nurses who are employed to work in residential care.

Care at home – a care at home provider's reference group has been set up which will help providers to share and support ideas of good practice. An action plan is being developed to help try and tackle some of the problems we are experiencing with commissioning care home services. The paper that will inform the plan is attached in **appendix 2**, and highlights the issues with care at home provision across the Borders.

Summary

Progress continues to be made in relation to understanding and jointly managing delayed discharges by NHS Borders and Scottish Borders Council. There is clear partnership commitment to continue to do this, and to realign and rebalance working practices in response to changes across the system.

The number of delayed discharge cases and the number of associated occupied bed days have both reduced over the last three years to March 2014, and this improvement has been maintained since then. However if further improvement is to be achieved it is imperative that joint working continues in order to address the issues, now ripe for resolution given the local ambition to have zero tolerance to delays for patients.

Recommendation

The Board is asked to **note** the report.

Policy/Strategy Implications	Delivery of the HEAT Target requires that no patient will more than 28 days to be discharged into a more appropriate care setting once treatment is complete from April 2013: followed by a 14 day maximum from April 2015
Consultation	N/A
Consultation with Professional Committees	The Delayed Discharge Report is developed in conjunction with the Delayed Discharges Operational Group
Risk Assessment	Risks associated with the delivery of Delayed Discharge Standard are outlined within the Local Delivery Plan. Performance against the target is reported in the monthly Clinical Executive Performance Scorecard and given a rag status based on whether the trajectory has been achieved.
Compliance with Board Policy requirements on Equality and Diversity	An impact assessment is made for the standard as part of the Local Delivery Plan
Resource/Staffing Implications	There are no resource implications associated with this report

Approved by

Name	Designation	Name	Designation
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APPENDIX 1

Table 1
Total Delayed Discharge Cases in Borders, April 2010 to March 2014

Month	2010/11	2011/12	2012/13	2013/14
Apr	30	63	66	46
May	14	69	66	54
Jun	20	68	46	39
Jul	51	58	60	42
Aug	51	72	51	60
Sep	70	58	53	62
Oct	90	46	68	50
Nov	102	53	49	53
Dec	81	59	40	45
Jan	73	54	45	59
Feb	86	54	46	42
Mar	79	50	48	48
Grand Total	**747**	**704**	**638**	**600**

Table 2
Total Associated Occupied Bed Days in Borders, April 2010 to March 2014

Month	2010/11	2011/12	2012/13	2013/14
Apr	2244	1103	741	523
May	1792	1175	874	586
Jun	2154	1180	657	547
Jul	908	1266	751	518
Aug	947	1327	690	704
Sep	1135	898	616	704
Oct	1685	911	774	479
Nov	1334	720	543	824
Dec	1545	575	533	742
Jan	1290	638	624	885
Feb	1228	739	522	584
Mar	1317	523	641	657
Grand Total	**17579**	**11055**	**7966**	**7553**
% of Associated Occupied Bed Days	**11.9%**	**8.0%**	**6.1%**	**6.0%**

Appendix 2

Care at Home – Issues Paper and Actions

Background

Over the last 2 years there has been an increasing difficulty in resourcing care at home. This was evident with the independent providers but is also now being experienced with the in house services.

A meeting with the providers across the Borders has provided insight into the issues that the providers are experiencing.

Providers have informed us that:

1. They are all experiencing difficulty in recruiting staff, this is equal across the Border
2. There is difficulty in retaining staff once they have been recruited.
3. Providers do not equate the difficulties being experienced with the terms and conditions or hourly rate.
4. Travel costs and use of own car is cited as being an issue and one of the reasons why employees choose to leave to an environment where this is not required. This has been evidenced with the development of the Housing with Care models. So, staff are not necessarily leaving the care sector, but are choosing to work within an environment that does not require them to use their own care or spend time travelling.
5. All providers are trying to recruit and are utilising all mechanisms to do this. In fact one provider had been able to get hold of the list of all unemployed people within the Borders. There were over 1000 on the list however only 25% of the people were able to drive. Providers commented on how this reduces the number of people who they could recruit into homecare. ***Providing transport and drivers requires further investigation.***
6. The rapid reaction team has been successful in retaining staff. The providers felt this was because the employees were not required to use their own transport, they had guaranteed hours and shifts that were regular along with working alongside a colleague.
7. There are also clients who have very large packages of care and this is creating a drain on the scarce resources.
8. Care Inspectorate reports and bad press. All providers, in unison, felt that the press coverage regarding the CI reports was having an impact of staff retention. Staff felt demoralised and also ashamed of wearing a uniform that could identify them with the provider. It was noted that the CI contact the press when they publish the report.

Actions that have been considered

1. Work has been undertaken to consider how best to manage the situation.
2. A task group has looked at the geography and who is providing in which area to consider whether there are 2 or 3 providers going into the area. Although there were plans to look at zoning areas to prevent this from happening this was unsuccessful. This was due to the individual choice as they did not want to change providers.
3. There are plans to set up another rapid reaction team along the A7 corridor. It is well evidenced that the rapid reaction model does not suit the rural areas since the driving time is greater than the direct care time.

4. Housing with Care – 3 Housing with Care schemes have been launched and it is anticipated that these will have an impact of :
    a. Large packages of care – as these client should be offered HwC, where appropriate
    b. Free up homecare within the area

5. Work is underway to implement rehab and reablement which should help release hours back in to the locality.
6. Flexing the use of beds in the community to prevent admission or assist with discharge should have an impact on the level of care required.
7. All providers have been contacted within the area and beyond to scope out new providers in the area.
8. Out of hour's workers – it has been agreed to test a model for out of hour's workers. These workers would offer an on call service within the rural localities and across the Borders. Costing for this is to be completed.
9. Providing transport and drivers requires further investigation.
10. Matching unit – this will be tested with the START team with 1.5 posts over a three month period to see if this assists with locating homecare.
11. The reviewing team will continue to review individual packages using a reablement approach, although they are not using the reablement plans unless it is a short piece of work.
12. The reviewing team are working with the P3 waiting lists. This work should have a positive impact on avoiding admission and preventing crisis.

Jane Douglas