Update on Discharges from University Hospital Southampton – February 2017

Southampton City Council Health Overview and Scrutiny Panel

Introduction

Our last update in January 2016 discussed a considerable body of work that had been undertaken internally within the Trust and externally in collaboration with commissioners, community providers and the councils in relation to discharge and centred around the three pathways outlined in *Figure 1*. This work, a local and national priority, is essential for the successful running of the hospital and to deliver high quality, safe NHS care for the population of Southampton.

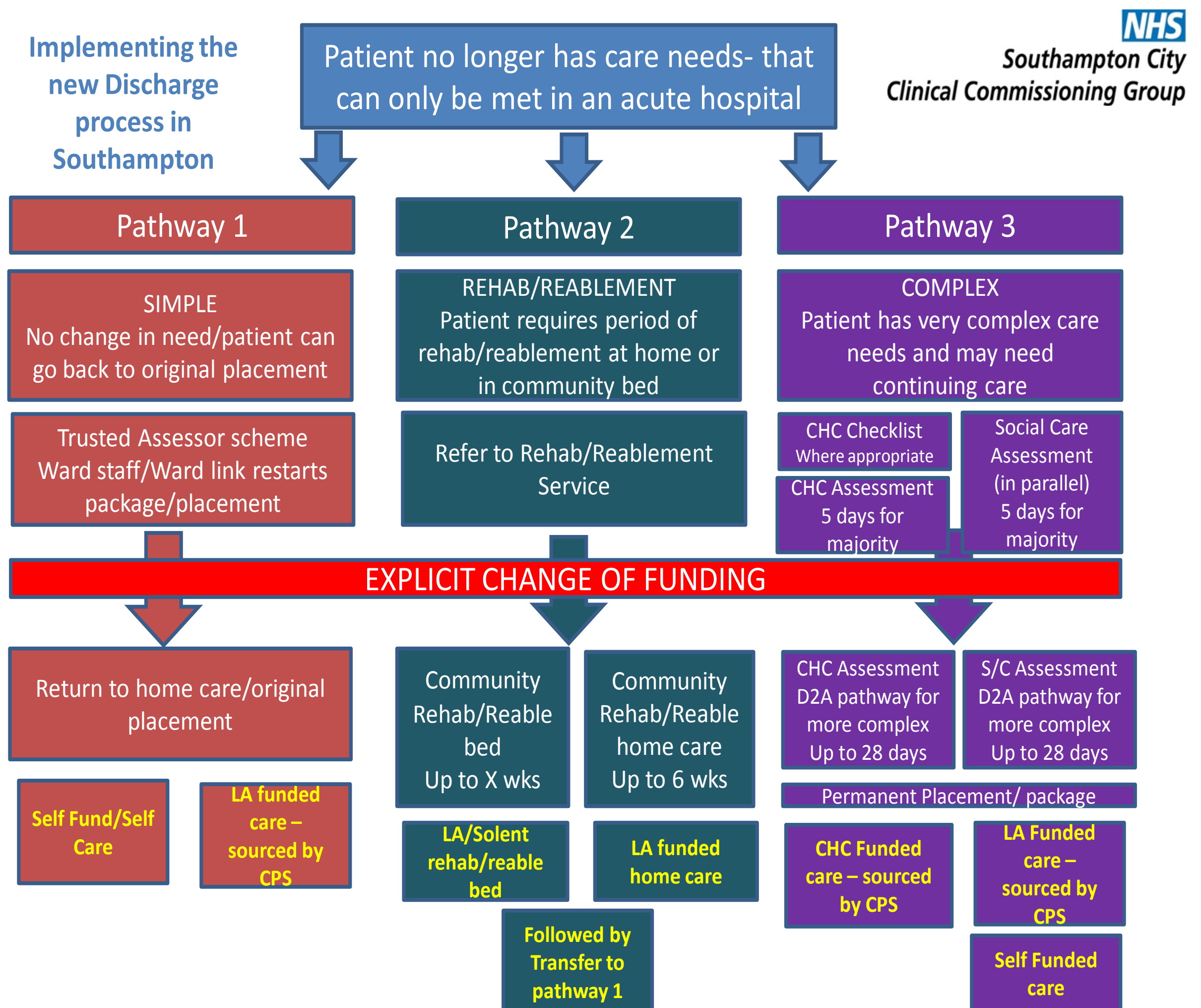

Figure 1: discharge pathways out of hospital

Details of work undertaken / ongoing

a) Agreed recovery trajectories with Southampton and West Hampshire Clinical Commissioning Groups for Delayed Transfer of Care (trajectory in Annex)
- Reduce the system Delayed Transfers of Care rate to 6.5% by March 2017
- Reduce the system Delayed Transfers of Care rate to 3.5% by March 2018

b) Ongoing development of the UHS discharge team and Integrated Discharge Bureau
- Development of Discharge Officer team to co-ordinate and case manage the discharge of complex patients in clinical ward areas
- Employment of integrated discharge bureau manager
- Embedding of new discharge IT systems and new Social care act compliant system
- Ongoing trust wide education

c) Development of processes within the Emergency Department and Acute Medical Unit
- Plan discharge from admission
- Rapid turnaround of patients who don't need hospital admission / only need short admission
- Investment in resource and Frailty service
  - Nursing, therapy and geriatrician input
  - Closer co-ordination with community services

d) Development of systems within the hospital to support flow
- Electronic Patient Status At a Glance (ward white) boards
- Red and green days
- 'Stay active' campaign trust priority for 2017

e) Development of processes to enable UHS staff to discharge patients down pathway 1 / simple pathway without the involvement of social care
- Trusted assessment agreements in place
- Training due to start within the next month with full roll out Spring 2017

f) Successful roll out of Supported pathway in conjunction with Solent NHS trust
- Discharge to assess scheme increased capacity to 22 patients per week with significant long term benefits to patients in terms of better independence and to the system in terms of the correct prescription of long term care (approximate 1/3 reduction in home care)
- Reconfiguration of Royal South Hants to support better flow into non-acute step down beds
- Further investment from Southampton City Clinical Commissioning Group in year 2017/18 and national recognition from NHS England.

Continuing healthcare (CHC) processes

The trust has worked closely with the CCG to refine processes both in terms of putting fewer patients through CHC and the speed in which this happens. This has been partially successful but a combination of increased admissions, increased complexity and unexpected staff shortages has resulted in deterioration in performance. In the immediate term UHS has used internal and locum staff to increase capacity. In the longer term the health system plans to perform a higher number of CHC assessments in the community: either prior to admission or on a discharge to assess basis. This is increasingly mandated by NHS-England.

Time to wait for domiciliary care

This is the major issue for the national and local system. Delays in sourcing packages of care reach crisis points especially over holiday periods and in winter months. This impacts patients leaving the General Hospital and also those in the RSH and the effectiveness of the supported discharge to assess pathway. This is the major priority for the Southampton Health and Social care system.

Time to wait for rehabilitation beds

Flow into rehabilitation beds at the Royal South Hants has improved considerably and associated waits are usually no more than a few days. This is expected to improve further as the supported pathway attracts more investment from the CCG and as the domiciliary care market is strengthened. This will enable the RSH to take a greater volume of patients and better support UHS Delayed Transfers of Care.

Conclusion

Good progress has been made in many areas towards improving safe and timely discharge from hospital - the joint work we have put in is starting to show its results in terms of the increasing numbers of discharges and operational position at the hospital relative to the regional and national picture. We continue to develop the system complex discharge action plan in response to challenges as they arise.

The Panel should be aware that there are still significant risks and challenges as we move forward. Major pressures are a consequence of increased admission rates, increased frailty within the population and ongoing crises within the domiciliary care market.

UHS is very aware of the serious financial challenges that face local authorities. We are very concerned that if these are translated into reductions in front line social service provision, this will directly impact upon patients delayed in hospital. Therefore, we are pleased to note that locum positions are being recruited to permanently to stabilise the workforce.

Annex