GATESHEAD HEALTH AND WELLBEING BOARD

21 October 2022

TITLE OF REPORT: Delayed Discharges Harm Assessment

Purpose of the Report

To seek the views of the Health & Wellbeing Board on current and future plans to support Health and Social Care to prepare for winter and reduce the harms caused to individuals by delayed discharges and unavailability of social care support to effect timely, safe, discharge.

To appraise the Board of the request for regular monitoring of the situation by Gateshead Health Trust Board.

How does the report support Gateshead's Health & Wellbeing Strategy?

The report supports Gateshead's ambition to:

- Put people at the heart of everything we do
- Support our communities to support themselves and each other
- Work together and fight for a better future for Gateshead

Background

Once people no longer need hospital care, being at home or in a community setting (such as a care home) is the best place for them to continue their recovery. Unnecessary delays in Gateshead are leading to many people remaining in hospital long after they have been deemed safe to discharge.

Whilst it is agreed that staying within an acute setting such as a hospital for longer than is clinically necessary can be harmful we must ensure that resources to enable timely discharge are considered alongside pressures across the system such as care market capacity and prevention.

The substance of this paper was prepared initially at the request of Gateshead Health Trust Board so that they could better understand the challenges with discharges requiring a social care package of support. It highlights the issues around discharges which have been delayed due to a number of issues. These include the seamless coordination of health and care pathways, lack of adult social care provision, additional pressure on NEAS and Accident and Emergency, increased patient safety concerns due to the length of time patients now wait for a bed to become available on our back of house wards. The system financial outlay associated with delayed discharges is significant and in effect creating sustainability issues for all partners. This is having a direct impact on the wellbeing of patients and staff. However, the costs associated with additional and earlier discharges and the impact of central government choosing not to fund Discharge to Assess must also be understood, especially in the context of a social care system which is nationally recognised to be in severe need of additional funding. Despite considerable work being undertaken to date, underlying problems in achieving timely discharge persist.

The Board is asked to support the multi-agency response focusing on continued joint working across Health and Social Care to ensure system sustainability and enable timely discharge and develop system capacity outside of hospital for patients who can return home.

The Board is asked to note the challenges faced in maintaining prompt and effective discharge and why partners across Gateshead need to urgently address this.

1. Introduction

The introduction of Discharge to Assess within Gateshead as a response to the COVID 19 Pandemic allowed patients to be discharged effectively to the most appropriate setting for their care and followed up in the community where longer-term plans could be made.

However, from November 2021 a steady increase in those awaiting a social care package to facilitate their discharge has had a significant impact on all parts of the health and social care system. This includes patient treatment and care. This paper below outlines the reasons for delayed discharges, the impact on all providers within the system including the ambulance service, the effect on patients and highlights why partners across Gateshead need to urgently address this.

Discharge to Assess was funded by Central Government through a range of schemes up until March 2022. Central Government made the decision not to fund Discharge to Assess from April 2022, therefore it is not a requirement, but is strongly encouraged as best practice. Partners in Gateshead agreed to work together to sustain the Discharge to Assess arrangements, with temporary funding identified for 2022/23. Unfunded discharge to assess pathways that create additional need for capacity on the social care market would be considered as 'new duties' on local government under current legislation and local funding solutions to resolve system issues need to be agreed in the absence of a national funding settlement.

2. Key Issues and findings

At the commencement of December 2022, NHSE set Trusts a target of reducing their delayed discharges in order to ensure that there was enough capacity to manage any winter surge in patient activity. At the time the target was set, 25 patients within Gateshead were waiting for care outside hospital. Despite efforts from all partners, this number peaked in January 2022 at 106 patients and each day there remain between 30 and 40 patients in hospital whose needs could be met in another setting. Whilst the Government has recognised the pressures in the social care system, there is national consensus that the measures identified to address the issues will not 'fix' the endemic issues within social care.

There are a number of reasons why patients are waiting longer for social care support.

These include:

- The capacity of the home care market in Gateshead reduced by around 15% from April 2021 to May 2022 resulting in lengthy delays to find packages of care.
- This compounded an already significant crisis in the social care market, largely driven by poor recruitment and retention to social care roles (which is reflected nationally as well as locally and regionally).

- Discharge to assess means people are earlier on in their recovery journey, which in turn increases the acuity of the people requiring support.
- The array of social care employees who left care homes and domiciliary care organisations due to their refusal to be receive Covid vaccinations, impacted upon the resources of Providers and recruitment issues for some organisations to replace such employees, continues to prevail (102 care home workers were identified as having left; the number was harder to quantify in domiciliary care).

- Since June 21, the waiting list for people waiting for home care has risen from an average of 10 to around 130packages of care (August 2022 figures - for individuals within their own homes) in addition to those awaiting discharge.
- Other sectors (commercial employers) have increased the amount they pay for their workers. They have been able to recruit and retain both existing ASC workers and the future workforce.
- Council directly provided bed based provision has reduced (Shadon House closed)
- PRIME reablement service prioritised to capacity however this affects the ability to support and keep people out of hospital[1], and is also impacting on overall success of reablement (i.e. reduction in longer term needs) which will have an adverse impact across the health and care system.
- The marked increase in complexity of PRIME referrals (high proportion of 'double-up' poc) elicits recurring social care costs for the Local Authority.
- Existing providers have seen challenges with sickness and staff retention. Week commencing 11 July 2022, it was estimated that 14% of staff in these providers were unavailable through illness or isolation due to Covid.
- Long term provision of social care – many patients leaving hospital require a longer-term package of care (post 28 days). At present it is proving difficult to move these patients from the short-term services in a timely manner due to the long-term Home Care challenge.
- Additional Short-Term Support – Many people continue to need services in excess of 4 weeks before they can withdraw support. The 28 days is the national guidance but true reablement averages around 6 weeks.
- Availability of Care Home beds: Only the PIC's are set up to support Pathway 2 discharge to assess with a dedicated staff team, including health. Due to the funding challenge, Gateshead has operated on a spot placement model since April 22 with homes accepting cases on a case-by-case basis. Additional Health resources haven't followed the patients into these beds, which is ultimately reducing the chances of reablement to move people back home. The Independent Providers aren't contractually obliged to accept people from hospital. There are 150 empty care home beds in Gateshead with about a third of these with staff available. Our contract arrangements, processes and reluctance of some providers is the challenge, not the availability of beds
- Finance: although there is a pooled budget, this amount is fixed for hospital discharge and Discharge to Assess was not funded by the Government. The pooled budget

[11] There has been a 72% reduction in community access to intermediate care services since the pandemic and the focus on hospital discharge. However, this has a significant impact on admission avoidance.

was set up to meet the social care and nursing needs of people but didn't include redirections of resources to invest in therapies in the Community as per the hospital guidance.The overall number of individuals in hospital within Gateshead has not reduced thereby making the redirection of resource extremely challenging.

- Funding for the recovery of Health and Social Care (from the NI levy) has largely been allocated to the NHS

All of these have impacted discharge and it is important that we work together as a system to solve these going forward and the Discharge Strategic Group agreed a number of measures to mitigate the above with varying degrees of success. These included measures to support staff retention, including expediting the pay aware and retention and recruitment grants.

3.1 The scale of the problem

The Trust records all patients who no longer meet the criteria to reside and are awaiting discharge on pathways 1-3 (i.e. waiting for support outside hospital). NHSE suggested a target for a Trust the size of Gateshead should be that no more than 18 patients (which represents 2/3 of a ward). The following is the position since November 2021, consistently above the NHSE target. It should be noted that during the January peak, no elective surgery could be carried out, 60 escalation beds were opened and the Trust considered calling a major incident due to lack of available bed capacity.

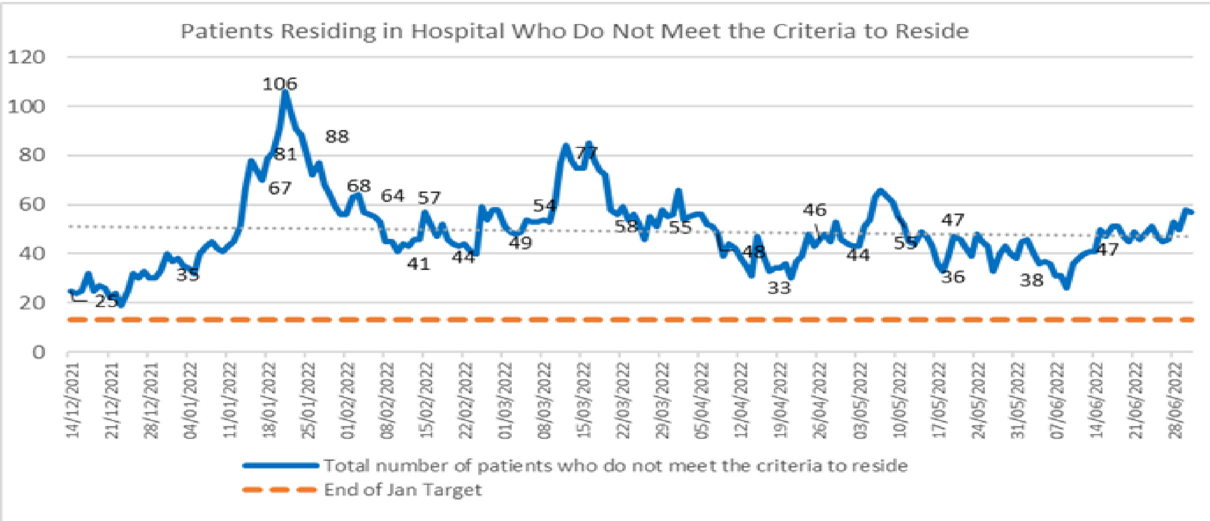


Figure 1 – Patients who remain in hospital who longer meet the Right to Reside, Daily Sitrep. Please note that these figures include Sunderland and Durham delayed discharges.

Appendices 3, 4 and 5 provide further detail on those patients who have remained in hospital after they have been declared as not meeting the criteria to reside there.

3.2 How does this effect our Gateshead patients?

3.2.1 Inpatients waiting for discharge

Evidence shows that it is better for people to spend as short a period of time as possible in hospital. Health and social care can then be delivered in a joined up way at home. Hospital stays are associated with increased deconditioning, higher likelihood of hospital acquired infection, pressure damage due to decreased mobility, increased inpatient falls, isolation from friends and family (even when open visiting is in place) and increased vulnerability in the older population. Inpatient falls within the Trust can be seen at appendix 1 and show an increase during this winter as staff are stretched managing patients. This is due to extra beds being opened due to delayed discharges which significantly depletes staffing ratios.

Between January and March, seven patients contracted COVID in hospital while waiting for a discharge placement; this could have been avoided had they been discharged in a more timely manner.

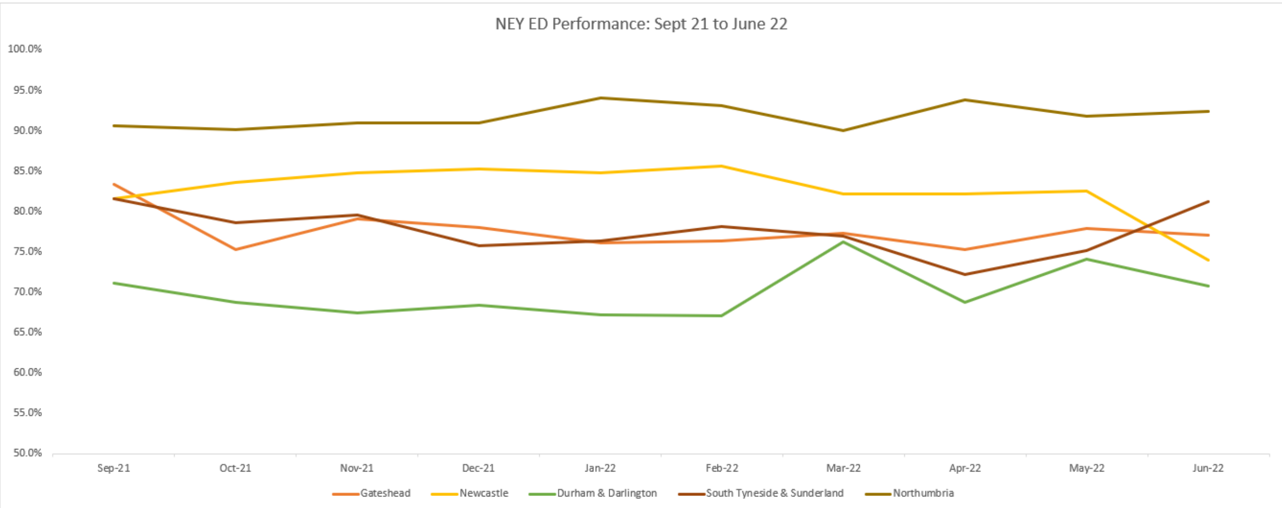
Patients have an increased chance of readmission: delays of two or more days as been shown to negate any benefits from intermediate care or rehabilitation efforts and delays of greater than 7 days leads to a decline in muscle strength of 10% due to the inevitable immobility associated with inpatient stays[2].

Patients who are not discharged in a timely way to their home with support may never return home as they become deconditioned, become more challenging to rehabilitate effectively and then require long term residential care, this is not a good outcome for those patients.

It is also a poor outcome for the system as residential placements are more expensive and these costs are borne on a long term basis by social care.

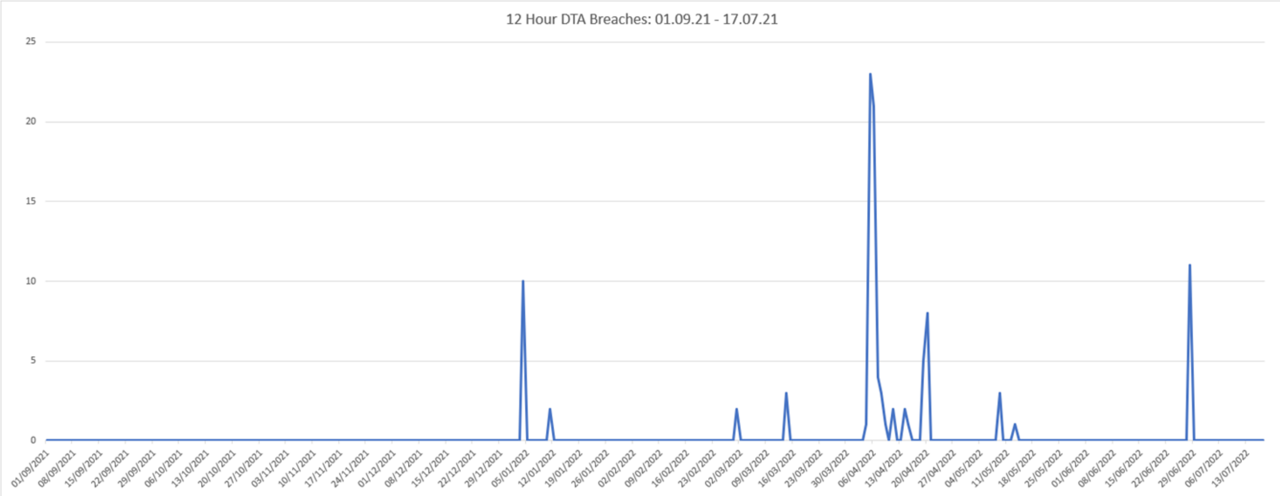
3.2.2 Patients waiting for a bed to become available

Maintaining effective flow across the hospital is vital for patient safety and delivering good care. When beds are occupied by patients awaiting discharge, there are overall less beds for patients to be admitted to and this means longer waits in Accident and Emergency. Gateshead has consistently been good for A&E performance with figures at the top end of regional performance but recently we have been challenged to maintain this position, partly due to the decline in the availability of social care provision.



Gateshead Health experienced problems with patients waiting more than 12 hours in A&E due to availability of inpatient beds. This led to increased complaints from patients and a much poorer care experience as A&E is not equipped to offer longer term care.

2 Hospital-associated complications of older people: a proposed multi-component outcome for acute care - PMC (nih.gov)



The days of 5th and 6th of April were particularly challenging. There were three days where more than 300 patients attended A&E each day. There were 56 patients waiting for discharge on pathways 1-3 and COVID continued to affect the Trust with 67 inpatients. In one of the worst days on record for the Trust, 45 people waited for more than 12 hours a bed. This caused immense stress to the staff on the ground and led to a number of case reviews. This could have been avoided if even half of the discharges delayed had been effectively discharged.

3.2.3 Patients waiting at home or in the ambulance queue

Another significant impact is for patients who have called 999 and are waiting for an ambulance. NEAS must respond to a life threatening emergency within 7 minutes and a serious emergency within 18 minutes. If the ambulance cannot admit patients to hospital, they cannot remain on the road and instead queue outside A&E. This means that patients will wait at home longer for an ambulance before they are transferred to hospital and both ourselves and NEAS have examples of where patients have suffered significant harm as a result of this.

The scale of the harm caused to these patients was iterated in a HSIB report and the relevant information can be found in appendix 2[3]. This information shows that an increase in hospital of patients who no longer meet the criteria to reside leads to an increase in harm to patients seen by the ambulance service.

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3.2.4 Patients waiting for planned surgery

The Covid response has resulted in significant delays for patients awaiting surgery, often in chronic pain while they wait. Patients requiring cancer surgery and investigation are prioritised but are waiting an increased length of time for their surgery, a difference which can mean the difference between cure or not. This group needs to be accommodated in a bed with nursing support, if this resource has been allocated to patients waiting for discharge, surgery needs to be cancelled which causes unnecessary distress to these

[3] Harm cause by delays in transferring patients to the right place of care (June 2022) Healthcare Safety Investigation Bureau

patients. This is also expensive as theatre time is lost and the Trust relies on increased levels of elective activity to generate income as part of NHSE's Elective Recovery Fund.

3.3 The quality of care provided to patients

Safe staffing levels are key to maintaining quality patient care. The RCN suggests that one nurse should look after no more than eight patients during the day. The very sickest people in Gateshead are in hospital, they are often unable to undertake basic tasks for themselves and require support with all personal care. Due to the volumes of patients waiting for discharge a the ratio of nurse to patient has been stretched to one to 14 patients. This happens when escalation beds are opened in bays taking these from 4 patients to 6 patients. Patients are also asked to "sit out" on chairs if they are likely to go home that day. This means that staff are telling us they are "burnt out" and increases sickness rates and retention.

How much does this cost?

The Trust estimates that the cost of having the escalation areas open is approximately £1.2 million per month.

The table below identifies the volumes of patients who have stayed in hospital who no longer meet the criteria to reside, with their total length of stay and the bed days lost since medically optimised and associated costs of the delays on discharge.

Delays attributed to Local Authorities account for a total of 977 patients who have not met the criteria to reside, been medically optimised and remain in hospital. Split per pathway is given below.

Local Authority Responsible																									
	Volumes of patients in hospital who do not meet the criteria to reside (based on reason at 8am on reporting day)						Lengths of Stay for patients who do not meet the criteria to reside (Discharged Patients)						No of days lost (since medically optimised) who do not meet the criteria to reside (Discharged Patients)						Cost to the Trust (£400 per bed day) since medically optimised - for those who no longer meet the criteria to reside (Discharged Patients)						
	Jan	Feb	March	April	May	June	Jan	Feb	March	April	May	June	Jan	Feb	March	April	May	June	Jan	Feb	March	April	May	June	Totals to date
Pathway 1	75	67	109	111	59	136	98.5	70.5	42.1	47.3	37.6	33.9	5721	2747	2693	3343	2586	1979	£2,288,400	£1,098,800	£1,077,200	£1,337,200	£1,034,400	£791,600	£7,627,600
Pathway 2	51	55	68	78	35	94	102.7	83.1	42.9	59.2	45.1	41.8	2184	2141	1143	1970	1133	1126	£873,600	£856,400	£457,200	£788,000	£453,200	£450,400	£3,878,800
Pathways 3	7	5	14	14	9	40	95.3	87.3	47.6	62.7	48.9	46.1	260	445	179	514	293	622	£104,000	£178,000	£71,600	£205,600	£117,200	£248,800	£925,200

Figure 2 – LA Summary Table. Assumes bed day cost of £400.

Number of patients in hospital who do not meet the criteria to reside 1 Jan to 28 June 2022

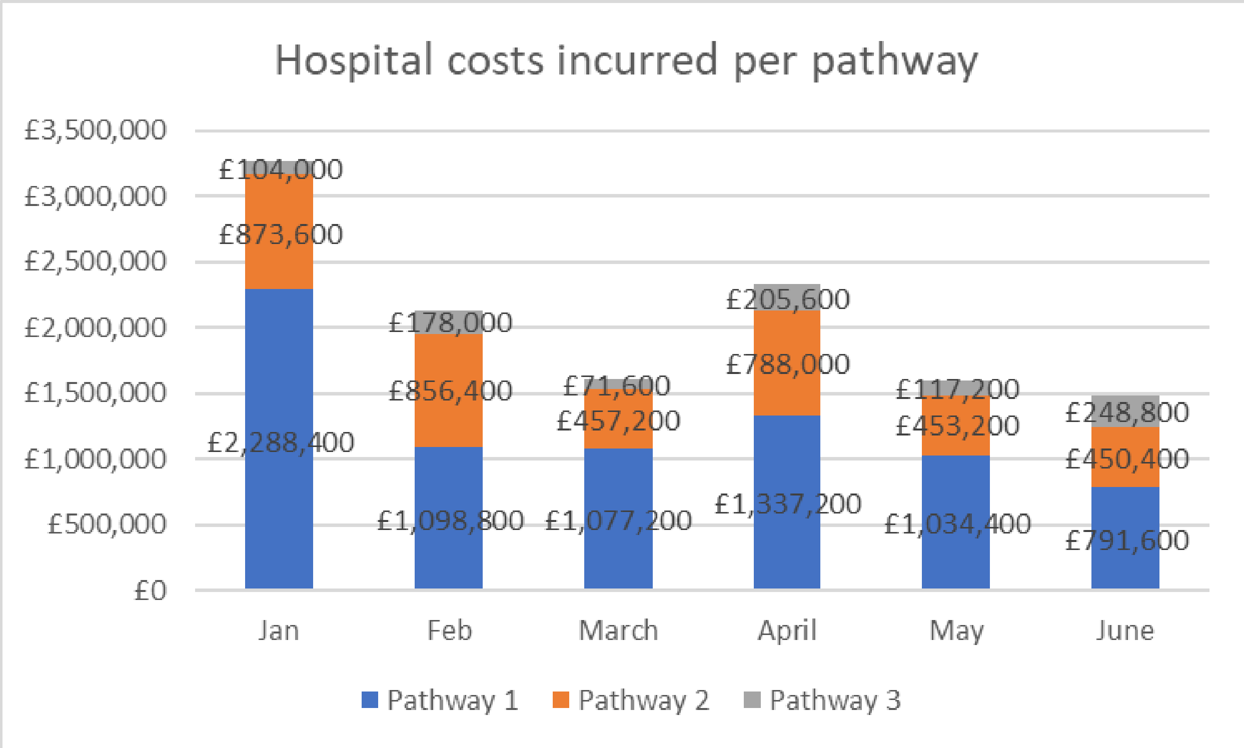

Figure 3 – LA patients: volumes per pathways (up until 28/06/2022)

These figures do not include the costs of ongoing social care for people who have been unable to return home at the time they are ready to do so because of a lack of a care package. These individuals have then been placed in a residential setting and then moved into long term 24 hour care at a significant cost.

3.4 From the Patients'/Persons' perspective

Some of the issues this winter in hospital have resulted in care far below the level which our staff want to provide. These include:

Accident and Emergency Challenges

- A patient aged over 60 with cancer which had metastasised to their bones waited on a trolley for 17 hours in A&E before a suitable bed could be found. This would have further exacerbated their discomfort.

- A 48 year old patient with suspected sepsis needed to lie down due to an acute headache. There were no trolleys available due to pressure on equipment.

- A 70 year old patient with Chronic Obstructive Pulmonary Disease remained in the Emergency Department for over 12 hours as their condition deteriorated partly due to a delay in admission to a respiratory ward where they could be cared for by specialists but instead they had to be moved back into the resuscitation area.

- An 80 year old patient attended A&E , she was very frail with minimal medical issues, however she had significant social stresses and her family believed she was unsafe at home. She will be going home but due to non availability of beds waited 12 hours on a trolley before she could move to an assessment area. On assessment, she was medically fit to return home but needed support in the form of a respite bed or package of care which delayed her discharge leading to an admission.

Discharge Challenges

A patient aged over 90 was admitted with heart failure. Patient declared medically optimised on 10 days later and no longer needing of acute hospital care. However, by this time pre-existing POC (QDS x2) with Comfort Call had been closed. For 7 days Comfort Call tried to source new POC but were unable to owing to staffing capacity issues. Possibility of utilising an interim bed was broached with the family, however, several concerns were raised about this not being a suitable place for the patient who has underlying comorbidities. At the time Care Homes were not allowing visiting. The package was then sourced, by this was almost two months had passed after the patient was ready to leave hospital.

Post discharge/admission avoidance challenges

- 83 year old man admitted to hospital following a fall, with comorbidity of stroke, heart bypass and diabetes. Required a package of care x4 daily, with 2 care workers. This couldn't be sourced for discharge, so he was admitted to a care home, where he became deconditioned and sadly wasn't able to return to his own home.

- 88 year old man with Alzheimer's Disease and heart failure, who was waiting for a package of care for four months. In the meantime PRIME reablement were supporting, but this meant they couldn't support hospital discharge or admission avoidance.

3.5 Staff experience

These pressures put enormous strain on our workforce across the health and social care system. The site resilience team, who are responsible for unblocking any barriers to patients moving smoothly through the system report feeling frustrated with the ongoing delays. Staff in ED and the Emergency Admissions Unit cannot deliver the work they need to as they have insufficient space to see and treat acutely unwell patients. Social Care providers are having to support people with much greater complexity, often with less resource. Colleagues working in the discharge hub, and those sourcing services feel under significant pressure and scrutiny, often in response to issues which they have no strategic control over.

Staff are working very hard to ensure that patients do not come to significant harm and are kept safe. Some of the more established staff report that they have worked here over twenty years without experiencing such as they currently are, even though summer normally allows some respite from pressures. They are finding the situation concerning and demoralising.

Proposal

It is proposed that an urgent system response is required to prevent further issues entering the winter period from overwhelming existing services. A key issue is The availability of domiciliary care and residential care services that can meet the increasingly complex needs of people discharged from hospital.

Being in hospital for an extended period of time and more than clinically required is proven to have adverse effects on patient outcomes and overall recovery. It is vital that we work together as a system to prevent patients remaining in hospital longer than they need to.

Patients who are discharged with potential to improve should be offered rehabilitation and therapy services which in some instances this results in them no longer requiring care. The current lack of availability in therapy and reablement services partially being exacerbated by lack of appropriate provision within the care market is preventing flow in the system and increasing need on a long term basis.

The actions taken to date are:

1. The Chief Operating Officer for Gateshead Health has been identified as the system lead Executive for discharge.

2. A daily operational meeting and weekly (which can be escalated to daily) strategic meeting is in place to ensure that discharges take place and review any issues which have prevented a discharge. These bring together the Director for the Gateshead system, the Lead Commissioner for Social Care, the Director for Social Care, Two service managers from Adult Social Care, Director of Nursing at the (former CCG), Deputy Director of Finance at the (former CCG), Director of Operations for Community Services and the Community Services transformation lead.

3. Joint collaboration meetings have been set up with support from NHSE/I. Including an appraisal of the Trust's discharge process.

4. Self assessment against best practice for discharge has been undertaken, this has informed areas for improvement.

5. Work to improve live data flows has commenced to promote more same day discharge.

6. Two further domiciliary care providers have been commissioned to provide care to patients returning home. These operate on a different model to make provision more attractive for providers. (this is in addition to the work undertaken to bolster the social care market at the beginning of 2022).

7. Agreement between partners and ICB for an enhanced discharge budget to pay for care for individuals outside hospital on discharge in order to maintain a discharge to assess model.

8. Demand and capacity has now been completed to understand the gap analysis for social care provision.

9. A Rapid Process Improvement Workshop has taken place to identify areas for efficiency and improvement on discharge between hospital and social care provision – 26 problems were identified.[4]

10. A Discharge system co-ordinator post is in process, the creation of this post is designed to resolve any blockages which may impede discharge.

[4] RPIW 22/7/2022 https://youtu.be/cN_Box0TQmo

11. A company has been engaged to work with us from October 2022 to March 2023 to speed up the placement of individuals in care home settings (pathway 2).

However, there remains concern that despite these steps, the underlying problems with the social care market remain in terms of long term funding, labour market shortages and same day provision. In order to address these we have committed to the following actions:

1) The 100 Day Discharge Challenge – this involves our patients in pushing for their own discharge and highlights the benefits of safe, early discharge.

2) Further help has been requested via the ICS and we are exploring options around external support and have suggested a peer review with Durham who do not appear to be experiencing the same difficulties.

3) A system review of flow across health and social care systems to maximise access to reablement and therapy services, reduce demand whilst improving access to long term care is to be completed asap. This will inform future models and commissioning arrangements including the consideration of direct service provision where this does not currently exist.

4) A peer review by Durham colleagues of the discharge process.

It remains vital that partners have full consideration of any changes made to out of hospital provision that will impact on other parts of the system and ensure that these are understood by all partners and mitigating actions taken.

Recommendations

The Health and Wellbeing Board is asked to consider the contents of this report and support ongoing work to expedite timely discharge thus ensuring that we can safely care for all our patients.

Members are asked to note that the ongoing challenges suggest that this situation is unlikely to resolve without significant decisive action to improve the situation within social care for both hospital discharge and longer term packages of care.

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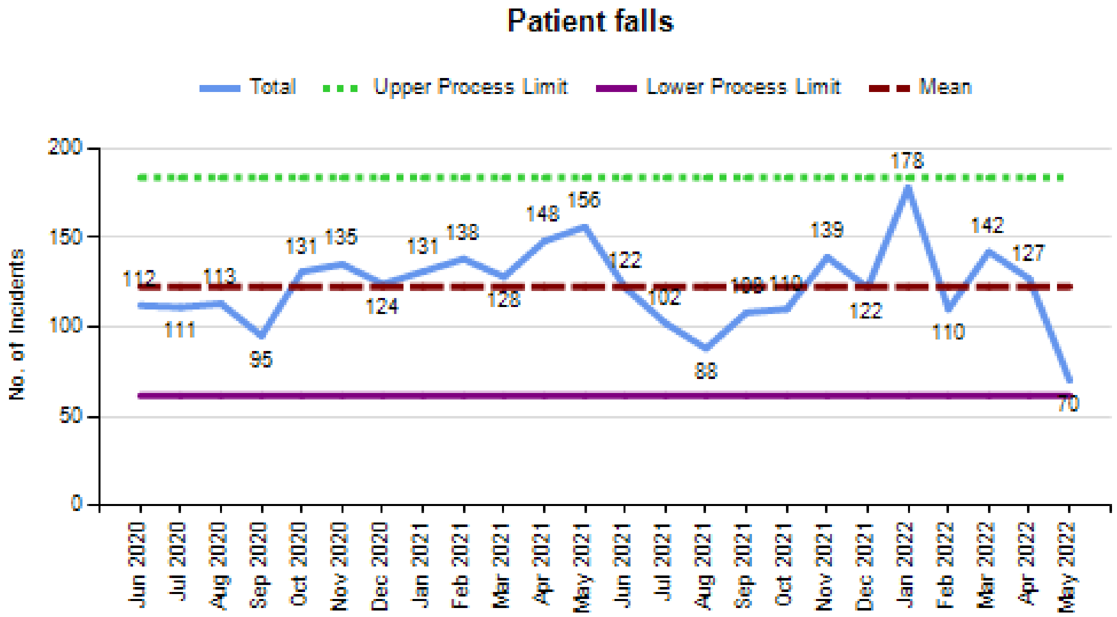
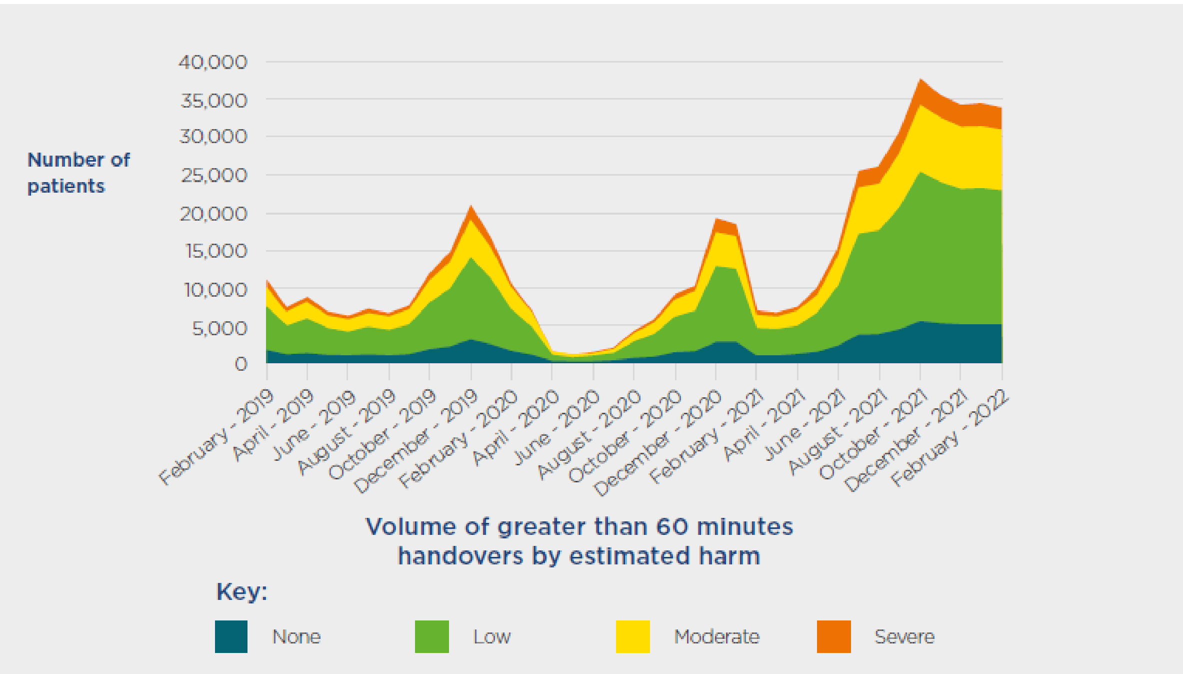
Contact: Joanne Baxter, Chief Operating Officer, Gateshead Health
Dale Owens, Director of Social Care, Gateshead Council

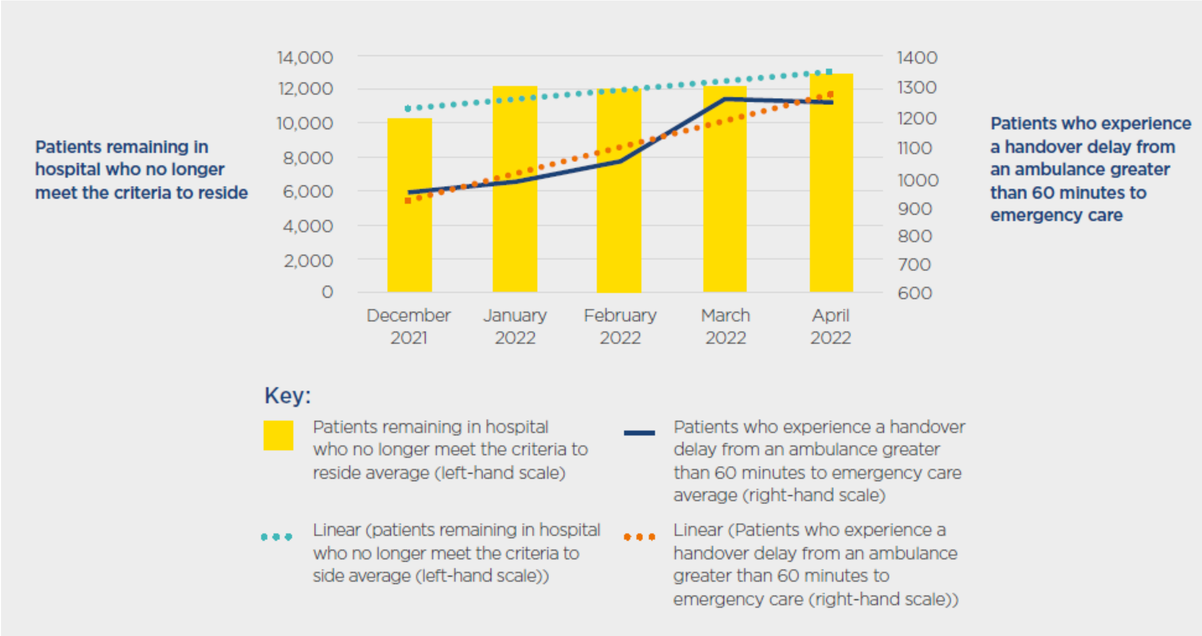
Appendix 1 – Patient Falls



Appendix 2 Data on harm from HSIB Report

Figure 3 Representation of volume of patients by potential harm: time series (Association of Ambulance Chief Executives, 2022)





Appendix 3 Patients not meeting the criteria to reside as a % of all patients in hospital

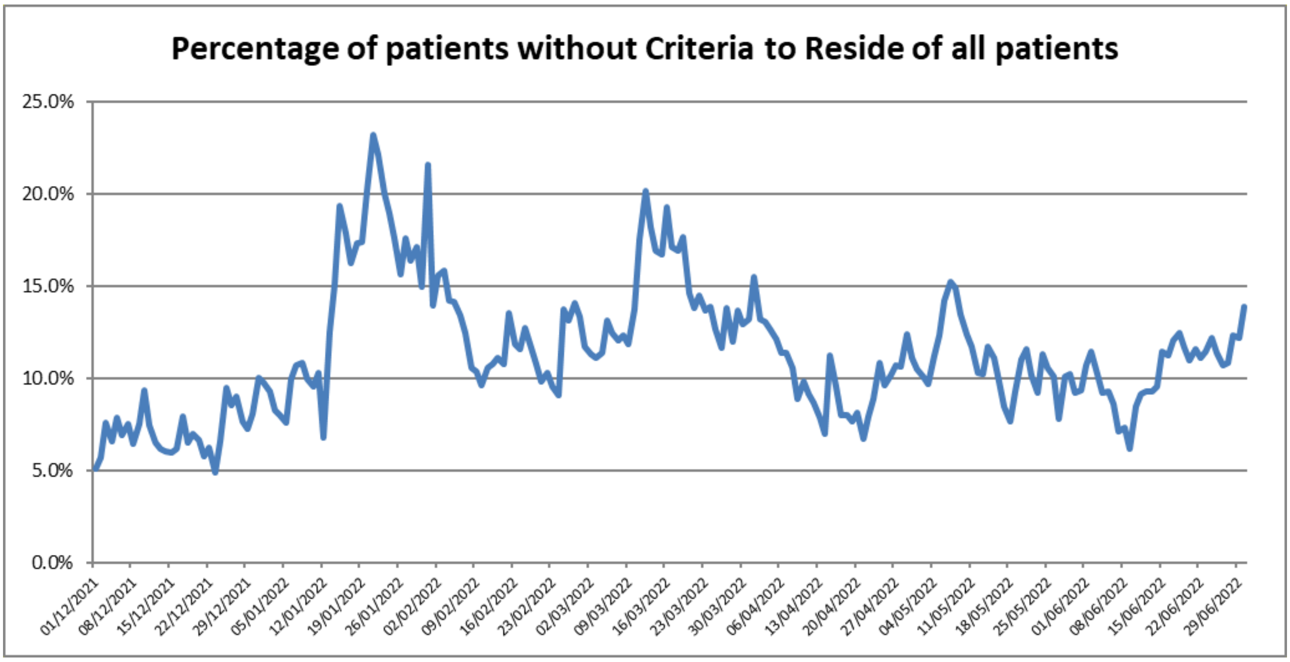
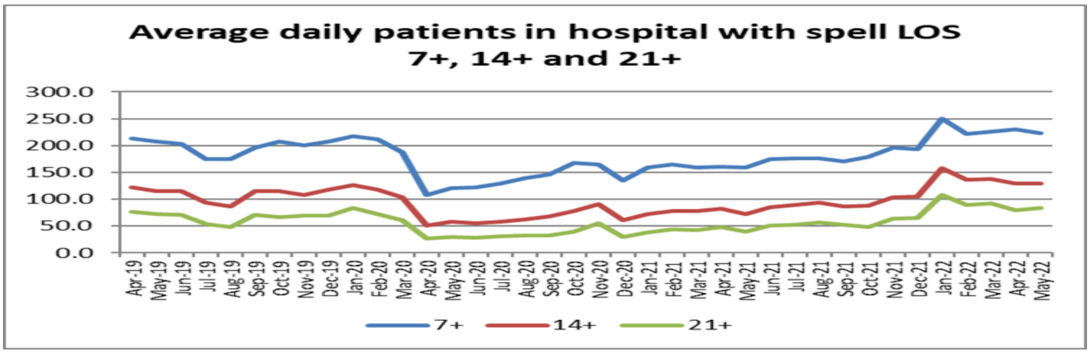


Figure 2 – Percentage of patients in hospital who do not meet criteria to reside as a % of all patients residing in hospital.

This has also had an impact on patient Length of Stay in hospital which has steadily risen over the last 24 months and is currently higher than pre-pandemic levels

Appendix 4: Average Length of Stay in Hospital



Appendix 5: Length of Stay after patient no longer meets the right to reside