Reducing long hospital stays

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Why is this important

- Staying in hospital is bad for patients – acute and community it leads to deconditioning and harm and for many patients never returning to their homes after their hospital admission
- This is about improving quality – better outcomes for people – better for staff and maximises the use of resources improves flow and reduces time people spend in ED
- 20 – 25% admissions do not need to have come into hospital
- 50% of bed days are not required for clinical reasons could be managed in a lower level of care preferably at home
- 39% of people could have been discharged on lower level pathways.
- At least 50% of the reasons for not needing to be in hospital are in the direct control of the hospital
- 350000 patients spend over three weeks in hospital each year
- We want to move from solely focussing on DTOCs who are a small part of this cohort of patients
- For most systems a reduction of between 27 – 23% in beds days for people who have been in hospital more than 21 days
- The aim to free up 4000 beds by December
- Overlaps with DTOC targets in BCF, about 25% of people in hospital 21 days and over
This is about people
First Steps

• Have to understand the problem?
• Guide to Reducing Long Length of Stay
• Review weekly on the wards of all patients 21 days and over
• Focus on frailty
  • Identify at the front door (frailty screen)
  • Diagnose and manage delirium
  • Track through the hospital those at risk of increased stay (PARIS)
  • Ask every day ‘why not home, why not home today’?
What does good like for over 65’s?

- Discharged NFA 700
- Admitted to Hospital 1,000
- Discharged requiring further support 300
  - "Low-level" support (eg follow-up from therapist or District Nurse) 50
  - Intermediate Care
  - Short-term Reablement based residential care bed with therapeutc and nursing support 25
  - Domiciliary Support (eg Reablement based) 225
  - On-going Domiciliary Support 86
  - Residential Care 8