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.

The Discharge Task Force recommended in December 2014that integration authorities are asked to describe improvement against the following indicator:

The proportion of adults discharged within 72 hours of their ready for discharge date

If implemented it is envisaged that there would be a lead-in time of between 6 and 12 months. The Task Force therefore recommends that we use the proposed 2 week standard from April 2015 until the new measure can be rolled out.

The Task Force also recommends that integration authorities in addition measure their performance on *bed days lost to delayed discharge.* In addition it was recommended that this measure be introduced at the same time as the 72 hour indicator, after which the two week standard would become obsolete. The Task Force further recommends that integration authorities set improvement trajectories for the rate of bed days spent in hospital after emergency admission, and not just the proportion of the days that are recorded as delays.

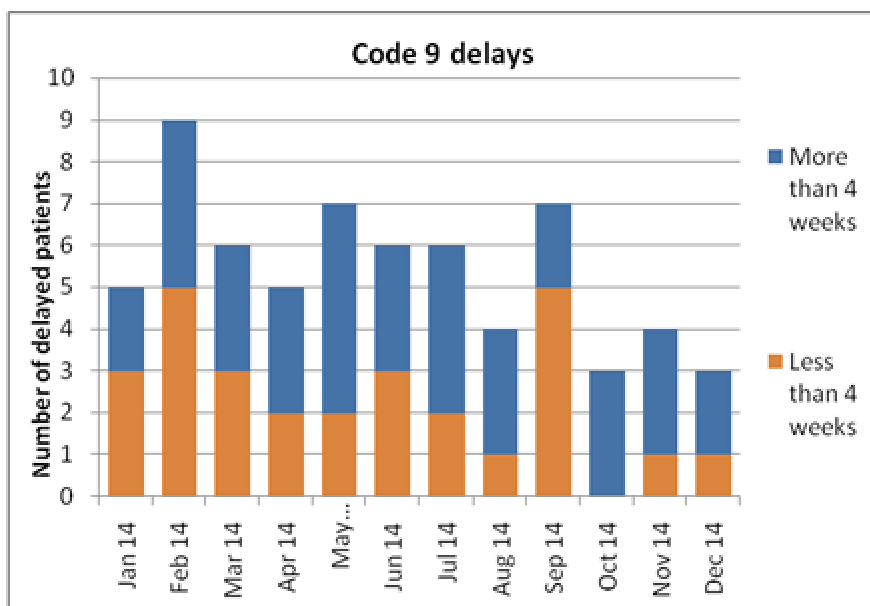
Performance Overview

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.** If performance in January and February of 2014 is replicated this year, then the percentage of occupied bed days due to delayed discharges will be 7.2% and the improvement in performance achieved in consecutive years since 2010/11 will not have been continued.

Complex Cases

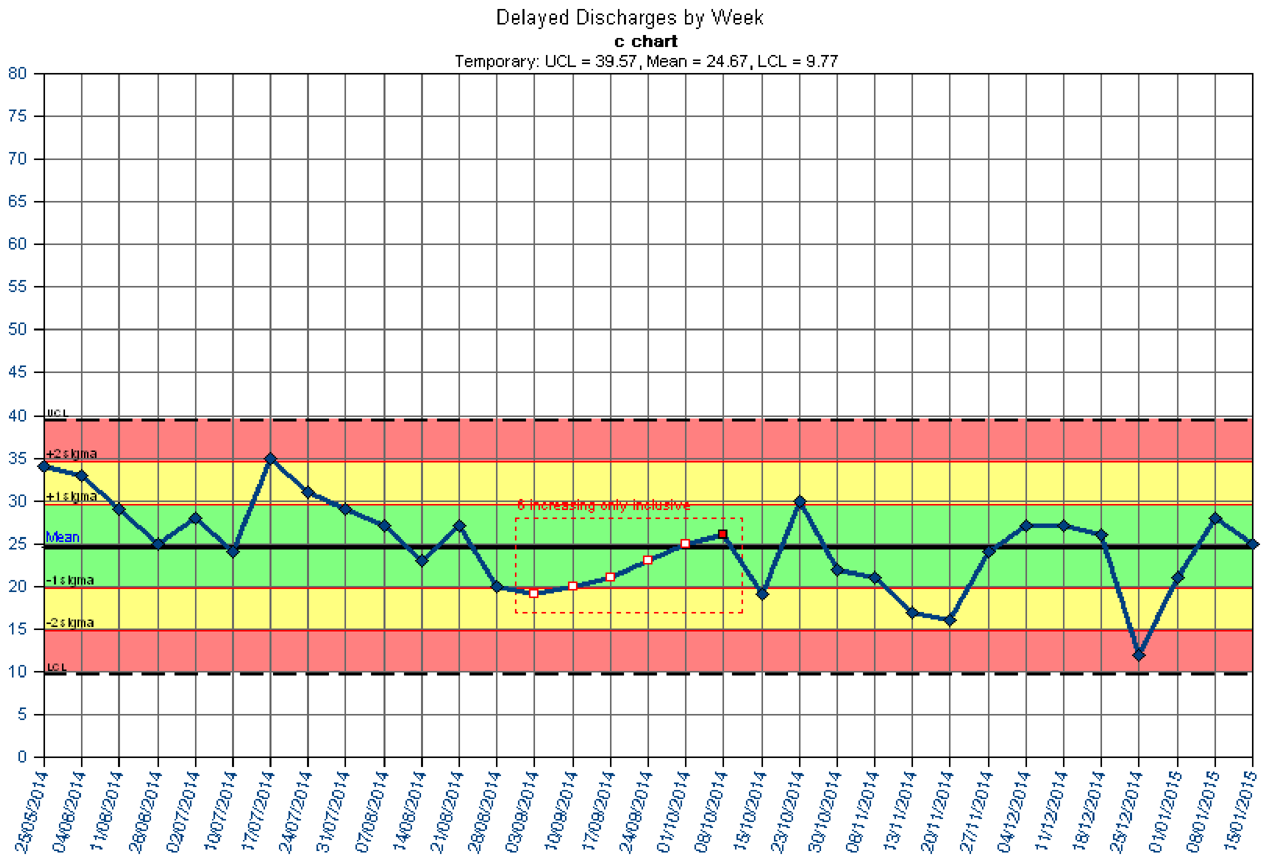
Complex cases are often referred to as code 9 patients for reporting purposes. This was introduced for very limited circumstances where Partnerships could explain why the discharge of their patients could not be achieved within the national targets.

The table below highlights the number of such patients within NHS Borders during 2014 and the proportion of those who have been delayed less than or more than 4 weeks each month at the team of measurement and reporting.

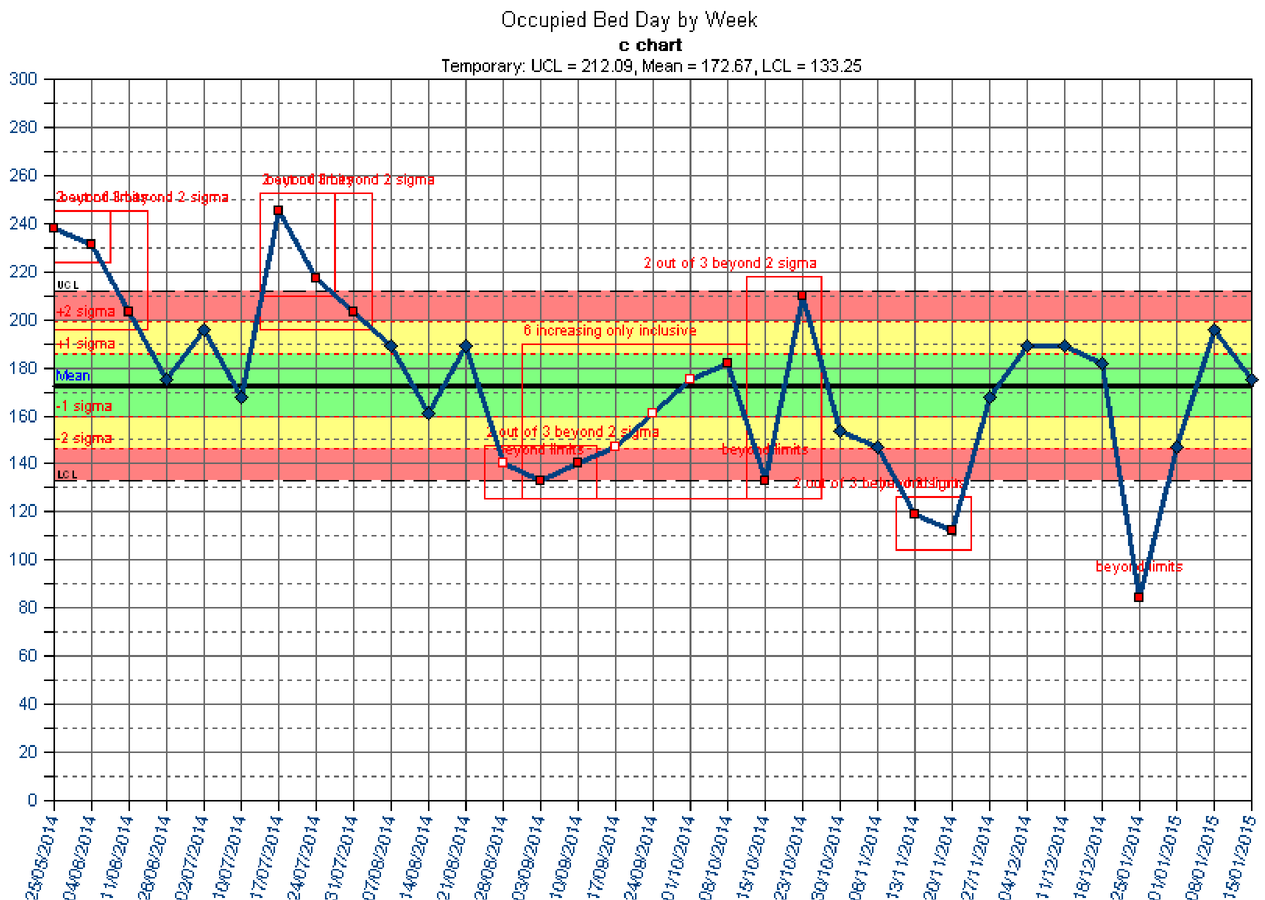


Current Position

Throughout 2014/15 the Partnership has endeavoured to maintain the improvement seen since 2011, however achieving the 2 week target is proving to be challenging and on occasion there have been breaches of the 4 week target. The chart below covers the period from 25 May 2014 to 15 January 2015 indicating the number of people, including complex cases on the delayed discharge list.



Whilst the number of delayed patients in the system has not fluctuated significantly in the statistical sense, the same cannot be said in respect of occupied bed days due to delayed discharges (see chart below).



Areas of concern

1. Older adult mental health – this is an area that we have identified as problematic. There is difficulty in sourcing community support to meet the complex need presented by older adults with dementia. Work is underway to tender for 24 beds across the Borders (3 units = 9 beds). The tender is programmed to go live in approximately 2 weeks. Additionally we are undertaking a case review on cases that have the longest length of stay.

2. Care at home – we continue to be challenged in sourcing care at home across the Borders.

Operational Response

1. A 2nd fast reaction team was put into place on Monday 2nd February. The team will concentrate work around the A7 corridor. The impact of the new team is being monitored through Connected Care.
2. Flex beds – a number of beds within the care homes across the Borders have been block purchased for a 3 month period. Flex beds are being utilised for assessment, intermediate care, interim moves.
3. Additional focus is being placed upon supporting the discharge of patients within BGH who have been in hospital more than 28 days. This is within the context of work taking place to create adequate patient flow to ensure the achievement of the 4 Hour ED Standard and the avoidance of disruption to planned surgical admissions.
4. A dedicated social worker has been appointed and is now in post to support the MHOAS.
5. The partnership has agreed a Project Initiation Document with the aim of ensuring that when a patient no longer requires to remain in hospital, they should be discharged home and the post hospital rehabilitation, care and support needs met by the community health and care team. If return home is not possible in the short term, they should transfer to a step down facility in the community for a period of intermediate care and rehabilitation. A Project Officer has now been identified to support this work, which will require system wide commitment to the project aims and improvement plan incorporating:

- Implementation of CEL 23 (2013) Guidance on choosing a care home on discharge from hospital
- Selected Actions from the Joint Improvement Team “Home First – Ten actions to Transform Discharge”
- JIT Discharge Task Force 2014 outcomes
- Revision of the NHS Borders/Scottish Borders Council Adult Patient Discharge and Transfer Policy”
- A focus on implementation and sustainability of improvements
- Connected Care Programme Delivery

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 the operational response to the areas of concern outlined above are intended to deliver maintained improvement has been maintained since then.

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. Details of a new 72 hours target are awaited.
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

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APPENDIX 1

Table 1
Total Delayed Discharge Cases in Borders, April 2010 to March 2015

Month	2010/11	2011/12	2012/13	2013/14	2014/15
Apr	30	63	66	46	55
May	14	69	66	54	70
Jun	20	68	46	39	66
Jul	51	58	60	42	74
Aug	51	72	51	60	63
Sep	70	58	53	62	53
Oct	90	46	68	50	73
Nov	102	53	49	53	54
Dec	81	59	40	45	71
Jan	73	54	45	59	62
Feb	86	54	46	42	42
Mar	79	50	48	48	48
Grand Total	**747**	**704**	**638**	**600**	**731**

Table 2
Total Associated Occupied Bed Days in Borders, April 2010 to March 2015

Month	2010/11	2011/12	2012/13	2013/14	2014/15
Apr	2244	1103	741	523	840
May	1792	1175	874	586	1173
Jun	2154	1180	657	547	865
Jul	908	1266	751	518	1000
Aug	947	1327	690	704	715
Sep	1135	898	616	704	661
Oct	1685	911	774	479	898
Nov	1334	720	543	824	604
Dec	1545	575	533	742	717
Jan	1290	638	624	885	794
Feb	1228	739	522	584	584
Mar	1317	523	641	657	657
Grand Total	**17579**	**11055**	**7966**	**7553**	**9508**
% of Associated Occupied Bed Days	**11.9%**	**8.0%**	**6.1%**	**6.0%**	**7.2%**

Red figures are forecasts based on the previous year's activity

Appendix 2

Options to enable increase capacity in care at home

Background

Over the last 18 months there has been a steady decline in care at home capacity resulting in an inability to meet demand across the Borders. The capacity issues were predominantly in the East of Borders and the Tweeddale areas initially, but this has now spread to encompass the whole of the Borders.

In the past, internal homecare were able to meet demand where external providers could not supply, however over the last 12 – 8 months we have noticed a steady decline in their ability flex their resources to demand.

A number of new models of care have come on stream, such as housing with care, and we have seen staff working within homecare transfer to these new posts. There is an attraction since the housing with care model provides a contract for guaranteed hours and there is no travel time. A person does not have to use their own transport to fulfil their tasks.

Recently a number of complaints have been received by SBC and media reports highlighting the crisis in the capacity and availability of care at home which is resulting in individuals being delayed in hospital or being placed in a care home until adequate resources can be identified.

Where a person is not able to return home because of the lack of provision in their area they become a delayed discharge and are ultimately at risk from hospital acquired infection or injury. There is strong evidence to support that the longer a person remains in hospital the more unlikely they are to return home.

In order to respond to the need for more flexible provision a fast reaction team has been introduced which has worked well along the A68 corridor. Resource is available to support a further team but we have not been successful in being able to recruit to this service.

Options for consideration

The options considered below provide a short risk analysis in regard to implementation of these. It is important to note that in doing nothing there are greater risks as continued difficulties with demand will persist.

1. *Increase the hourly rate to all providers who currently do not pay travel time*

    a. This would ensure that all workers were paid for the number of hours that they work regardless of whether this is direct care hours
    b. In doing this we would ensure equity across the system. Internal homecare provides payment for travel time as do some of the other providers in the Borders, where we are paying a higher rate. We are currently operating two systems across the Borders

    Risks

The risk associated with this is purely financial. Given the current budget issues a financial impact assessment would be required. However any increase should be assessed against costs being incurred elsewhere

2. *Purchase blocks of hours in all areas such as 6 hours plus 6 hours, for a 6 month period.*
    a. This would enable providers to recruit with the added attraction of guaranteed hours and contracts. Plus travel time would be included.
    b. These staff would be utilised to provide support to fast reaction teams and out of hours.
    Risks
        - There would be a financial pressure created similar to option 1
        - This would create further inequity since we would still have a proportion of commissioned services without travel time included

3. *Provide hire vehicles for staff to utilise with or without a driver. We are informed that there are a number of potential recruits but they do not holder a licence.*
    a. In providing a car capacity could be increased by either providing a driver or pairing a non-driver with a driver.
    b. There maybe scope to consider utilising the voluntary sector to provide volunteer drivers
    c. Travel time should be included in this option
    Risks
    As above