Hospital Discharge Performance

People & Health Scrutiny

3rd July 2023

Presented by
Dr Dean Spencer, Chief Operating Officer, Dorset Integrated Care Board, Becky Whale, Deputy Director – UEC and Flow Operations Directorate, Dorset Integrated Care Board, Jonathan Price, Director of Commissioning & Improvement, Dorset Council, Sue Evans, Head of Service, Dorset Council & Lou Ford, Performance Business Partner, Dorset Council.

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NHS Dorset

Adult Social Care is about People, Places and Partnerships

We work with people, in the places that they live, in partnerships with others

The aim of the service is to:

- Promote people's independence, through prevention and early intervention to lead fulfilling lives
- Support people at times of crisis and help them to regain their independence and wellbeing
- Safeguard and protect people who are vulnerable
- Create a sustainable and vibrant provider market to ensure the right care is available for people who need support
- **Preventing admissions and discharging people from hospital**

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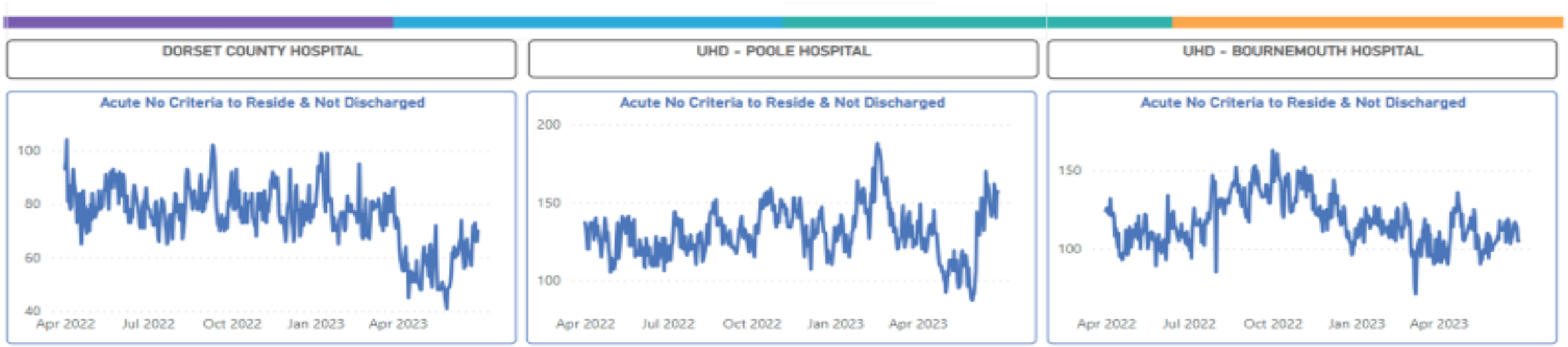
A system approach to tackling delays in discharge: Discharge to Assess



97% discharges are Dorset Council residents

30% discharges are Dorset Council residents

13% discharges are Dorset Council residents

Decision to reintroduce Discharge to Assess model in Jan 2023

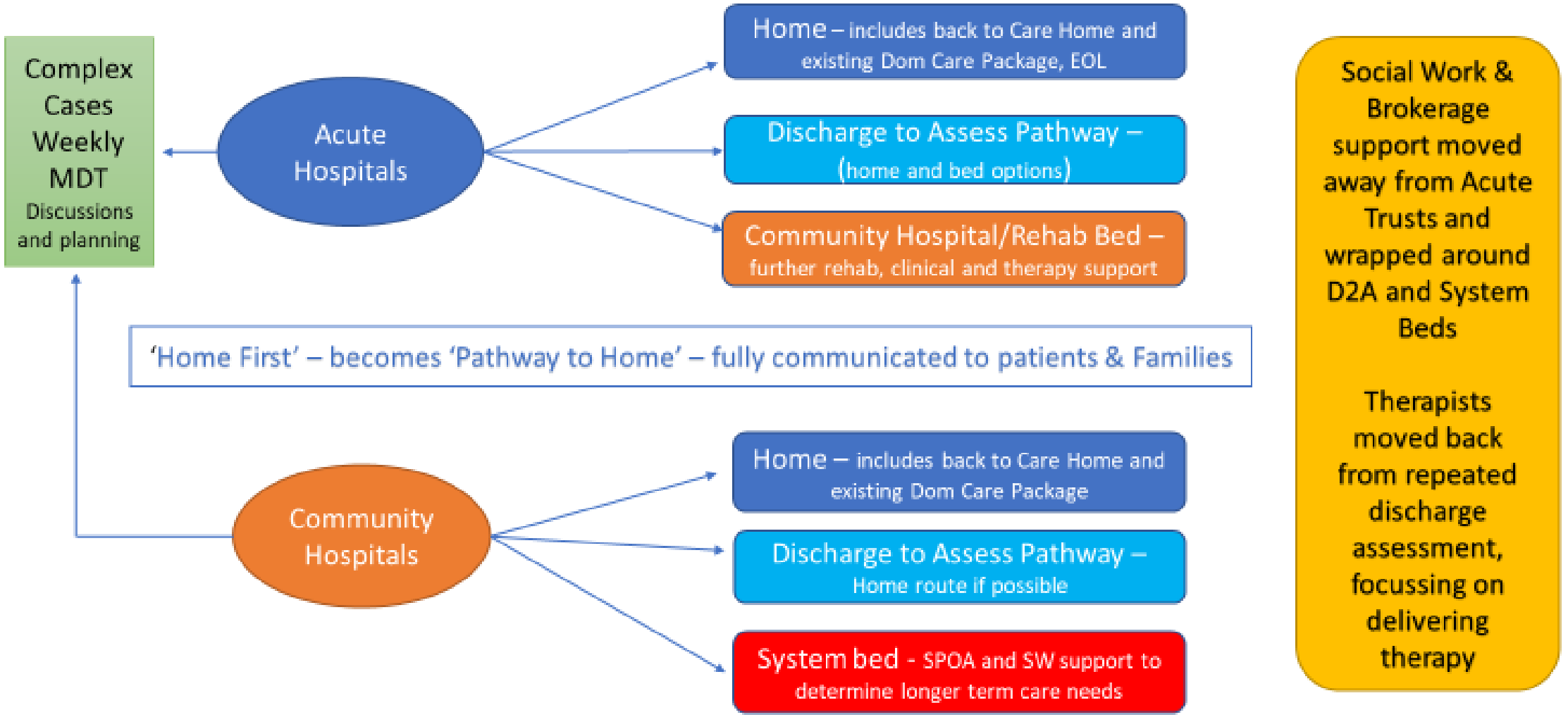
Investment in new capacity to support this e.g. Reablement and D2A beds

Introduced simplified ‘Pathway to Home approach’

Continued focus in 23/24 on developing an integrated intermediate care model across health and care

*The purpose of **discharge to assess** it to enable safe and timely discharge from hospital for people who need a further period of recovery in the community before they can be assessed for their long-term need*

New simplified Discharge Pathways



Social Work & Brokerage support moved away from Acute Trusts and wrapped around D2A and System Beds

Therapists moved back from repeated discharge assessment, focussing on delivering therapy

Building the right capacity in the community: Home First approach

1. The purpose of the Home First programme is to mobilise an integrated recovery-focused intermediate care service for Dorset people (bring together and right-size current fragmented offer)
2. To be delivered at place-level and integrated across health and social care and aligned to local primary and community services.
3. Shift in focus from step-down (supported discharge) to step-up care (admission prevention) by upstreaming interventions to keep people safe and well at home.
4. Creation of a single oversight model for Dorset that enables real-time tracking of demand, capacity and flow at patient, place, and system level.
5. Will contribute to:
    a. Better outcomes (more people supported to return to living well and independently in line with their recovery goals)
    b. Better flow (reduced hospital and community delays; fewer avoidable acute admissions)
    c. Better experience (more people engaged in managing their own health and care needs, more people supported in their home environment or place of choice)

Building the right capacity in the community: Approach to delivery

- Multi-agency design and delivery approach working across health and social care, and with VCSE and community partners
- **Phased delivery over next 12m that combines:**
  a) A bottom-up test and learn approach working with front-line teams to model and embed new ways of working with
  b) The development of a system-wide strategic plan that is focused on aligning and right-sizing resources needed to deliver a sustainable and outcome-focused service model.
- **Key deliverables in 23/24**
  1. Development of place-based integrated intermediate care teams across health and care
  2. Embedding new ways of working premised on person-centred care planning and delivery from earliest point of intervention
  3. 7-day Transfer of Care hub to bridge interface between hospital and community and provide central intelligence function
  4. 4. Pan-Dorset demand and capacity plan to inform right-sizing of intermediate care capacity and skills at place level
  5. 5. Joint ICS commissioning strategy aligned to Better Care Fund outcomes

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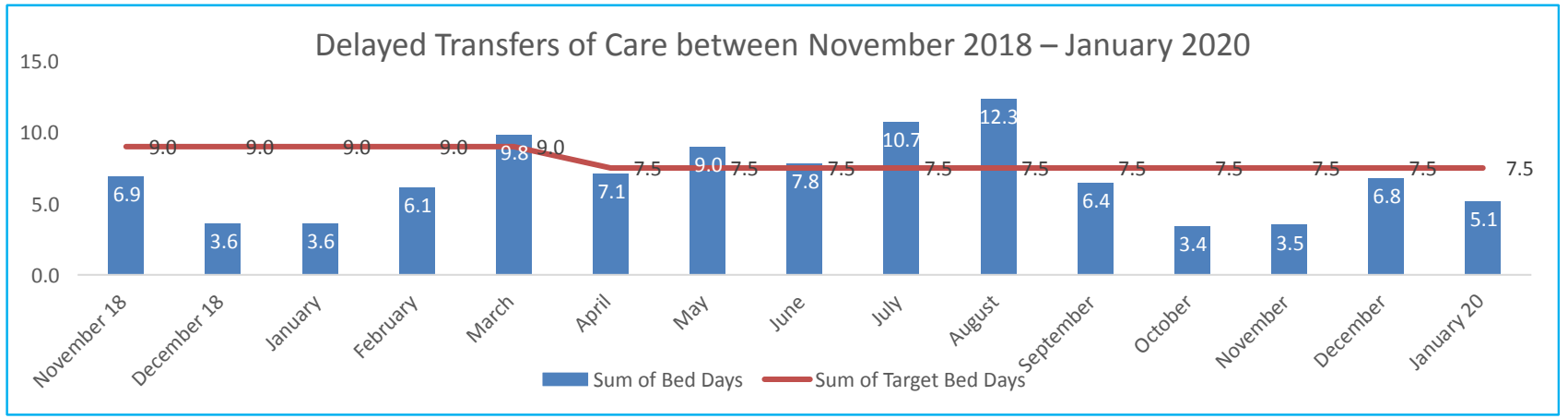
Pre & post covid comparisons

- Pre covid the focus was on Delayed Transfers of Care (DToC). Data was provided by NHS England, 6 weekly in arrears and calculated locally for the most recent 6 weeks.
- Better Care Fund recorded progress against this indicator. During 2019-20, the Dorset Council target was 7.5 delays per day, in 2018-19 the target was 9 delays per day.
- In October 2019, Dorset Council recorded its lowest ever rate at 3.5 delays per day. The rate remained low in November 2019, 3.5 delays per day and increased in December 2019 and January 2020 to 6.8 and 5.1 delays per day respectively but, was still below the Better Care Fund target rate.
- The most frequent reasons for delay include delays in sourcing Long Term care or reablement for people in their own home or Residential Care placement.
- During covid this indicator was suspended and has not been reinstated. The data is therefore not comparable pre and post covid.



Adult Social Care is now required to assess and arrange care for all Dorset residents referred to it by Dorset Hospitals irrespective of their eligibility for Council funded care

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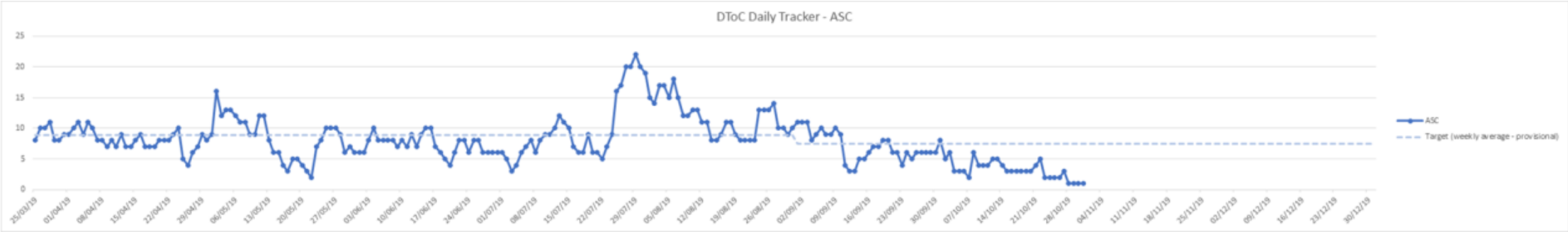
Hospital Discharge – Pre and Post Covid

Referrals from Hospital Pre and Post Covid

In October 2019, Dorset Council had a referral rate of 315 from 5 acute hospital with referrals from community hospitals unrecorded and direct to locality teams

Post Covid, the SPA data includes community hospital referrals and between January – March 2023 the average referral rate is 399 per month.

The data, pre and post covid is not directly comparable.



Delayed Transfers of Care

In 2019-20, Dorset Council had a Better Care Fund target of 7.5 delays per day and at the end of October 2019 this was reported as 3.35 days. The falling trend is shown in the chart above. During Covid, this measure was suspended and will not be reinstated.

Hospital Discharge Funding Policy 2019-20

The policy used a set of well defined 'clinical criteria to reside' to determine who remained in hospital, Hospital discharge and community support guidance - GOV.UK (www.gov.uk) (pg 39). Additional funding to support people discharged from hospital with new or additional care needs provided rehabilitation and reablement at home, announced August 2020.

Covid Response

Dorset CCG (as was) commenced a programme of work in March 2020 in the wake of covid to clear beds and manage the demand from the pandemic using COVID 19 funding. Due to issues building capacity at pace with domiciliary care providers this led to many care home admissions. Covid and Brexit have had recruitment implications across the care workforce.

Following the announcement of the Covid pandemic Dorset Council supported Providers with a 10% uplift for the period April to June which equated to £3.7m. At the end of this period the annual uplift was agreed and backdated to the 1st April 2020. Dorset Council received grants including Infection Control, Rapid Testing, Omicron and Workforce around £15m was passported directly to Providers.

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Hospital Pathway (Discharge to Assess)

The D2A process aims:

- To facilitate safe and timely discharge for patients.
- To enable assessment and follow up in the most appropriate environment for patients.
- To provide patient centred care.

Patients are discharge on one of the following pathways:

- **Pathway 0** - less complex discharge, no formal input from health or social care needed once home. Including patients who return home with no change in their care needs
- **Pathway 1** - support to recover at home; able to return home with support from health and/or social care.
- **Pathway 2** - rehabilitation or short-term care in a 24-hour bed-based setting
- **Pathway 3** - require ongoing 24-hour nursing care, often in a bedded setting. Long-term care is likely to be required for these individuals.

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Hospital Discharge into Adult Social Care

Pathway 0

Currently, there are approx. 120 Pathway 0 discharges per day. In comparison, there are approx. 30 Pathway 1-3 discharges per day

Pathway 1

95% of Adult Social Care provided to support hospital discharges is for people aged 65+

Care is provided in the community and at home .

Hospital Discharges more than halved comparing Jan-Mar 2021 with the Apr-Sep 2022

In the last 6 months, Oct 2022-Mar 2023, numbers have risen by 33% compared to the lows in Apr-Sep 2022

Pathway 2

Predominantly used to support people aged 65+

Care is provided in a residential care home

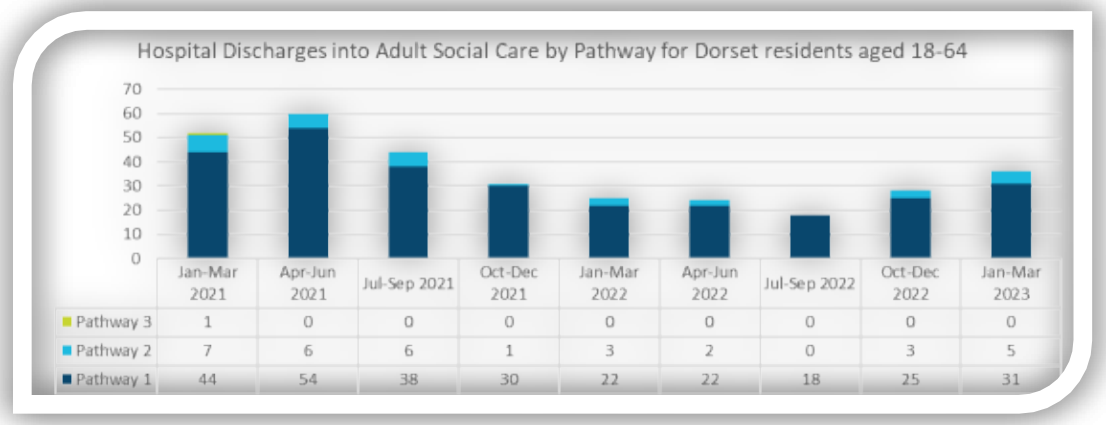
People discharged into this pathway appear to 'peak' Jan-Mar with an overall reducing trend comparing Jan-Mar in 2021,2022 and 2023

Pathway 3

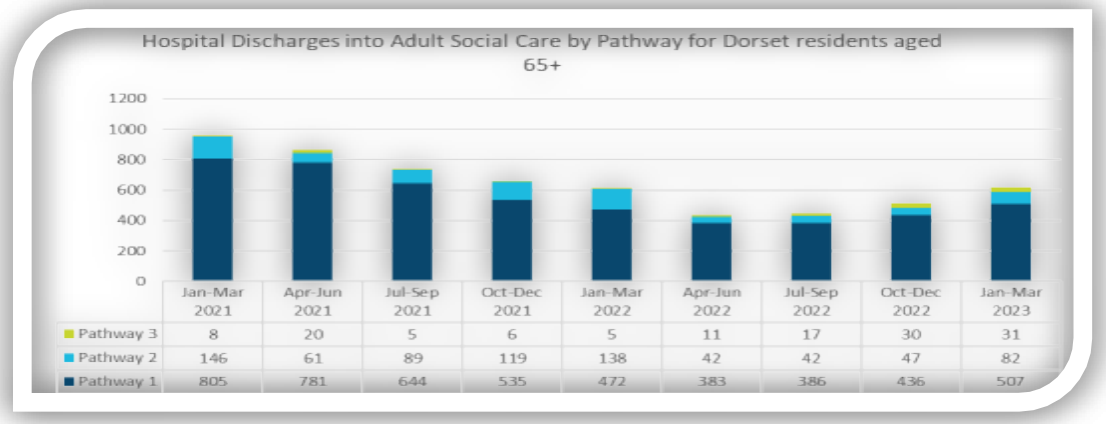
Volume of people discharged is low

Care is provided in either a residential care home or a nursing care home

Demand for people aged 65+ has risen over the last year to exceed levels in 2021 suggesting an increase in more complex discharges from hospital into ASC



People aged 18-64 discharged from hospital directly into ASC by Pathway Jan 2021-Mar 2023



People aged 65+ discharged from hospital directly into ASC by Pathway Jan 2021-Mar 2023

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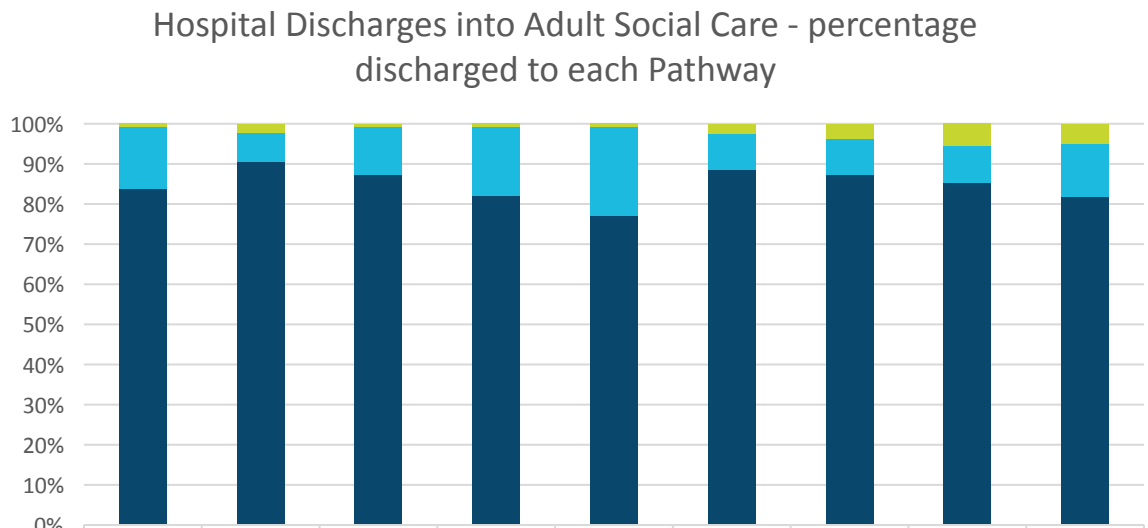
Pathway 1-3 data from SPA (System One) 11/04/2023, Pathway 0 data from DiiS Home First dashboard 10/04/2023

Hospital Discharge into Adult Social Care

Bed Based Care

Autumn and Winter show peaks of bed-based Care.

Over the last year there has been increased demand for Pathway 3 beds suggesting that people with more complex needs are being discharged from hospital.



	Jan-Mar 2021	Apr-Jun 2021	Jul-Sep 2021	Oct-Dec 2021	Jan-Mar 2022	Apr-Jun 2022	Jul-Sep 2022	Oct-Dec 2022	Jan-Mar 2023
Pathway 3	1%	2%	1%	1%	1%	2%	4%	6%	5%
Pathway 2	15%	7%	12%	17%	22%	9%	9%	9%	13%
Pathway 1	84%	91%	87%	82%	77%	88%	87%	85%	82%

Graph shows the proportion of pathway referrals from acute and community hospitals into Adult Social Care

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Pending Hospital Discharge

Summary (12 June 2023)

Currently 168 individuals are waiting for hospital discharge; 59 are confirmed to be waiting for adult social care support (Dorset Council residents)

Pathway 1

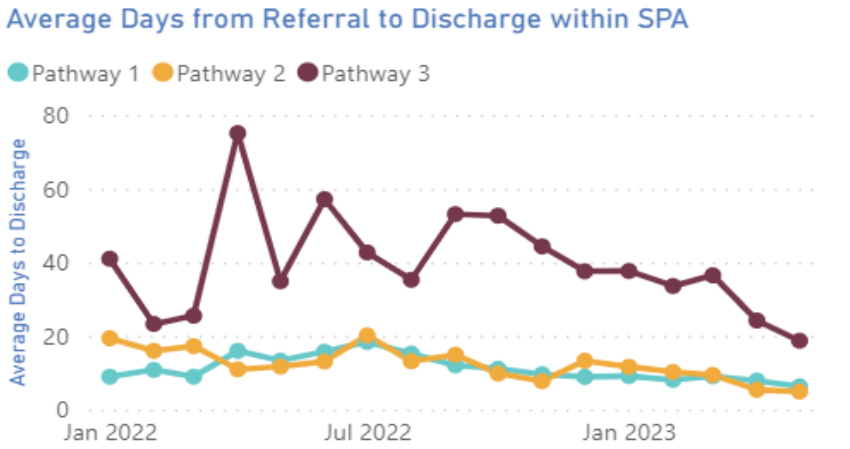
14 individuals are awaiting discharge into Pathway 1

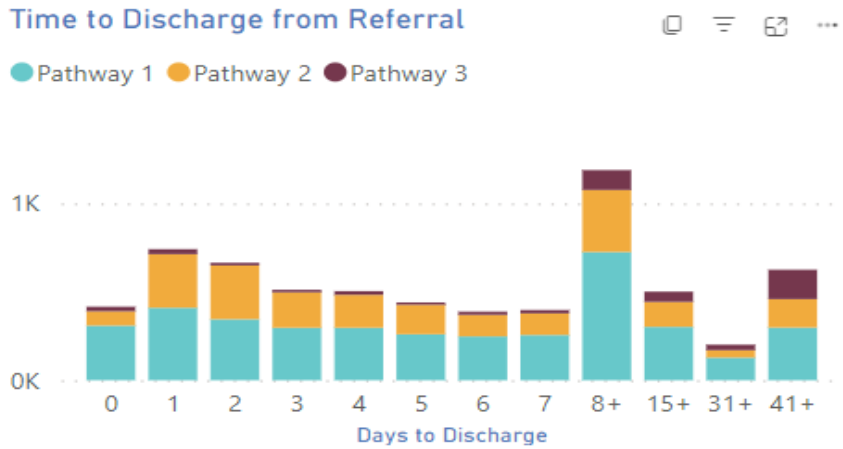
Pathway 2

16 individuals are awaiting discharge into Pathway 2

Pathway 3

29 individuals are awaiting discharge into Pathway 3





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Visuals from DiiS Home First Dashboard (SPA - System One) 12/06/2023