ITEM No …7……..

REPORT TO: **PERFORMANCE AND AUDIT COMMITTEE – 27 SEPTEMBER 2023**

REPORT ON: **DISCHARGE MANAGEMENT PERFORMANCE - UPDATE ON COMPLEX AND STANDARD DELAYS**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC26-2023**

1.0 PURPOSE OF REPORT

1.1 To provide an update to the Performance and Audit Committee on Discharge Management performance in Dundee.

2.0 RECOMMENDATIONS

It is recommended that the Performance and Audit Committee (PAC):

2.1 Note the current position in relation to complex delays as outlined in section 5, standard delays as outlined in section 6, and discharge without delay as outlined in section 10.

2.2 Note the improvement actions planned to respond to areas of pressure as outlined in sections 8 and 10.

3.0 FINANCIAL IMPLICATIONS

3.1 None.

4.0 MAIN TEXT

4.1 Background to Discharge Management

4.1.1 A delayed discharge is a hospital inpatient who is clinically ready for discharge from inpatient hospital care and who continues to occupy a hospital bed beyond the ready for discharge date (Public Health Scotland Delayed Discharges Definitions and Data Recording Manual).

4.1.2 The focus on effective discharge management is reflected through the National Health and Wellbeing Outcomes and associated indicators. There are two indicators that relate directly to effective discharge management:

- National Indicator 19: Number of days people spend in hospital when they are ready to be discharged; and,
- National Indicator 22: Percentage of people who are discharged from hospital within 72 hours of being ready.

4.1.3 Within Dundee, key staff work collaboratively with the Tayside Urgent and Unscheduled Care Board in order to deliver on the strategic plan as set out by the National Urgent and Unscheduled Care Collaborative. The focus of this work is to deliver care closer to home for citizens of Dundee and to minimise hospital inpatient stays wherever appropriate.

4.1.4 The Tayside Urgent and Unscheduled Care Board is chaired jointly by the Head of Health and Community Care for Angus Health and Social Care Partnership and the Associate Medical Director for Medicine in NHS Tayside. Membership of the Board is made up of senior staff from key clinical areas. The Dundee position is represented by the Associate Locality Manager for

Acute and Urgent Care. Liaison between the local Board and the national team is undertaken by a Programme Manager within the NHS Tayside Improvement Team.

The Urgent and Unscheduled Care Board is currently working on the revised workstreams for 23/24, which will continue to focus on the existing agreed priorities, but will also expand the scope. A particular focus this year will be on a further expansion of the Discharge Without Delay work with the aim of achieving upper quartile performance against length of stay in all inpatient areas across Tayside.

4.1.5 A large amount of weekly and monthly reporting is provided at management level to monitor, plan and make improvements with regards to discharge management. This includes:

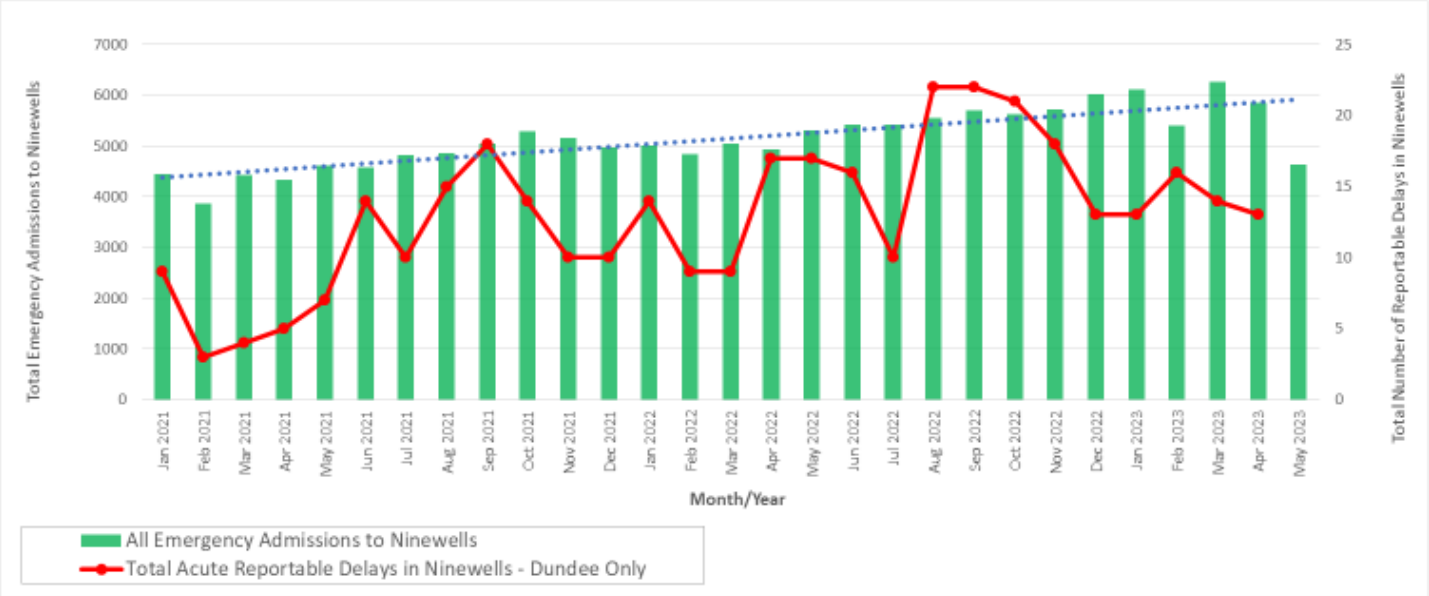
- weekly 'RAG' snapshots across all sites;
- weekly Tayside level 'Discharge Without Delay' key measurement which is also used to populate the Local Oversight Reporting suite of measurement;
- monthly 'Planned Date of Discharge' report;
- Discharge Without Delay Action plan updated weekly.

In addition, on a weekly basis a snapshot report of the delayed discharge position in Dundee is provided to the Dundee Health and Social Care Partnership Chief Officer, the NHS Tayside Chief Operating Officer and other key senior staff across Dundee Health and Social Care Partnership and NHS Tayside. This information is used to maintain an ongoing focus on enabling patients to be discharged from hospital when they are ready, as well as to inform improvements outlined in this report.

5.0 CURRENT PERFORMANCE IN RELATION TO DELAYED DISCHARGES

5.1 Performance in relation to delayed discharge has continued to improve since October 2022, despite a sustained increase in unscheduled admissions during that time period. Since a peak of delayed discharge in mid-August 2022 of 18 acute delays, and a total of 55 delays across all sites, performance in relation to the locally agreed RAG matrix has consistently been in amber status since week beginning 10 May 2023 and continues to reduce. Performance reporting beginning 22 May 2023 is now within the green section of the RAG matrix for both acute and non-complex delays (6 and 16 respectively) and in amber for the total delay figure (38).

Graph showing level of reportable delayed discharges for Dundee HSCP in the context of increased admission rates to Ninewells Hospital on a monthly basis



Source: Qlikview – Filters: All emergency admissions to Ninewells. Includes patients of all ages from all Local Authorities between Jan 2021-April 2023 coded as an emergency admission to hospital. Delay figure taken from monthly census point (last Thursday of the month) for each month – only includes complex and non-complex reportable delays with Dundee City as the Responsible Local Authority. Health delays and code 100's are not included as these are not reportable to SG.

5.2 This demonstrates a specific improvement in relation to the management of non-complex delays the reason for which had predominantly been the ongoing increased demand for social care. Despite sustained increase in admission rates, performance in relation to the management of non-complex acute delays has continued to improve.

6.0 CURRENT PERFORMANCE IN RELATION TO COMPLEX DELAYS

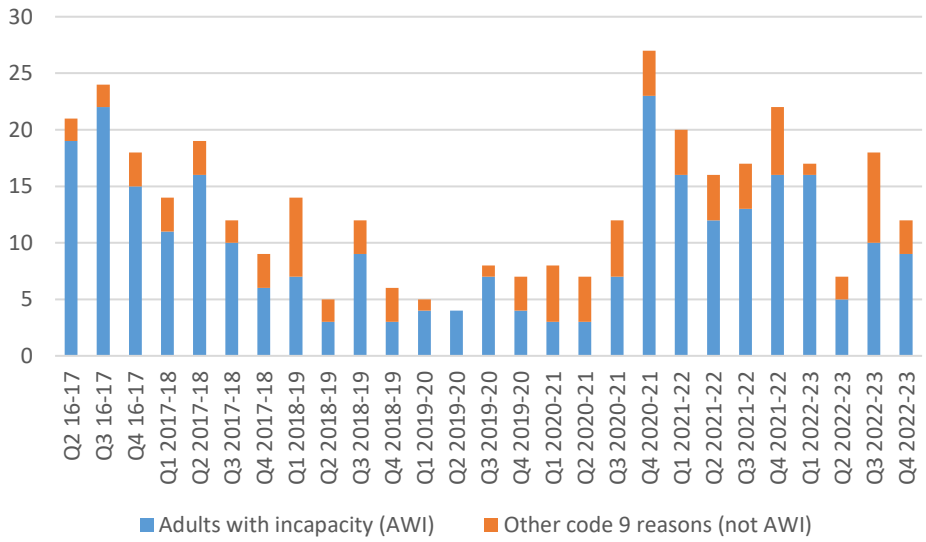
6.1 Complex Delays - Current Situation

6.1.1 A 'Complex Delay' (also known as a 'Code 9' delay) counts adults aged 18+ who have been delayed in their discharge from inpatient hospital care due to: waiting for a place in a specialist facility and no such facility exists in the partnership area and no interim option is appropriate; awaiting completion of complex care arrangements in order to live in their own home; Adults with Incapacity legislation requirements; or, people exercising their statutory right of choice where no interim placement is possible or reasonable.

Complex delays can be split into two main age groupings, and specific approaches to improvement have been adopted for each.

The position in relation to the 75+ age group is detailed in Chart 1 below:

Chart 1: Number of Complex Delayed Discharges Split by Reason for Delay Age 75+



Source: PHS Delayed Discharge Census

As previously reported, there was a significant improvement in performance in relation to complex delays for the 75+ group between 2016/17 and 2020/21. In part, this reflects the success of the 'Discharge to Assess' model which promotes discharge prior to major assessment decisions being made. The aim of this is to reduce the numbers of patients moving directly to a care home from hospital, and therefore reduces the demand for guardianship applications under the Adults with Incapacity legislation.

Delays linked to Adults with Incapacity guardianship applications in the 75+ age group began to rise during 2021 and they have remained high since. This is largely due to the impact of the COVID-19 pandemic, which increased hesitancy in the general population around the safety of care homes, at a time when the ability to recruit to social care reduced significantly and demand for social care rose sharply. These factors have led to a situation where there has been less resource available to continue with the 'Discharge to Assess' model and a consequent increase in the numbers of patients requiring to move directly to care homes from hospital.

As the Discharge to Assess model continues to remobilise post pandemic, it is expected that performance in this area will begin to improve again.

Additionally, a dedicated Mental Health Officer (MHO) is once again working within the Integrated Discharge Hub, and is tasked with raising awareness of issues associated with Adults with Incapacity, as well as streamlining and reducing delays associated with guardianship applications.

There is a growing number of older adults whose needs cannot be accommodated within the current local care home resource and for whom more complex discharge planning is required. Plans are ongoing to remodel local authority care home provision as a means of ensuring older people with the most complex needs receive appropriate care and support.

6.1.2 Chart 2 outlines the position for the 18-74 age group. Again, a programme of long-term improvement work between the Partnership and Dundee City Council Neighbourhood Services which was planned to release further housing stock throughout the second half of 2019/20, has been further delayed due to the pandemic and other delays in construction. This plan remains in place and will provide accommodation for the majority of these younger adults with complex needs.

Chart 2: Number of Complex Delayed Discharges Split by Reason for Delay Age 18-74

Source: NSS ISD Delayed Discharge Census

6.1.3 In collaboration with the Urgent and Unscheduled Care Board and the NHS Tayside Improvement Academy, an additional discharge coordinator has been recruited on a permanent basis, who will focus specifically on implementing the good practice already established in the acute hospital within General Adult Psychiatry.

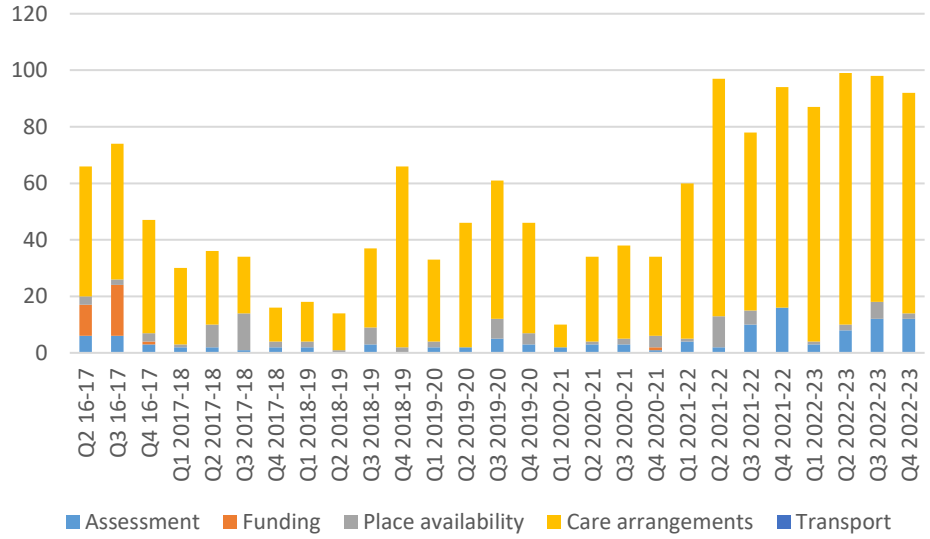
7.0 CURRENT PERFORMANCE IN RELATION TO STANDARD DELAYS

7.1 The position in Dundee regarding standard delays has continued to deteriorate over the previous 12 months as a result of the challenges noted above in relation to the matching of social care availability with rising demand. During 2017/18, the introduction of the 'Discharge to Assess' model enabled the majority of patients to be discharged on their Planned Date of Discharge as the assessment of their needs could be undertaken in a community setting.

7.2 Throughout 2022/23, local care agencies continued to experience recruitment challenges which has been the main contributor to the increase in standard delays. Although interim care home placements have been offered to those patients awaiting social care packages to facilitate their discharge from hospital, many patients and their families have chosen not to accept this option.

7.3 As we remobilise post pandemic, social care recruitment is beginning to improve. Additionally, Dundee has entered into a new test of change with British Red Cross aimed at enhancing those improvement measures outlined in previous reports. As a result, a reduction in standard delays can be seen in Q4 22-23. Chart 3 below shows the deteriorating position in relation to standard delays. Chart 3 also demonstrates that standard delays are now almost exclusively attributable to the non-availability of social care.

Chart 3: Standard Delayed Discharges by Principal Reason for Delay 18+ at Census Day each Month



8.0 IMPROVEMENT ACTIONS IDENTIFIED TO ADDRESS INCREASE IN STANDARD DELAYS

8.1 As previously reported, a locality modelling programme has commenced to ensure best use of existing staff resource across the Partnership. This will create multi-professional teams based within geographical localities, thereby reducing duplication and maximising efficiencies. This will support workforce remodelling and create staff resource to undertake social care review function more robustly. A barrier to this is the increasing vacancy levels within both care management and community nursing teams.

8.2 Building on the existing community urgent care services in Dundee, the Partnership has now launched the Dundee Enhanced Care at Home Team (DECAHT), aimed to work in a multidisciplinary way across a single frailty pathway which promotes patient focussed decision making and fewer barriers between stand-alone services. The service is GP cluster focussed and multidisciplinary, drawing on the clinical expertise of the Hospital at Home clinicians as well as the cluster geriatricians who are based in inpatient settings but who will provide support and advice to the Advanced Nurse Practice led cluster teams. The service has a single point of access for GP practices, thereby simplifying the referral process and ensuring the patient receives the appropriate level of clinical assessment and input. The service will be supported by the developing Discharge to Assess social care service which will provide wraparound support for people in their own homes during periods of ill health as a means of avoiding hospital admission wherever possible and appropriate. Additionally, a Transitions Team comprising occupational therapy and physiotherapy staff has been developed which will functionally assess patients at the front door assessment areas of the acute hospital or within urgent care, and follow the patient to their own homes to embed the rehabilitation plan within the social care assessment package. Regular whole system multidisciplinary meetings will ensure the patient's care continues to be provided in the right place, at the right time by the right person. In order to make best use of the scarce social care resource, third sector partners are also involved in these discussions.

8.3 A Programme Manager for Urgent and Unscheduled Care has now been appointed within the Partnership which adds extra resilience in terms of creating a governance and reporting structure around this developing work. Priorities have now been grouped into distinct workstreams which focus on the further development of the above service with the aim of creating a seamless pathway of care for frail older adults which supports primary care and delivers care and treatment closer to home.

8.4 This structure is being developed with support and collaboration from the NHS Tayside Urgent and Unscheduled Care Board in recognition that the focus of our work is increasingly community facing.

8.5 Linked to the development of DECAHT, as described above, is the crucial relationship with the Acute Medicine for the Elderly Unit (AME). The new model will ensure transitions between this inpatient assessment area and community urgent care are seamless in order to ensure frail older adults spend as little time in hospital as possible. .

8.6 The eight bedded unit within Turriff House continues to provide step up/down alternatives to inpatient psychiatric rehabilitation for older people.

8.7 In addition to the DECAHT service, alternative advanced practice models such as advanced paramedic roles, are also being explored with a view to the ongoing multidisciplinary development of the urgent care service.

8.8 The Care Home Team continues to undertake development work with local care homes as a means of preventing admission to hospital when appropriate.

8.9 Testing of a Lead Advanced Nurse Practitioner (ANP) model is ongoing with 3 Lead ANPs now in post (2 permanent and 1 temporary). These postholders are tasked with leading on the implementation, governance and management of the ANP led cluster model, as well as developing a competence framework which supports continuous professional development for all ANP staff. As the governance and reporting structure for the DECAHT workstreams above is developed, clearer measurement of the impact of this model will be available.

8.10 The other major improvement workstream identified as part of the Urgent and Unscheduled Care programme for Dundee is the development of a stroke/neuro pathway. Again, the focus will be on reducing length of stay through the creation of more community rehabilitation and support services.

9.0 OCCUPIED BED DAYS DUE TO DELAYED DISCHARGE

Chart 4 Average daily delayed bed days occupied, age 18-74

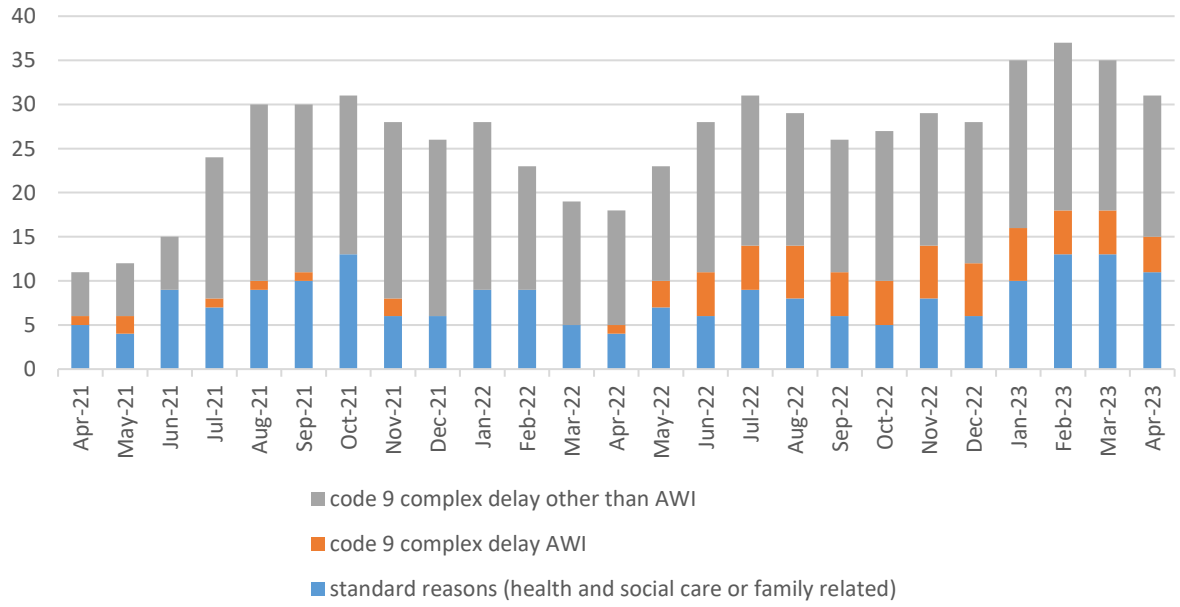
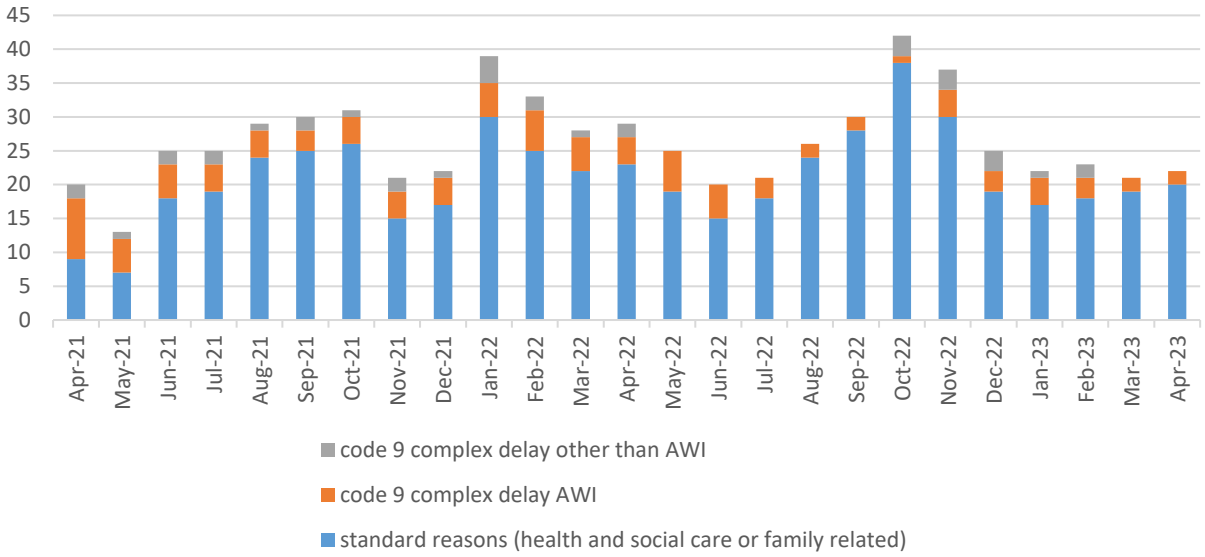
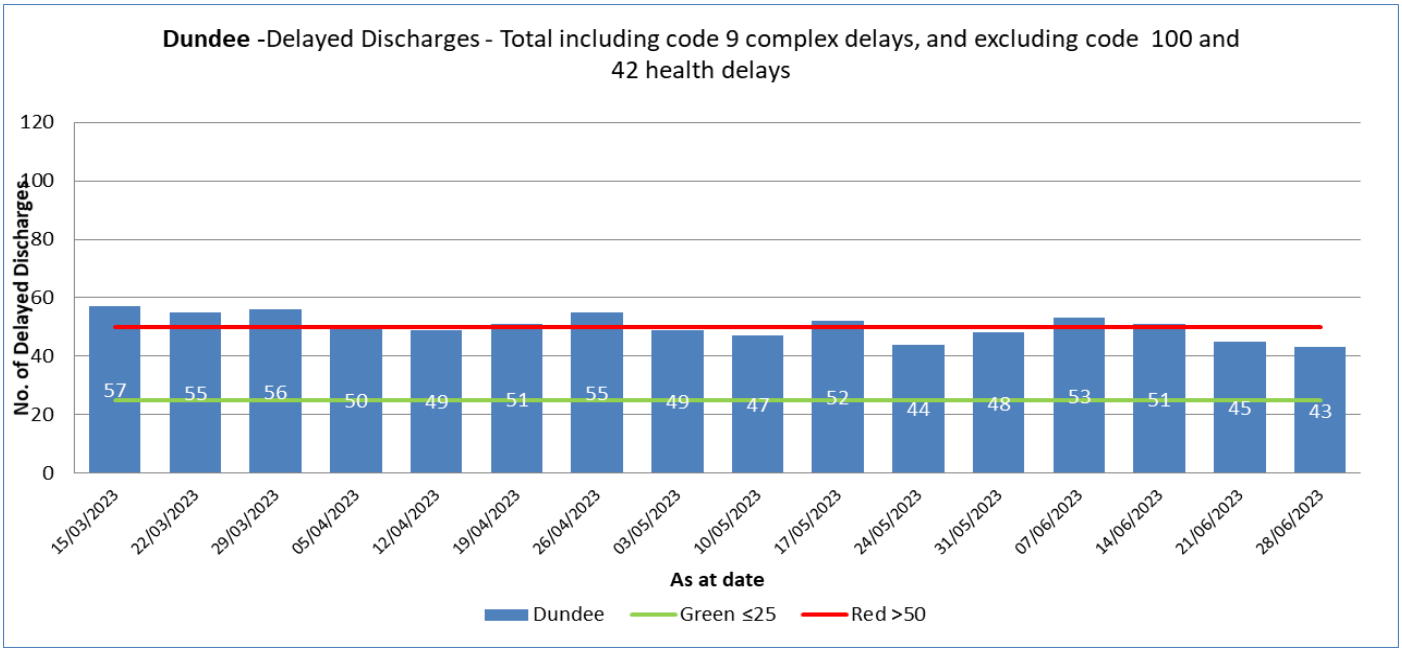


Chart 5 Average daily delayed bed days occupied, age 75+



9.1 It can be seen from charts 4 and 5 that the principle reason for delay in the 75+ age group is almost entirely attributable to the demand for social care as a means of supporting people to remain in their own homes.; both the average daily occupied bed days and the number of people delayed are high, whereas, delays for the younger adult age group continue to highlight a lack of availability of more specialised accommodation and support options predominantly for adults with complex mental health issues and/or learning disabilities. Both the average occupied bed days and the number of delays are high.

Chart 6 Dundee Delayed Discharges – Total including complex delays

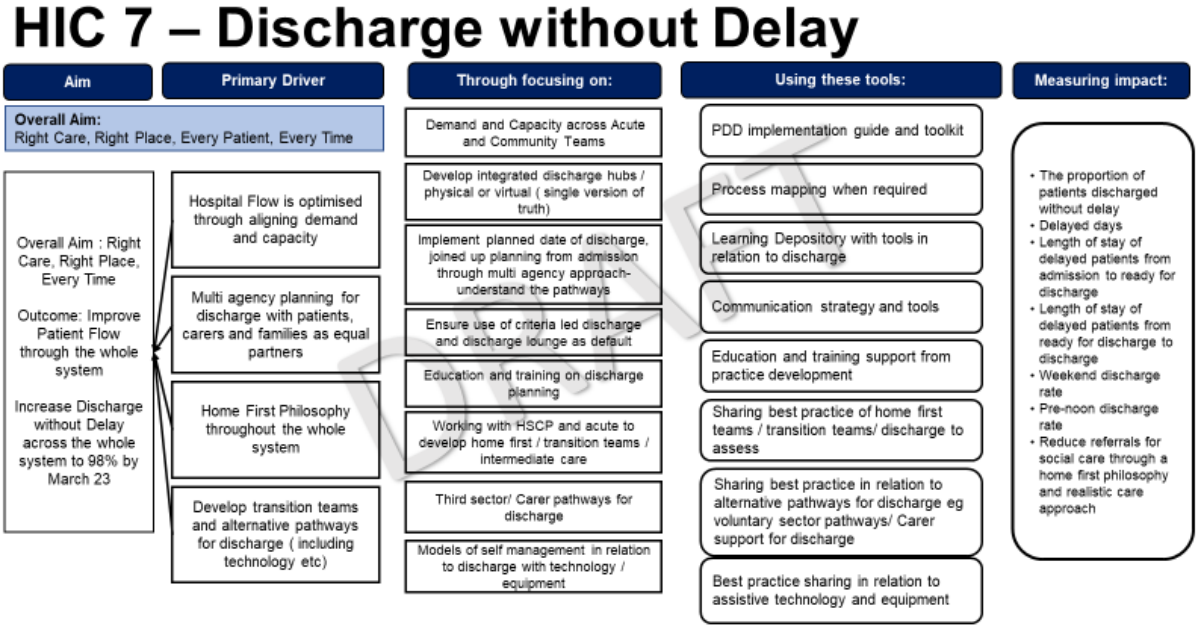


9.2 The overall Tayside delay position is presented as part of the Board Business Critical Tayside level report for scrutiny at the Tayside Operational Leadership Group, which is chaired by the Medical Director and attended by senior representatives from each Tayside authority. As part of the Tayside wide strategic approach, local targets with timescales have been set for each Health and Social Care Partnership both for overall reduction in delays and specifically reductions in standard delays within the acute hospital. Chart 6 above demonstrates the

improving Dundee performance against the target set to reduce to AMBER status (<50 delays) by end of October 2022. Whilst the target for October 2022 was not reached due to ongoing increased demand and winter pressures, Dundee has consistently reported AMBER since April 2023 with the non-complex delays continuing to reduce. Complex delays within General Adult Psychiatry remain stable but high, which is a key contributor to our inability to date to reduce to GREEN RAG status.

10.0 DISCHARGE WITHOUT DELAY (DWD)

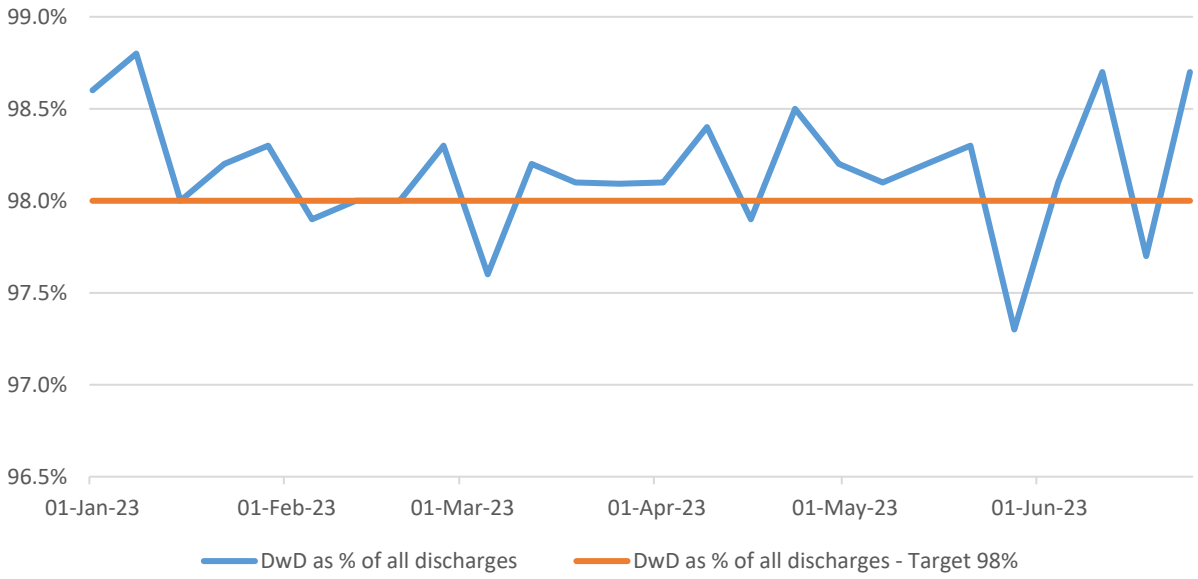
10.1 The Scottish Government Urgent and Unscheduled Care National Collaborative relaunched the Programme in July 2022, identifying 8 High Impact Change areas and asking each Health Board area to identify their priorities in progressing the work. NHS Tayside and the 3 Health and Social Care Partnerships identified Discharge Without Delay (DWD) as a key area of high impact change.



10.2 Tayside continues to perform well, sustaining 98% performance across all discharges at a time where we have seen an approximate rise of 20% in numbers of patients.

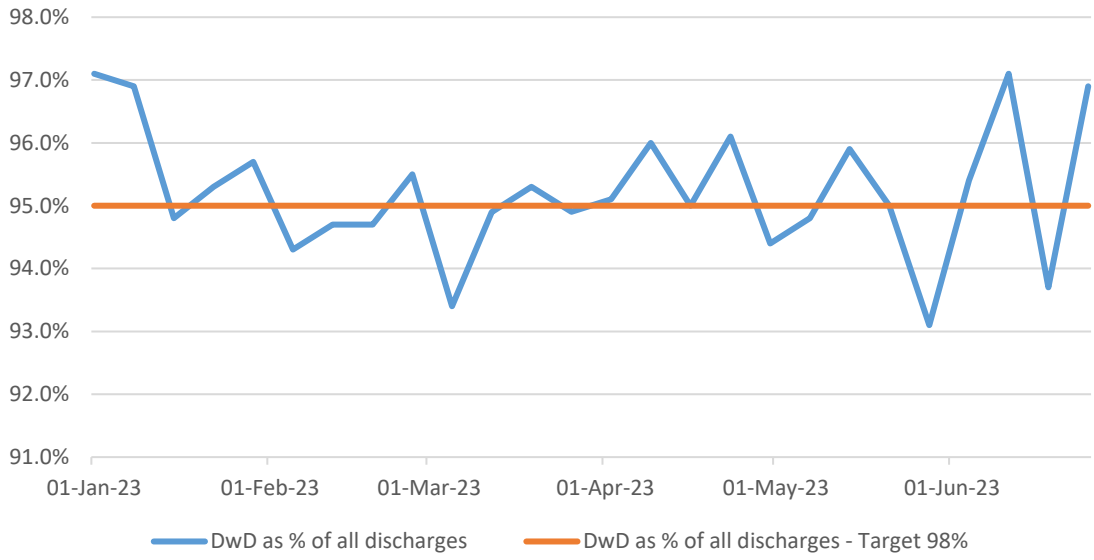
10.3 Charts 7, 8 and 9 demonstrate how the % of discharges without delay can vary by age group and specialty. Whilst overall, 98 of discharges were not delayed, performance particularly for the 65+ age group and Medicine for the Elderly specialty is more challenging due to the reasons already noted in sections 6 and 7 of this report.

Chart 7 % of DWD Discharges 18+ Dundee residents



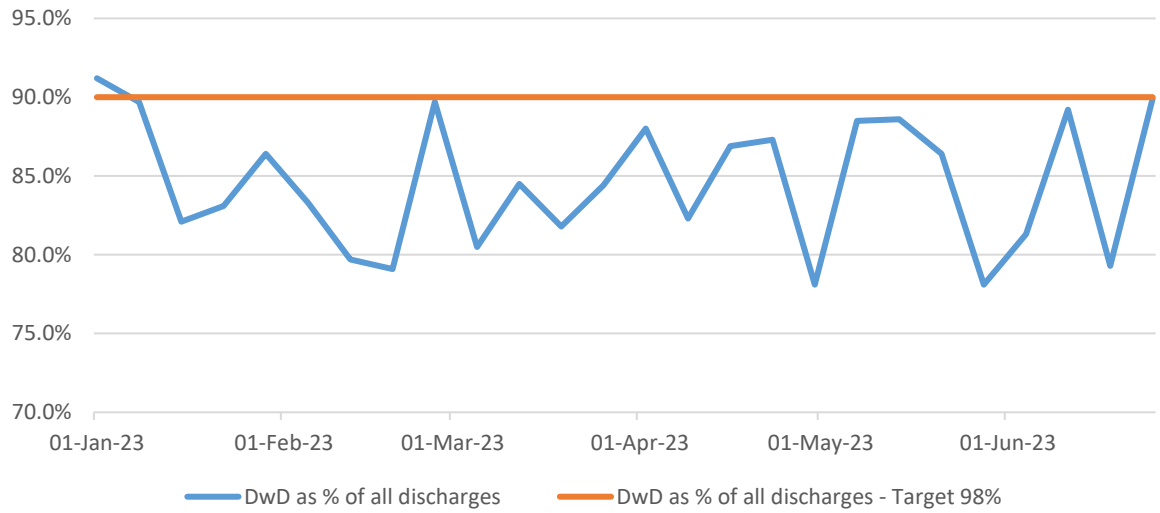
At 25 June 2023 98.7% of discharges were without delay (target 98%) for the 18+ age group.

Chart 8 % of DWD Discharges 65+ Dundee Residents



At 25 June 2023 96.9% of discharges were without delay (target 98%) for the 65+ age group.

Chart 9 - % of Medicine for the Elderly (MFE) DWD as a % of all MFE final discharges - Tayside



At 25 June 2023 90% of discharges were without delay (target 90%) in Medicine for the Elderly.

10.4 Following the successful Discharge Without Delay programme in 22/23, it is essential to maintain momentum in terms of embedding this good practice approach across all ward areas. Funding has been provided by NHS Tayside for a permanent Senior Nurse for Urgent and Unscheduled Care hosted within Dundee Health and Social Care Partnership but with a focus on supporting all inpatient areas to achieve length of stay performance in the upper quartile in terms of national benchmarking. Each area has been provided with a target based on the national data, and will be supported to develop measurable improvement actions to achieve these targets. This links well with the work described in section 8 of this report, which aims to provide more robust community alternatives to inpatient stays.

11.0 SUMMARY

11.1 Progress has been made in Dundee in relation to enabling people to be discharged when they are ready but we also recognise that further realignment is now required within social care and rehabilitation services to support the increased demand in community settings. The proposed actions above are targeted at ensuring the whole system is better equipped to manage the increasing demand for community-based support. Whilst there continues to be improvement opportunities as noted above, it is important to note that our increasingly frail, older population will have limited rehabilitation ability and therefore, long term investment in support services will be necessary in order to continue to achieve positive outcomes.

12.0 POLICY IMPLICATIONS

12.1 This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

13.0 RISK ASSESSMENT

Risk 1 Description	Every unnecessary day in hospital increases the risk of an adverse outcome for the individual, drives up the demand for institutional care and reduces the level of investment that is available for community support.
Risk Category	Financial, Governance, Political
Inherent Risk Level	Likelihood 3 x Impact 5 = Risk Scoring 15 (Extreme Risk)
Mitigating Actions (including timescales and resources)	- Weekly review of all delays. - Significant programme of performance reporting in place at local, regional and national level. - Action plan and monitoring at the Home and Hospital Transition Group. - Tayside Urgent and Unscheduled Care Board in place. - Additional improvement and governance posts have been recruited to support performance reporting and improvement planning and implementation. - Range of improvement actions underway to reduce risk of delays.
Residual Risk Level	Likelihood 3 x Impact 5 = Risk Scoring 15 (Extreme Risk)
Planned Risk Level	Likelihood 3 x Impact 5 = Risk Scoring 15 (Extreme Risk)
Approval recommendation	The PAC is recommended to accept the risk levels with the expectation that the mitigating actions are taken forward.

14.0 CONSULTATIONS

14.1 The Chief Officer, Heads of Health and Community Care and the Clerk were consulted in the preparation of this report.

15.0 BACKGROUND PAPERS

15.1 None.

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DATE: 23 August 2023

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