Gateshead Council

TITLE OF REPORT: **Hospital Discharge and Residential Care Admissions**

REPORT OF: **Steph Downey, Service Director, Integrated Adults and Social Care Services**

Summary

The following report sets out the interface between Hospital Discharge and the impact on admissions into residential care. It reflects the challenging position health and care services experienced during the winter period 2022/2023, the additional investment made across the health and care system during 2023 and the impact this has had for winter 2023/2024.

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Purpose of the Report

1. To update the Committee regarding the work undertaken to improve the flow of people from hospital to their own home, with a focus on the Department of Health and Social Care's polices on Admission Avoidance, Home First and Discharge to Assess, and the improvements that additional Better Care Fund monies have achieved both for individuals and for the health and care system.

Background

2. **Admission Avoidance** seeks to prevent people being unnecessarily admitted to hospital. This is particularly important for vulnerable older people, given that time spent in hospital can adversely affect their ability to mobilise, reduce their skills and debilitate the person, whilst conversely vulnerable older people are one of the groups most likely to be admitted to hospital unnecessarily.

3. **Home First** principles are that wherever possible the person should be supported to return to their home, rather than to a residential establishment (even on a temporary basis) and support provided in the person's own home to enable them to recover their previous level of independence.

4. **Discharge to Assess** recognises that people who have been unwell in hospital often require a temporary solution before a full assessment of their needs.

Therefore, where possible a person should be discharged with a temporary care arrangement, before an assessment for a longer term care plan is undertaken.

Impact of Covid 19 on reablement services

5. Committee received regular updates regarding hospital discharge during the covid 19 pandemic. One of the successes of the work across health and care in Gateshead was the alignment of the Councils PRIME reablement service and Promoting Independence Centres to support hospital discharge.

6. However, this led to a reduction of support for people in the community to prevent admission in the first place, and the intermediate care services moved from a pre pandemic position of 50:50 ratio between admission avoidance services and discharge support services, to a ratio of 84:16 in favour of discharge services, meaning a significant reduction in admission avoidance support.

7. Whilst there was this significant focus on services to support discharge, the increased acuity of people in hospital during and since the pandemic, and the crisis in social care recruitment during 2021/2022 meant that there remained significant pressures on hospital capacity, and the significant reduction in admission avoidance services created further pressure, albeit the need to focus on discharge meant it was not possible to redirect the existing resource back to pre pandemic levels.

Impact on residential care admissions

8. As a result of all of these factors (combined with the nationally reported pressures on hospitals during winter 2022/2023) the health and care system struggled to provide community support and therefore follow the Home First principle.

9. This led to an overreliance on bed-based care services, often in traditional residential care homes, where the combination of a lack of reablement offer, and the ability to remain in such a home on a permanent basis, meant that many people who may have returned home from hospital if the right support had been available, ended up requiring longer residential care.

Actions taken

10. Following the reflections of winter 2022/23 it was agreed to invest additional Better Care Fund monies into community reablement services, and employ a Strategic System Lead who would oversee Transfers of Care on behalf of the NHS and Social Care.

11. With an investment of circa £400k an additional 16 FTE workers have been recruited into the PRIME reablement service.

12. Alongside this there has been investment via Central Government Market Sustainability Grants in the long term home care market, and a rebalancing of the Department's Medium Term Financial Strategy based on investment in community

services and a reduction in spend on bed based care, leading to an overall reduction in the forecast.

12. The Strategic System Lead for Transfers of Care commenced in post in September 2023 and the impact of her role so far and the work across the system is outlined in the presentation to the committee.

Impact

13. Across the health and care system we measure a number of key performance indicators relating to hospital discharge, reablement services and residential care admissions. Whilst the additional investment is relatively recent, and there are still challenges such as levels of need and demand, we are seeing a number of improvements borne out in data:

Discharge Data

Compared to last year the Trust has been able to discharge proportionately more of patients who no longer meet the criteria to be in hospital each day, standing at 65% compared to 59% last year
As a result of proportionately more people being discharged, the daily average number of patients the Trust reported each morning as in a bed but no longer meeting the criteria to reside has also fallen by 32%, to 41 patients this year, from 54 on average last year
Benchmarking data for the same week in December, in each year, provided by North East and Cumbia ICB as part of weekly discharge reports, shows the percentage of beds taken up by no criteria to reside patients improved from 12.9% last year, to 9.6% this year, and is well below the regional average of 17.5%
There are also fewer patients in hospital with longer lengths of stay, where average numbers reduced by 11% for those over 7 days, 16% for those over 14 days and 20% for those over 21 days

Community Packages data

In the peak of winter 22/23 there were 167 people waiting for a package of care. This is now down to single figures.

Reablement Data

The balance between Admission Avoidance and Discharge support now stands at 58:42 in favour of Admission Avoidance for PRIME services – which benefits both the NHS and Social Care, and supports people to stay at home.
In September – November 2023, 77% of people remained at home following an episode of PRIME reablement intervention – which is a 6% improvement on the previous 3 months. The service is aiming for a figure of 85% going forward.

In terms of those people who went through a period of reablement and at the end required either no support, or a reduced amount of support, this figure is currently at 84% compared to 72% the previous quarter

Residential Care Data

For the period September 2021 – March 2022, in comparison with September 2022 – March 2023 we have seen a 53% increase in people being discharged from hospital to recover at home. 345 people in 2021/2022 and 531 in 2022/2023. The data so far for 2023/2024 is continuing in a similar trajectory.
In the period Sept 2022 – Nov 2022 we had 116 people discharged into rehabilitation or short term care in a 24 hour setting but for the same period in 2023 we have reduced this number by nearly 10% (107).

Next steps

14. As highlighted in the presentation, there are a number of areas the Gateshead Health and Care teams have identified for further exploration in terms of continuing to improve pathways and address the remaining challenges. We also seek to share what works well in Gateshead with regional and national partners, though our networks and sector led improvement events.

Recommendations

15. Committee are asked to note the content of the report and presentation and comment on any areas of future development.

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