ITEM No …8………..

REPORT TO:	**HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 26TH OCTOBER 2022**
REPORT ON:	**MANAGEMENT OF DELAYED DISCHARGES**
REPORT BY:	**CHIEF OFFICER**
REPORT NO:	**DIJB75-2022**

1.0 PURPOSE OF REPORT

1.1 This report sets out the actions being undertaken to manage and reduce the numbers of delayed discharges attributed to Dundee Health and Social Care Partnership across hospitals in Tayside. Locally, a RAG matrix has been established which lays out the daily position in relation to delayed discharges and the targets agreed. The current position in relation to complex and standard delays in Dundee is 22 and 33 respectively, totalling 55 with a target of 50 by end of October. In relation to the national Urgent and Unscheduled Care Collaborative, measurement of the Tayside 'Discharge Without Delay' rate is also measured on a weekly basis against a target of 98%. Current performance is 97.7% across Tayside.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the work being undertaken to address delayed discharges

2.2 Notes the work of the Urgent and Unscheduled Care Board and the associated change projects.

2.3 Notes performance against the Discharge Without Delay indicators remain high at 97.7%.

3.0 FINANCIAL IMPLICATIONS

3.1 Investment has been identified from delegated recurring resources to Dundee Health and Social Care Partnership, additional recurring Scottish Government allocations, and National Urgent and Unscheduled Care Collaborative. Where appropriate, these investments have already been incorporated in and reported to the IJB as part of the 2022/23 Financial budget

3.2 These recurring investments include £5.5m to support increased capacity and new models of care, £6.5m to meet national policy relating to increased social care pay (to improve social care sector viability and secure longer-term sustainability), and £0.8m to support additional local social care sustainability.

3.3 £1m existing resources is to be re-invested in the Discharge to Assess social care model which is currently being reviewed and redeveloped (see section 4.5)

3.4 Non-recurring investments during 2022/23 include £0.6m to support interim and step-down care placements and packages, plus additional funding through Tayside Unscheduled Care Board funding £0.5m for tests of change to further develop team capacity and discharge pathways.

3.5 There are no additional financial implications as a result of the known and planned investments.

4.0 MAIN TEXT

4.1 The continued focus of strategic planning in Dundee remains the development of integrated, multidisciplinary services in community settings in order to shift the balance of care away from acute hospital and institutional settings towards a more community facing whole system pathway of care. While this strategy had proven itself effective prior to the pandemic, the recent combination of staff absence and turnover, increased demand and acuity have been challenging.

4.2 Availability of social care is the biggest challenge in relation to both complex and non complex delays. For a significant number of those delayed, the ability to source support packages is an ongoing challenge. This mainly surrounds internal and external care providers struggling to recruit and retain the level of staffing required. There has been a 23% increase in demand for social care services since August 2021. As at April 2019, DHSCP was providing 19,133 hours of social care per week across both inhouse and commissioned services. In the 2 years since then provision has risen by approximately 2000 hours per week. This is a broader issue within social care both locally and nationally.

4.3 In relation to adults with learning disabilities and mental health difficulties there are a number of additional challenges. One of the new housing developments was delayed prior to Covid and this has continued due to building/developer issues There are a number of specific individuals who present differently within the community compared to within a ward environment. This can lead to challenges in sourcing residential type care both locally and across Scotland.

There is the acknowledgment locally that we require to consider developing our own provision for a specific group of individuals that have complex and challenging behaviours. A local build of a new model of support for 3 people with complex and challenging behaviour has been awaiting development since before the pandemic. The model was developed through a multi- disciplinary assessment process and it is anticipated that similar developments could be commissioned Tayside wide into the future. The model provides the benefits of a housing model but incorporates communal areas, and will be staffed by a health and social care multidisciplinary team.

4.4 Of the 22 patients currently coded as complex delays, 13 fit within the mental health or learning disability category described above. The others are delayed almost exclusively as a result of ongoing Adults with Incapacity legal processes and are accommodated out with the acute hospital. Whilst Adults with Incapacity delays remain higher than they have previously been, this continues to constitute a significant improvement both in terms of number of people and bed days lost, due to the ongoing impact of previous improvement work.

4.5 A number of actions are in place to support improvement in our delay position. These support the overall strategic intentions to shift the balance of care and support people in their own homes with integrated Multidisciplinary teams. While at times a hospital admission will be required discharge planning should start at the beginning and not the end of their stay.

Development of the existing Discharge to Assess service to create a Home First social care service which supports early discharge from the acute hospital for completion of assessment in a community setting, as well as providing care to support clinical interventions in the community as an alternative to admission. When first tested in 2018, this approach demonstrated both significant reductions in delayed discharges and improved patient outcomes and experience.

4.6 Continue to roll out the Planned Date of Discharge policy across all ward areas to promote good discharge planning practice and encourage improved multidisciplinary working. A member of staff has been seconded to deliver training in each ward area, incorporating use of the Trakcare patient management system, good practice in multidisciplinary working, and support for ward areas to identify their specific developmental needs in relation to this.

4.7 Continue to develop a Tayside wide approach to discharge planning with the Dundee Discharge Team facilitating discharge for all patients in Dundee hospitals regardless of their home location.

4.8 Continue to promote the embedding of discharge coordinators within ward areas as a means of further promoting multidisciplinary working which is underpinned by locally agreed good practice principles.

4.9 Developing tests of change which promote increased morning discharges thereby creating additional capacity across inpatient settings.

4.10 Reinstate weekend working within the Discharge Team following covid contingency measures, as a means of supporting discharge planning across seven days. Across Tayside, 25% of our discharges are already taking place over the weekend which is significantly higher than the current national average.

4.11 Continue to develop the Transitions Team based at the front door assessment area of the acute hospital which provides rapid functional assessment by an occupational therapist and which is then followed up at the point of discharge by the same professional into a community setting.

4.12 Continue to offer interim care home placements to any patient delayed in hospital awaiting social care provision. In addition, 8 intermediate care beds are available for Older People Psychiatry in Turriff House, and a further 6 beds for step down from hospital for older people in Menzieshill House.

4.13 Continue to develop improved pathways in line with the National Urgent and Unscheduled Care Collaborative.

4.14 Relaunch existing Enhanced Community Support Team as multidisciplinary cluster focussed team including Transitions Team, Home First and Hospital at Home.

4.15 Alignment of inpatient geriatric consultant workforce to the four General Practice Clusters.

4.16 Recruitment to 2 additional support workers, and 2 additional Advanced Nurse Practitioners to coordinate and provide clinical leadership for the community multidisciplinary cluster focussed team.

4.17 Relaunch of community urgent care service incorporating all of the above cluster focussed services as the renamed Dundee Enhanced Care at Home Team. A further report will be prepared which provides more detail on this development.

4.18 Action plan in place to improve social care availability.

4.19 Additional investment in social care combined with a detailed action plan to address the capacity challenges which includes recruitment, retention, embedding of fair work principles, redesigning the front door to ensure people get the right support a the right time and work to establish multidisciplinary community teams.

5.0 COMPLEX DELAYS SPECIFIC TO MENTAL HEALTH AND LEARNING DISABILITY

5.1 Ongoing commissioning arrangements with both accommodation and support providers to address the complex and long term needs of these service users.

There has been significant improvement work undertaken across the whole system around pathways in and out of hospital care. A whole system capacity and safety huddle is now in operation, which centres around a Mental Health Command Centre dashboard. The dashboard provides real time patient movement and service capacity.

The development of a Mental Health Discharge Hub in Dundee during 2020 has served to strengthen support for people when they are discharged from hospital. A multi- disciplinary pathway approach, as part of our overall CMH provision, continues to be taken. The Hub was developed following learning gained from adverse events reviews, which highlighted the increased risk to people in the immediate weeks following a hospital stay

6.0 POLICY IMPLICATIONS

6.1 This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

7.0 RISK ASSESSMENT

No risk assessment required as report for information only.

8.0 CONSULTATIONS

8.1 The Chief (Finance) Officer and the Clerk were consulted in the preparation of this report.

9.0 DIRECTIONS

9.1 The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working) (Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Direction Required to Dundee City Council, NHS Tayside or Both	Direction to:	
	1. No Direction Required	X
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

10.0 BACKGROUND PAPERS

10.1 None.

Vicky Irons
Chief Officer

DATE: 28 September 2022

Lynne Morman
Associate Locality Manager