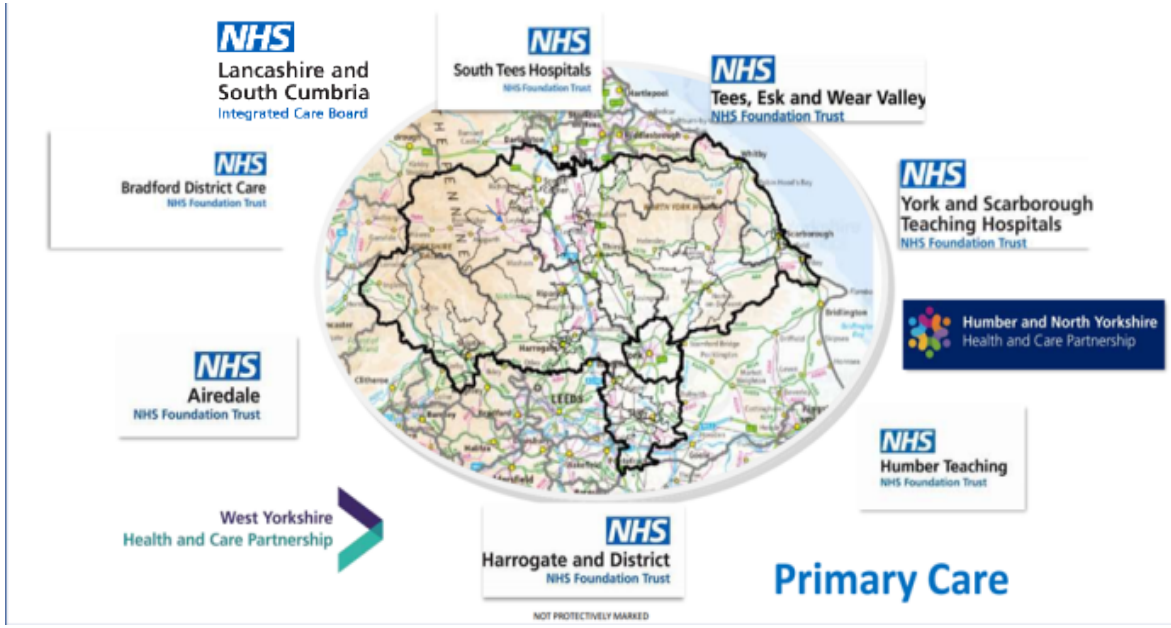
Hospital Discharge Overview

Quarter 1 2024

Hospital Discharge Overview

- 5 discharge hubs across North Yorkshire
- Working with 6 main Acute Hospital sites, but up to 17 hospitals refer in for discharge support
- Hub works as a multi-disciplinary team working virtually and in the hospitals to support discharge
- Hubs manage all discharges for:
  - Pathway 1 (home or to a usual place of residence with new or additional health and/or social care needs)
  - Pathway 2 (to a community bed-based setting which usually has dedicated recovery support)



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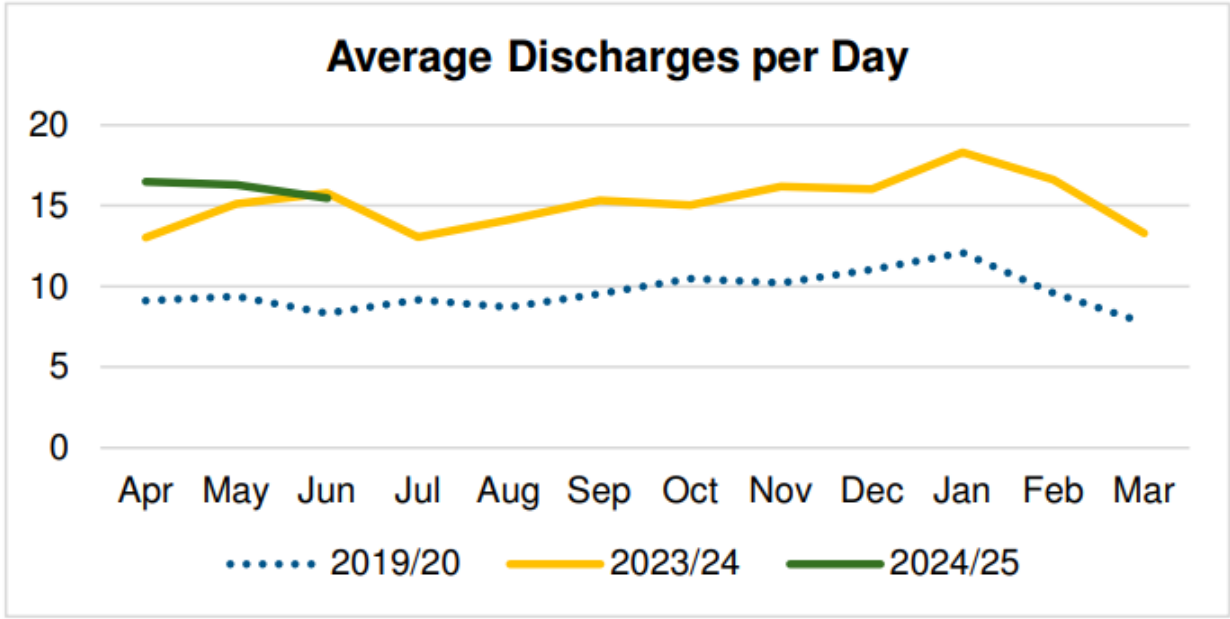
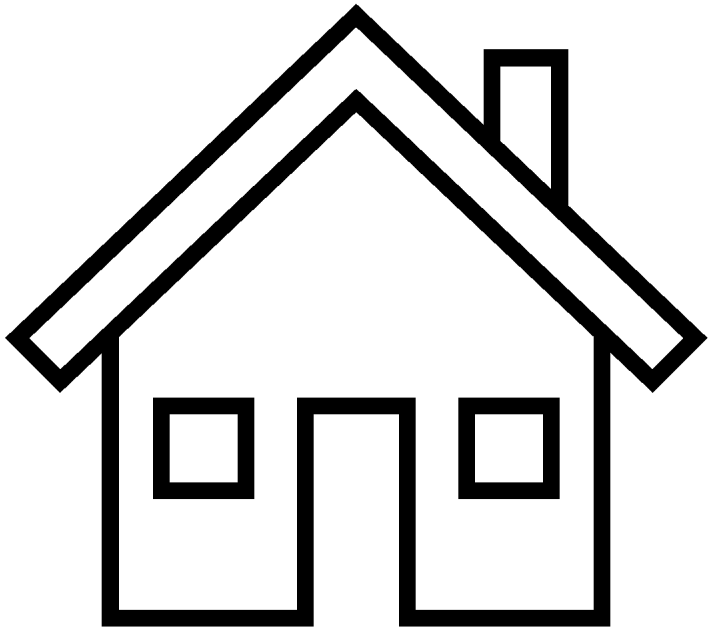
Pressures from hospital discharges

Key issues

- Hospital discharge activity averaged 16.1 per day during Q1, maintaining the level reported in Q4 (16.0) and Q3 (15.8). In 2023/24, the average for Q1 was 14.7 per day
- Pre pandemic discharges averaged at 9 per day
- Support to manage the increased demand for discharge is increasing pressures on reablement, discharge hubs and brokerage
- Regular high OPEL levels within the Hospital resulting in escalation
- Local activity is subject to high levels of volatility day-to-day, with local health and care systems continuing to be subject to localised surges in discharge activity, during Q1 there were 41 days where discharges exceeded 20 per day, compared with 34 days in Q4
- NYC receives a grant of £4m, but estimate of additional discharge-related short stay costs could be over £10m this year, this is a small fraction of the cost of people coming into social care following a hospital stay



Discharge to Assess



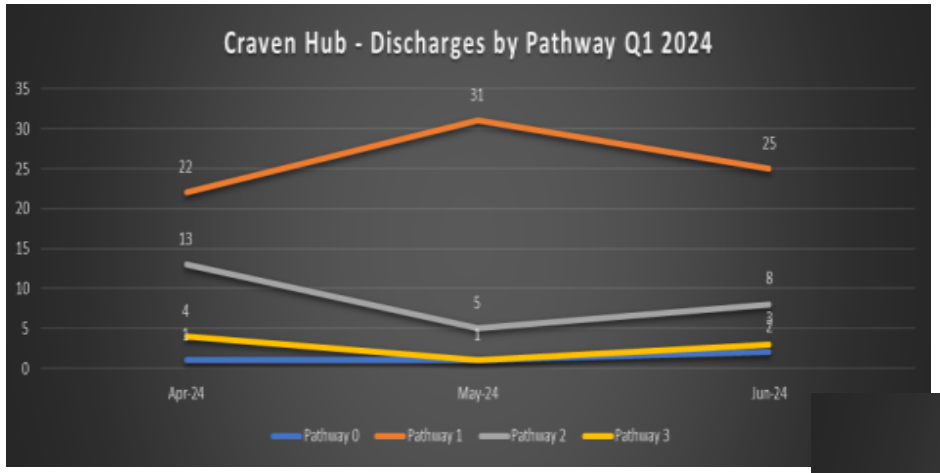
Pathway 0 – home with no support or restart of an existing service

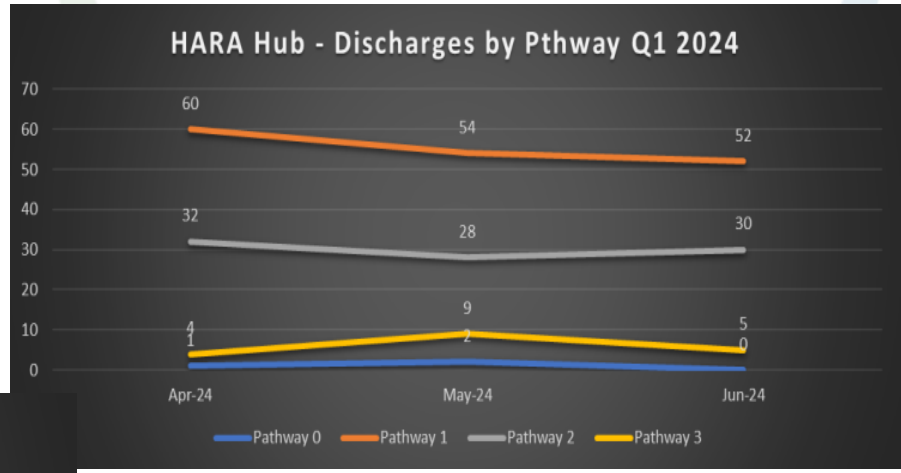
Pathway 1 – home with a newly commissioned service (reablement, bridging, package from the private market)

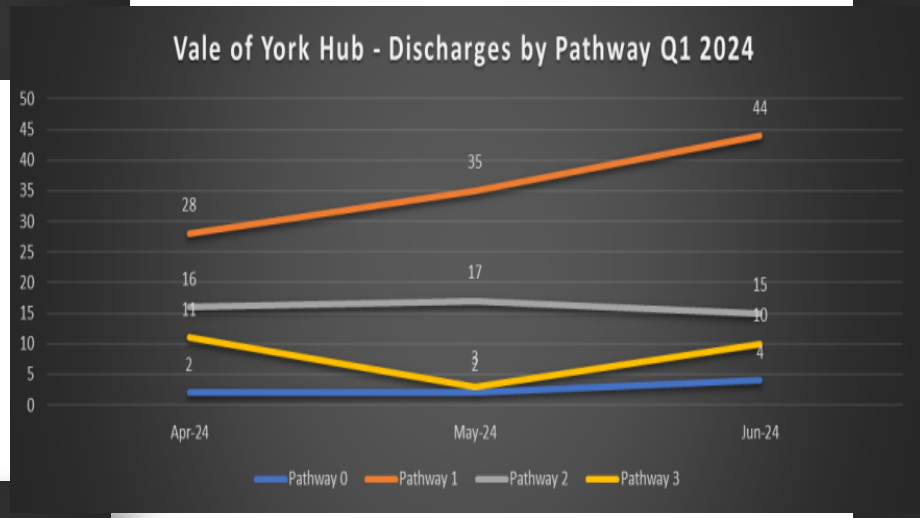
Pathway 2 – discharged to a short term placement (intermediate care bed, placement from the private market) with a view to retuning home

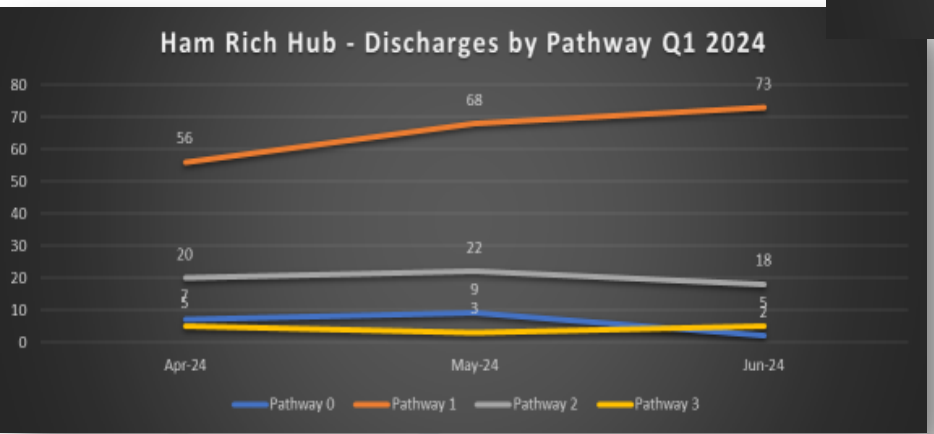
Pathway 3 – Discharged to short term placement with a view to most likely needing long term residential or nursing care

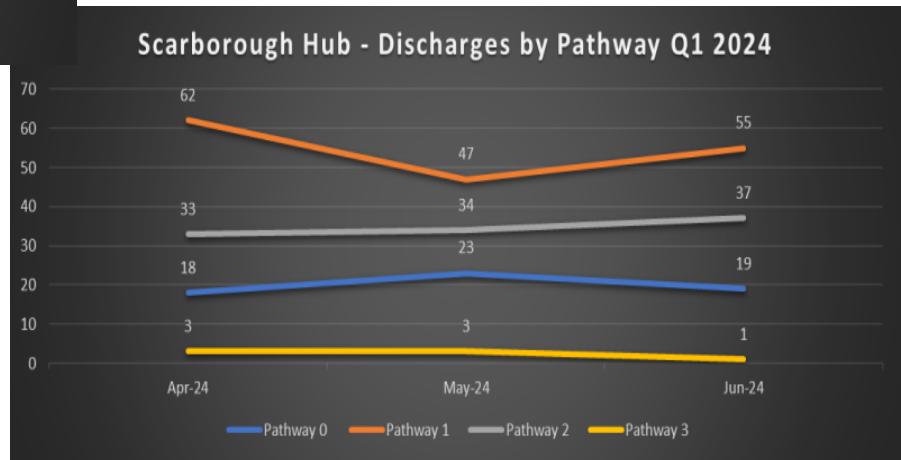
Discharge Hub Activity – Q1



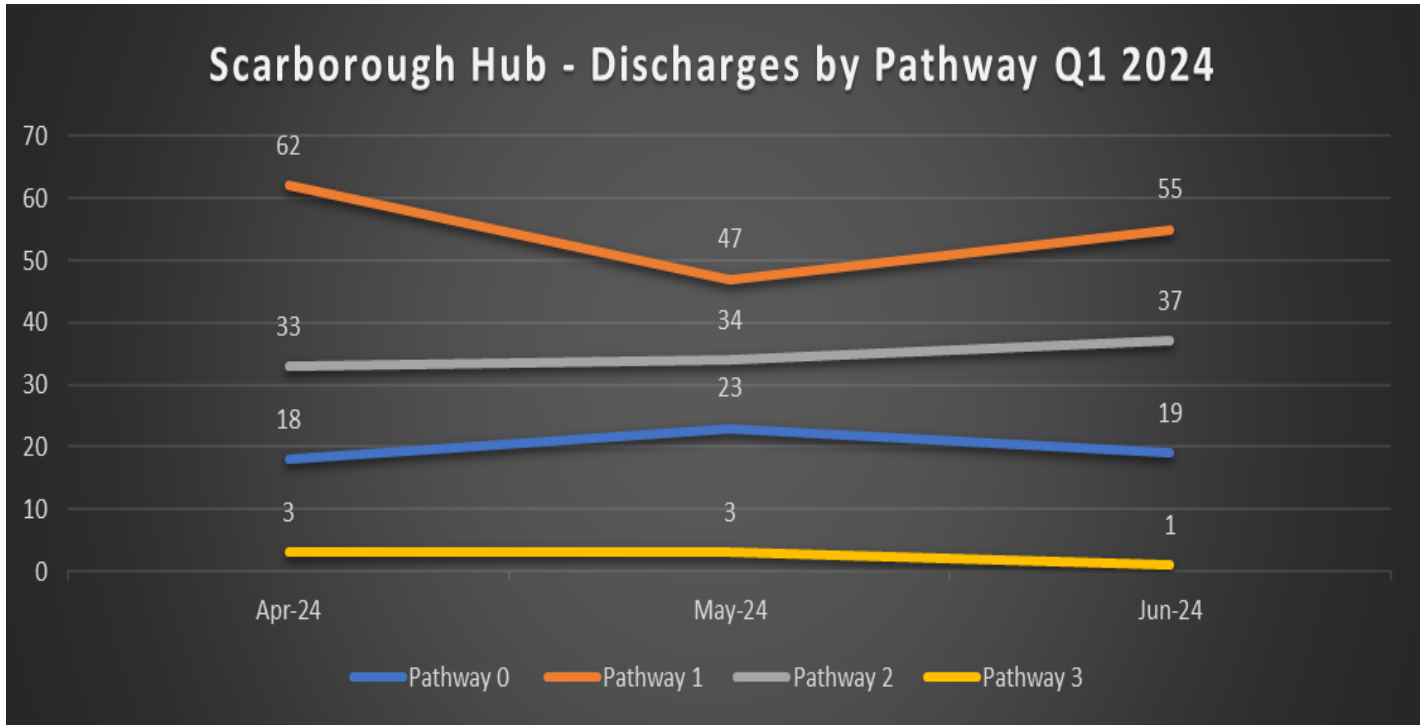








Focus on Scarborough Hub



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Pathway 3 – Discharged to short term placement with a view to most likely needing long term residential or nursing care

17% increase in referrals and discharges in Q1 2024 when compared with Q1 2023

Available in Scarborough to support discharges:

- NYC Reablement service (pathway 1)
- Bridging service – delivered by a home care provider (pathway 1)
- Spot purchased home care (pathway 1)
- Intermediate Care Beds – Block contracts with 3 providers in Scarborough and Malton (pathway 2)
- Spot purchased placements (pathway 2 & Pathway 3) Time to think beds commissioned by ICB for pathway 3

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Actions being taken

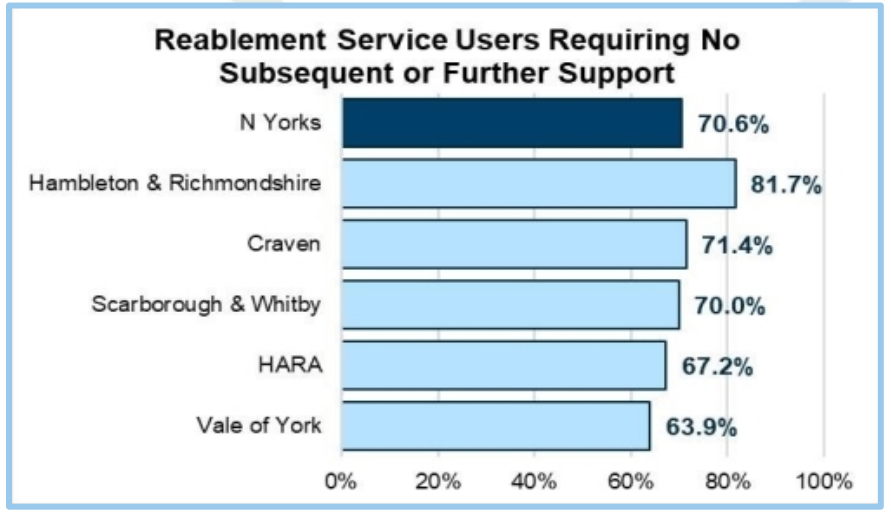
- Bridging service arrangements to address difficulties in sourcing home-based care and increased chances of short-term bed admissions
- Continuous improvement in reablement capacity, with less routine home care and less vacancies in reablement post s- this is a key improvement area for HAS
- Continuous implementation of the Home First principle
- Oversight of the use of short-term residential care beds
- Development of an integrated intermediate care offer, which includes a strong reablement offer and a focus on intermediate care through in-house provider services

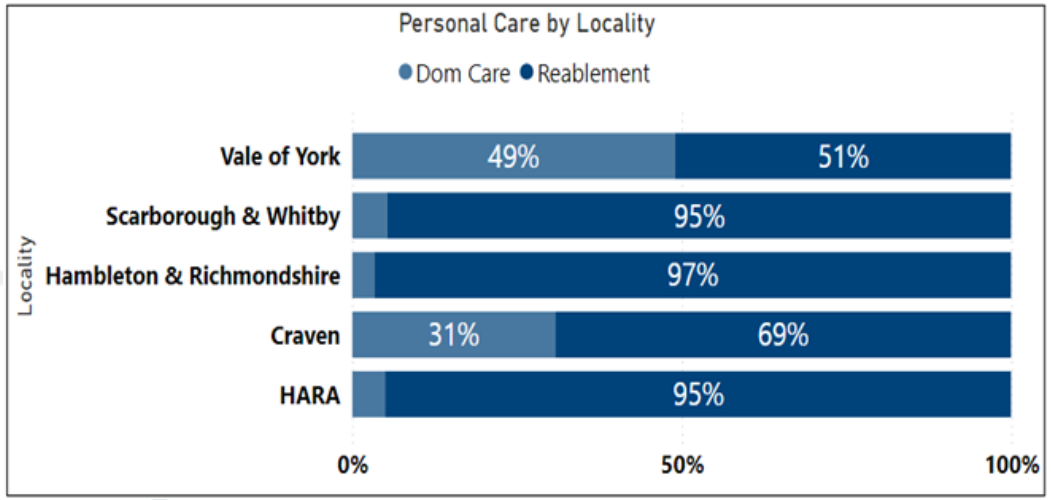
Key Improvement Priority – Reablement

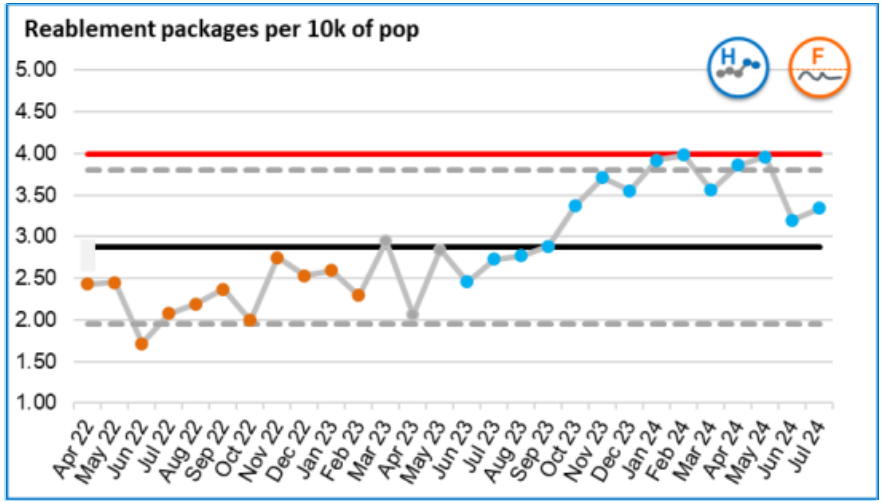
Headline: Significant progress made towards delivering ‘true reablement’ post Covid

Achievements over the past year

- Reablement activity continues to improve, 3.14 against a target of 3.99 Service starts for Apr-June were up by 42% compared with 2023/24;
- Social Care Coordinator linked to Reablement to provide extra support is being trailed;
- Vacancies in Reablement have reduced to around 10%







Actions being taken

- Continued focus to support people through the discharge pathways with a focus on home, monitoring of the length of stay in short stay residential care is ongoing (average 42 days in Q1)
- Need to secure more community-based therapy provision to ensure people coming out of hospital are receiving the best possible opportunity to return home to improve outcomes for people and reduce pressures on social care

Intermediate Care

Development of a new model

Objectives

Humber and North Yorkshire Health and Care Partnership

1. To build a new intermediate care model that delivers a more integrated and coordinated approach to health and social care, which supports people to be as independent as possible and enhances collaboration among health and care providers across different care settings.
2. To ensure prevention is embedded throughout the model, improving both short and long-term outcomes, preventing hospital admissions, re-admissions and long-term social care support
3. To develop and implement integrated processes for patients' pathway and residence decisions as part of hospital discharge planning and admission avoidance
4. To build on the strong front door and prevention model in adult social care and embed prevent, reduce and delay across the ASC (Adult Social Care) pathway

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Intermediate Care

High level principles of new model

Humber and North Yorkshire Health and Care Partnership

1. Person-centred and strength-based
2. ‘Home First’ approach
3. Therapy/Social work-led and MDT (Multi-Disciplinary Team) delivered
4. Free, responsive, 7-day delivery, single point of access.
5. Aligned with supporting services and health and social care community
6. Inclusive
7. High quality, outcomes driven, short term
8. Locality based
9. Single intermediate care hub for entry and exit
10. Prevention embedded throughout the model

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Intermediate Care - Key ‘ingredients’ for a high performing model

Capacity	Presence of a dynamic care market which can respond well to extra demand (both domiciliary and non-domiciliary)
Grip	Robust efficiency of services and oversight of provider performance, enabling accountability
Relationships	Strong and trusting relationships between providers and commissioners
Technology	Acute trusts, councils and care providers using the same systems enabling reliable and fast communications
Integration	Integration staff, aligning incentives across health and care
Optimisation	All parts of the system needs to be working at its optimum

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