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A case study about reducing delayed discharge from hospital

Exploring how East Ayrshire Health and Social Care Partnership (HSCP) ensures that people are safely and legally discharged from hospital to home, or a homely setting, as soon as they are medically fit.

This case study reports on several initiatives which have reduced hospital bed days and risks to patients associated with delays in discharge. A key finding is that this success must be seen in the context of East Ayrshire HSCP's whole system approach driven by strong, consistent and caring leadership at all levels in the organisation, and a determined focus on person-centred outcomes.

The success in numbers

East Ayrshire HSCP has consistently met the target of zero patients delayed in hospital for over two weeks. Figure 1 shows this in comparison to the Scotland-wide rate of over two-week delays. Note that these figures exclude delays associated with guardianship issues (recorded as "Code 9" delays).

In terms of bed days associated with delayed discharge, this is now around 5 per 1,000 population in East Ayrshire, compared to a Scotland-wide average of around 10.

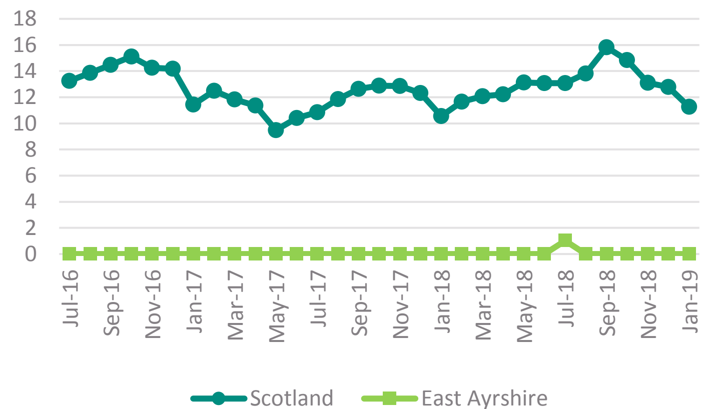

Figure 1: Number of delays over two weeks per 100,000 population (excluding code 9)

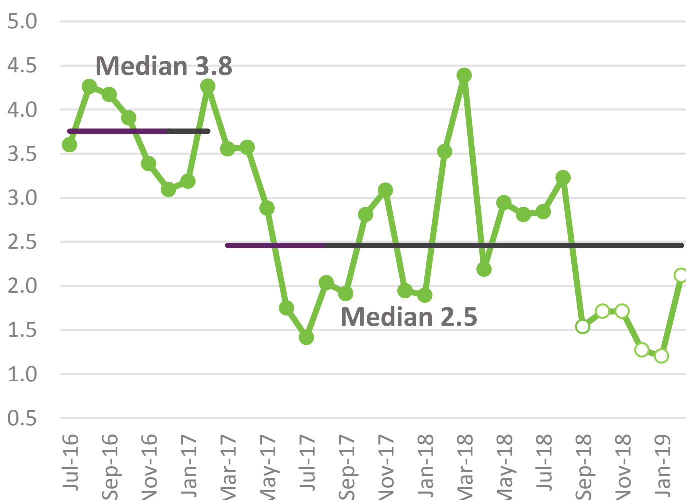

Figure 2: Monthly code 9 delayed discharge bed day rate per 1,000 population

There has been considerable progress, within this on guardianship issues (Code 9), with over 33% reductions in associated bed days saved per 1,000 population (see figure 2).

Care home placements reduced

This success has been achieved in tandem with reducing the need for care packages to support people at home (from 1,500 to 1,400 since 2015) and for care home placements. The HSCP now budgets for 700 care home beds, down from 760, enabling more budget to be shifted towards care services at home.

How did East Ayrshire HSCP do this?

Doing the right thing for the person

A health and social care partnership is a hugely complex operation, as is the management of hospital discharge so that it ensures the right support, at the right time and in the right place for each person. A case study of this scale can only begin to scratch the surface of this complexity. However, below we outline five initiatives thought to contribute most to getting people who no longer need hospital treatment, promptly, safely and legally home or to a homely environment. We then describe enabling factors thought to be key, in particular the HSCP's person-centred ethos and strong leadership.

Improvement initiatives

- **Early referral to hospital-based social work team (SWT) / presumption of return home**
  - The SWT worked closely with ward and hospital staff, monitoring patient data daily and taking part in hospital huddles in order to identify patients needing discharge support earlier in their hospital journey, as well as to ensure that the option of going home is fully explored.
  - This allowed more time for patients and families to make life-changing decisions and for appropriate support services and/or adaptations to be identified and organised.
- **Dedicated Mental Health Officer (MHO) for adults with incapacity (AWI)**
  - The MHO made applications for urgent interim court orders on the grounds of risk to health, to move AWIs to care homes, and supported families applying for guardianship orders.
  - Since 2016 this reduced average lengths of stays for those delayed awaiting guardianship orders by almost 40% and contributed to reducing the associated bed day rate by over a third.
- **Discharge to Assess (D2A)**
  - Some patients thought likely to need long term residential care, were moved to a care home (of their choice) for a full assessment – crucial for those becoming distressed or confused in an acute hospital environment.
  - There was an estimated annual saving of over 750 bed days, along with improved accuracy of, and patient engagement in, discharge assessments.
- **Intermediate care and enablement**
  - Where rehabilitation potential was identified, intensive needs-driven individualised support from a multidisciplinary team was provided, lasting typically four to six weeks. The focus was on supporting the individual to achieve their own goals, and maximise their independence.
  - By 2018, an estimated 3,000 bed days per month were saved due to facilitating earlier discharge, and more were saved through preventing admissions.
- **British Red Cross 'Home from Hospital' service**
  - This service transports patients home from hospital and supports them with initial settling in at home. Where need is identified, short-term case work is provided to address issues such as falls risk and social isolation.
  - An estimated 2,000 bed days have been saved every year by this service, of which approximately 1,500 were associated with reducing delayed discharge.

Key enabling factors

- **Leadership and person-centred ethos**
  - Strong, collaborative and enabling leadership, actively and visibly working to build and continually reinforce shared values and common goals across organisations and disciplines.
  - A widespread sentiment from the interviewees was "*do right by people and the money will look after itself*".
  - Finance also operates in alignment with these priorities.
- **Ownership of the delayed discharge target as a priority across the partnership**
  - "*Delayed discharge? Not on my watch*".
- **Flexibility of finance/budgeting to support priorities**
- **Whole system preventative approach**
  - A steady shifting of budget towards prevention and community/home care over years.
- **Integrated working values and practice**
  - Transparent, open approach to commissioning and service (re)design, engaging a diverse range of voices including from statutory services, third sector, service users and wider community.
  - Commitment to building mutual understanding of values and roles, and working with shared purposes across disciplines and health, social and community sector boundaries.
  - Spreading the understanding that hospital is not always the safest place to be for people.
  - A hospital-based social work team is integral to this, particularly to facilitating the development of better collaborative working between social work and healthcare workers.
- **Openness to improvement ideas from all parts of the partnership**
  - Creating a climate which encourages new ideas and contribution from all.
  - Acceptance of calculated risk-taking for improvement ideas: "*proceed until apprehended*".
- **Constructive party politics**
  - Senior managers noted that in relation to health and social care, the political groupings in the council work constructively together.

Sharing good practice

It is Healthcare Improvement Scotland's intent with this case study to share some of the ideas that have worked for East Ayrshire HSCP. We hope that the initiatives presented here, along with an exploration of key enabling factors, will provide enough information for other HSCPs to generate practical ideas for change in their organisation which reduce the time patients spend delayed in hospital once medically fit for discharge.

Acknowledgements

The successes described in this case study are down to the hard work, ingenuity, compassion and commitment of everyone working in and with East Ayrshire Health and Social Care Partnership. It is their achievement and we thank everyone who contributed for the not inconsiderable time they took to (patiently) share their knowledge and so make this study possible.

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