DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		WHOLE SYSTEM REPORT ON COMPLEX OR DELAYED DISCHARGES		
DATE OF DECISION:		26 MARCH 2015		
REPORT OF:		CHIEF EXECUTIVE, UHS AND SYSTEM PARTNERS		
CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

The University Hospital Southampton Foundation Trust and Southampton Social Services will update the committee on progress on reducing complex discharges in the Hospital. This paper was requested as a link to recent ED performance in UHSFT.

RECOMMENDATIONS:

(i) That the Panel notes the report and following discussions agrees any issues that may need to be brought forward to a future HOSP meeting.

REASONS FOR REPORT RECOMMENDATIONS

1. As part of the HOSP's terms of reference the panel has a role to respond to proposals and consultations from NHS bodies in respect of substantial variations in service provision.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None

DETAIL (Including consultation carried out)

Introduction

3. Complex discharges (or delayed discharges) are patients who need support in the community to leave Hospital. Everyone has support from their GP, but these patients need additional temporary support (rehabilitation or reablement at home or in a community hospital or residential facility) or long term care probably for the rest of their lives (at home or in a care home). A few patients may also need re-housing or for their homes to be adapted.

4. On any given day there are 150 to 200 patients in the Hospital who are identified by the UHS as being medically fit for discharge. This is between 15

and 20% of all ward beds in the hospital and most patients are in Elderly Care, Medicine, the Stroke Service or Trauma and Orthopaedics. Further assessments can be required to ensure safe discharge and patients are only deemed delayed discharges of care (DTOCs) 3 working days after a Section 5 (identifying a patient is medical fit for discharge) has been issued or until all health based assessments (assessments for continuing healthcare funding) have been completed. Sometimes patients will become unwell again before their discharge at which point they will be de-notified and their count starts again once they are well enough to leave Hospital.

5. This paper sets out the position on complex delays and what we in Southampton are trying to do about this.

6. Complex discharges may be transferring to:

- Services commissioned and funded by Southampton CCG and delivered by another health care organisation (Solent), or
- Services commissioned and funded by Southampton City Council or Southampton CCG and delivered by the private sector (domiciliary; care or nursing home care) or the Council (CCFS reablement service)
- Care that patients will pay for themselves at home or in a bedded environment.

Current Position

7. Every partner in the health and social care system has committed to discharging 26 patients per day or 13 each for Southampton and Hampshire (Appendix 2, graph 3). The latest data is attached as Appendix 1.

8. There graphs attached as Appendix 2 show there are more people than ever waiting to leave Hospital and there are more people being added each day as demand for care is increasing (Appendix 2, graph 1 and graph 2, to be clear these graphs show those patients that are medically fit not formal DTOCs). This impacts on the beds available to treat other patients and on the patient themselves as it is well evidenced that patients lose mobility and independence as length of stay increases.

Plan to improve the Position

9. There are four decisions that need to be made to plan a patient's discharge

a) Is the patient fit enough to leave the Hospital?
b) What are their ongoing care needs?
c) Who will pay for this?
d) Who will provide this?

10. These 4 questions apply whether a patient needs long term placement into a nursing home or two weeks of physiotherapy. The key to changing how we work is that not all of these decisions need to be made in Hospital and they don't need to be made sequentially. If we can change this we will change the system.

11. In changing the system there are a number of principals we should always stick to:

- Start discharge planning on the day of admission
- Don't make any decisions in Hospital other than decisions to support a safe discharge
- Have lots of different types of support available in the community as every patient is different with different needs.

- No one should be asked to make a decision about long term placement from a Hospital bed without a chance to improve in a community setting.
- Integrate everything possible (paperwork, IT, teams, skills, assessments etc) all of which needs to be based on trust
- Measure everything so we can celebrate success and spot problems early

12. Southampton has made inroads into this but there is still a long journey to travel. This is clearly linked to the delivery of the Better Care Fund plans which have for the first time joined the commissioning of services between health and the council and in response the providers of services also want to work in a joined up way.

13. There are some good local examples of delivery of the principals set out above:

- A new discharge to assess pathway for patients whose health condition may mean they are eligible for continuing health care funding (checklist positive) - this allows the patient's assessment to see if they qualify for health funding (rather than self-funding or council funding) to take place in a local nursing home in Southampton
- The new domiciliary care contracts will come into place on the 1st April increasing reliability of these packages of care and a new service specification is in place for crisis response (rehabilitation, reablement, rapid response)
- Considerable effort has gone into supporting private sector nursing homes to improve quality to ensure a better supply of placements and giving patients more choice.
- Adult Social Services have trained staff in the Hospital to undertake assessments for patients who need domiciliary care packages (restarts, in place now and minor changes, in the near future).
- IT systems are being shared so that staff in the integrated discharge bureau are able to access both PARIS and APEX, but this system isn't integrated and there is still considerable duplication.
- There is an agreed key performance metric to measure the 26 per day (13 for Southampton per day or 65 per week)

14. To see sustained improvement in the care for these patients every partner in the system has a role to play including the CCGs, the Hospital and the Council. The OSC needs to seek assurance from every organisations involved that there is sufficient capacity and robust plans to meet current and future demand.

Conclusion

15. The paper sets out that there is a broad understanding of the issues and actions have been taken to remedy the situation. The debate remains whether a new plan is needed or effective implementation of the existing plan is what is required. However, there is consensus that we must remove delayed discharges of care. It is widely acknowledged that prolonged stays in hospital are not good for patients and it is impacting on emergency patients who need admission from ED and on patients who require elective surgery.

RESOURCE IMPLICATIONS

Capital/Revenue

16. None

Property/Other

17. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

18. The powers and duties of health scrutiny are set out in the Local Government and Public Involvement in Health Act 2003.

Other Legal Implications:

19. None

POLICY FRAMEWORK IMPLICATIONS

20. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION

Appendices

1.	Current Count of 13 Discharges per day
2	Complex Discharge Key Trend Graphs 1 to 4

Documents In Members' Rooms

	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	