ITEM No …12……..

REPORT TO:	**PERFORMANCE AND AUDIT COMMITTEE – 29 MAY 2018**
REPORT ON:	**DISCHARGE MANAGEMENT PERFORMANCE UPDATE (INCLUDING CODE 9 ANALYSIS)**
REPORT BY:	**CHIEF FINANCE OFFICER**
REPORT NO:	**PAC34-2018**

1.0 PURPOSE OF REPORT

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 Notes the content of the report and the current position in relation to discharge management performance as outlined in section 5.2 of this report and Appendix 1 (sections 2.2 and 2.3).

2.2 Notes the current position in relation to complex delays as outlined in section 5.3 of this report and Appendix 1 (section 2.4).

2.3 Notes the improvement actions planned to respond to areas of pressure identified as outlined in section 5.2 and 5.4 of this report.

3.0 FINANCIAL IMPLICATIONS

Improvement actions described within this report are funded within current resource allocated to the Health and Social Care Partnership.

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 (Information Services Division 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 their 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;
- National Indicator 22: Percentage of people who are discharged from hospital within 72 hours of being ready.

4.1.3 Within Dundee a Home and Hospital Transitions Group, chaired by the Head of Health and Community Care, oversees performance and improvement actions in relation to Discharge

Management. The Group aims to ensure that citizens of Dundee are supported at home, but when people do have to go to hospital they are only there as long as they need to be.

4.1.4 On a weekly basis, an update is provided to the Chief Officer, the Chief Operating Officer and key Home and Hospital Transitions Group members on delay position. 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.

5.0 CURRENT PERFORMANCE

5.1 Discharge Data Types

5.1.1 Discharge delays are defined in two ways: - standard delays and code 9 (complex delays).

5.1.2 Standard delays are defined by Information Services Division (ISD) Scotland as delays where the standard maximum delay period applies. This includes Patients delayed due to awaiting assessment, care packages, housing, care home or nursing placements. The standard maximum delay period is now 72 hours.

5.1.3 Code 9 Complex delays are used by ISD Scotland to describe delays where the standard maximum delay, therefore 72 hours, is not applicable. This is in recognition that there are some Patients whose discharge will take longer to arrange and would include Patients delayed due to awaiting place availability in a high level needs specialist facility and where an interim option is not appropriate, Patients for whom an interim move is deemed unreasonable or where an adult may lack capacity under adults with incapacity legislation.

5.2 Standard Delays Current Performance and Improvement Actions

5.2.1 The Discharge Management Performance Report noted in Appendix 1 and our current performance data position highlights a positive trend towards reducing the number of people who are delayed where the standard maximum delay period applies.

5.2.2 The main reason for length of delay where the standard maximum delay period of 72 hours applies is due to awaiting completion of care arrangements. As a Partnership we have demonstrated a sustained reduction in delays over the past three years. The weekly monitoring arrangements in place have enabled pressures to be quickly identified and responses agreed.

5.2.3 This positive trend in relation to reduction in standard continues to be supported through a range of partnership activity across community and inpatient services. In particular, as a partnership we have refined communication systems, established integrated services and improved use of community resources to support patients to return home from hospital when they are well.

5.2.4 Case Study

The following case study about assessment at Home Test of Change demonstrates our integrated approach to discharge management where the standard delay applies .The assessment at home service can be provided to facilitate discharge for patients to complete their assessment in their own home, rather than in a hospital setting. The service can provide up to 24 hour care, for up to 21 days.

Mr A was referred to the Assessment at Home Team through the Integrated Discharge Hub's daily huddle on Day 1. Mr A had had several hospital admissions. Because Mr A was not managing at home and had been readmitted several times, it was the view of the multidisciplinary team on the ward that he would require admission to a care home where he would receive 24 hour support if necessary.

Mr A was not keen on the idea of a move to a care home as he saw this as an intrusion to his privacy but agreed to a referral to the Assessment at Home service through his Care Manager for a 24 hour package to complete the assessment in Mr A's own home. Staff from the Assessment at Home Team met with Mr A and his family on Day 2 to discuss the

service and to explain how the assessment would progress. Mr A then returned home with the 24 hour package.

On Day 6, Mr A was discharged after the care was reviewed. There was already evidence that Mr A was managing many aspects of his own care. Care staff had been prompting his medication for him to ensure he was taking them at the correct times, as Mr A had openly admitted that once he felt better he would stop taking his medication.

While undertaking this review, staff discussed the possibility of having community alarm installed. He had previously refused to have this service, but having received support for a short period of time, could see the potential benefits of this. Previously, Mr A had phoned for an ambulance, but could understand that a community alarm would enable him to get the support he required, while remaining in his own home, and protecting his privacy. In addition, through the support provided he also agreed to an Occupational Therapy referral for equipment which would enhance his ability to carry out tasks independently.

Five days after discharge (Day 13), a more formal review was held with Mr A and his social worker. By this stage, Mr A was receiving support at the right time for him and was able to live more independently. Six months after the hospital admission, Mr A was continuing to live at home independently and had not been readmitted to hospital in the last six months.

5.3 Complex Delays Current Situation

5.3.1 Through analysis of our performance data, the Home and Hospital Transition Group identified a negative trend during period 2016 to 2017 in relation to delays for Adults who have a complexity of circumstances. Detailed analysis of code 9 delays was provided to the PAC on 28th November 2017 (Article VI of the minute of the meeting refers). A further analysis is provided in Appendix 1 (section 2.4).

5.3.2 Key points from the analysis are:

- The reason for the majority of complex delays for adults aged 75+ remains due to adults with incapacity processes which includes decisions about guardianship, guardianship report preparations and court process.
- The majority of complex delays for adults aged 18 to 74 remains due to awaiting a place in a specialist facility and awaiting completion of complex care arrangements.
- The majority of occupied bed days are for adults aged 18 – 74. This is reflective of the reasons explained above for the delay for this age group in that gaining provision of specialist resources and care arrangements will take longer to arrange.
- The reduction in occupied bed days for adults aged 75+ is likely due to improvements made in relation to adults with incapacity processes and recruitment of additional Mental Health Officer. This reduction has demonstrated that Dundee is on target to meet performance measurement provided to Scottish Government.

5.3.3 There are a number of targeted improvement actions underway to finding sustainable solutions so that people aged 18 - 74 who have a complexity of needs and who require specialist accommodation or care can be discharged when they are ready.

5.3.4 The improvement actions include implementation of systems which improve communication and integrated working, monitoring of delays, further development of step down options, establishment of an early intervention model and planned development of specialist accommodation.

5.3.5 Furthermore, to reduce delays due to adults with incapacity processes, as a Partnership we continue to promote Power of Attorney through local and Tayside wide campaigns as a means of reducing requirement for Guardianship. Initial data suggests that the campaign is beginning to realise an increase in Power Of Attorney across Dundee and Tayside. Along-side this development, as a Partnership we have increased the Mental Health Officer resource to enable a timely response to Guardianship report requests.

5.4 Summary

5.4.1 The Partnership has made progress in Dundee in relation to enabling people to be discharged when they are ready but we also recognise that further work is needed to support patients who have a complexity of needs.

5.4.2 The Partnership has made a commitment to increasing the number of people who have a complexity of needs who are discharged when they are ready and with that a number of improvement actions and investment has been secured to support realisation of this commitment.

6.0 POLICY IMPLICATIONS

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

7.0 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. - Action plan and monitoring at the Home and Hospital Transition Group. - 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 risk is deemed to be acceptable with the expectation that the mitigating actions are taken forward.

8.0 CONSULTATIONS

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

9.0 BACKGROUND PAPER

None.

Dave Berry
Chief Finance Officer

DATE: 8 May 2018

Alexis Chappell
Locality Manager

Appendix 1

1.0 DISCHARGE MANAGEMENT PERFORMANCE REPORT

1.1 Background to Discharge Management

1.1.1 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. (ISD Delayed Discharges Definitions and Data Recording Manual)

1.1.2 The focus on effective discharge management is reflected through the National Health and Wellbeing Outcomes and their 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;
- National Indicator 22: Percentage of people who are discharged from hospital within 72 hours of being ready.

1.1.3 There are a number of other indicators which indirectly relate to discharge management and admission to hospital. These are percentage of people admitted to hospital from home during the year, who are discharged to a care home; percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency; readmission to hospital within 28 days; emergency admission rate and emergency bed day rate.

1.1.4 This performance report considers National Indicators 19 and 22 at August 2016 as this is the most recent published discharge data from ISD Scotland.

2.0 CURRENT PERFORMANCE AGAINST NATIONAL HEALTH AND WELLBEING OUTCOMES AND THEIR INDICATORS

2.1 Discharge Data Types

2.1.1 Information is presented in this report on discharge delays by both standard and code 9 complex delay types. By presenting information on both types of delays this provides a greater understanding about delay reasons and areas of improvement.

2.1.2 Standard delays are defined by ISD Scotland as delays where the standard maximum delay period applies. This includes Patients delayed due to awaiting assessment, housing, care home or nursing placements. The standard maximum delay period is now 72 hours. ISD now categorise this information as health and social care reasons in information provided by ISD about delays.

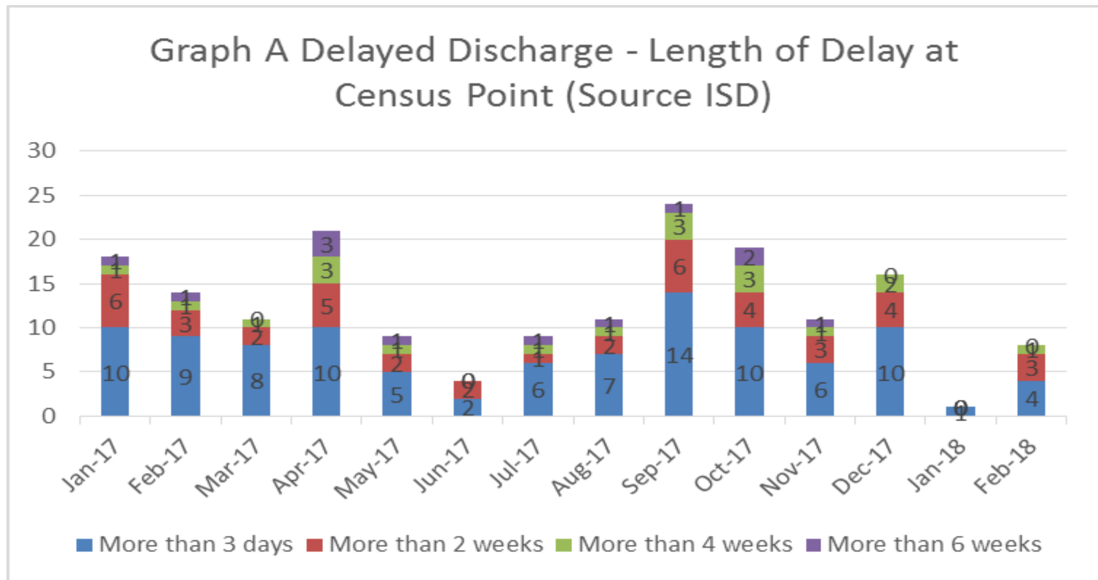
2.1.3 Code 9 Complex delays are used by ISD Scotland to describe delays where the standard maximum delay, therefore 72 hours, is not applicable. This is in recognition that there are some Patients whose discharge will take longer to arrange and would include Patients delayed due to awaiting place availability in a high level needs specialist facility and where an interim option is not appropriate, Patients for whom an interim move is deemed unreasonable or where an adult may lack capacity under adults with incapacity legislation.

2.2 National Health and Wellbeing Outcome Indicator 22: Performance against percentage of people who are discharged from hospital within 72 hours of being ready.

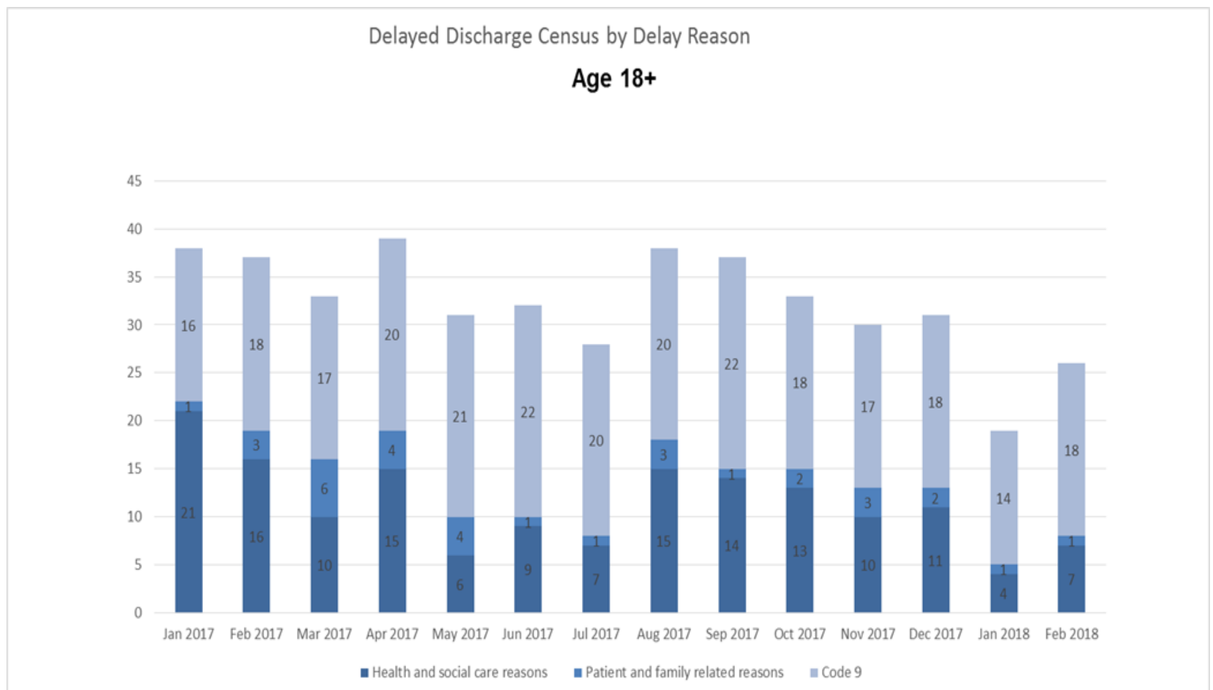
2.2.1 Previously approaches to reducing delays have been to focus on a target – first 6 weeks, then 4 and then 2, but the Delayed Discharge Task Force agreed that in future, focussing on increasing the % who can be discharged as soon as possible while allowing for the fact that there will be individual reasons that this is not appropriate will result in greater improvement. (Scottish Government, Core Suite of Indicators)

2.2.2 This indicator measures percentage of people who are discharge from hospital within 72 hours who are already delayed who are then discharged within 72 hours. For clarity, this measure does not calculate the percentage of people who were discharged within 72 hours from being an inpatient in hospital. It calculates patients who are already delayed and who have a wait over 72 hours of being discharged.

2.2.3 In this context, Graph A demonstrates our performance against the 72 target for people who already delayed for the period January 2017 to February 2018. The data identifies that we have reduced number of patients being delayed and for those delayed the majority of people are not waiting longer than 3 days before discharge.



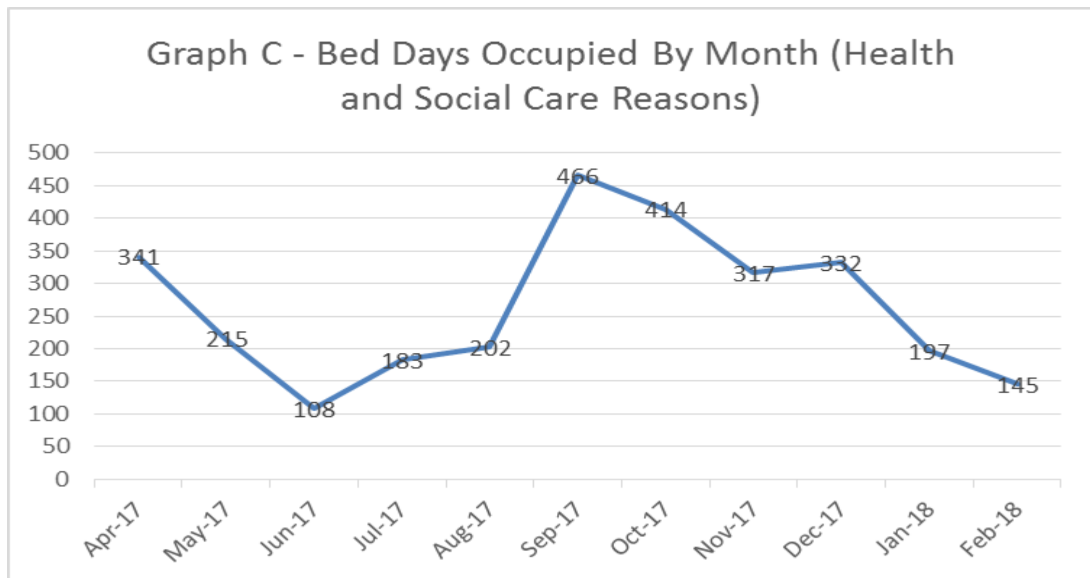
2.2.4 Length of delay for Dundee patients is provided in more detail in Graph B below for the period January 2017 to February 2018. This indicates that the majority of delays experienced are now Code 9 delays which relate to Adults who have a complexity of circumstances.



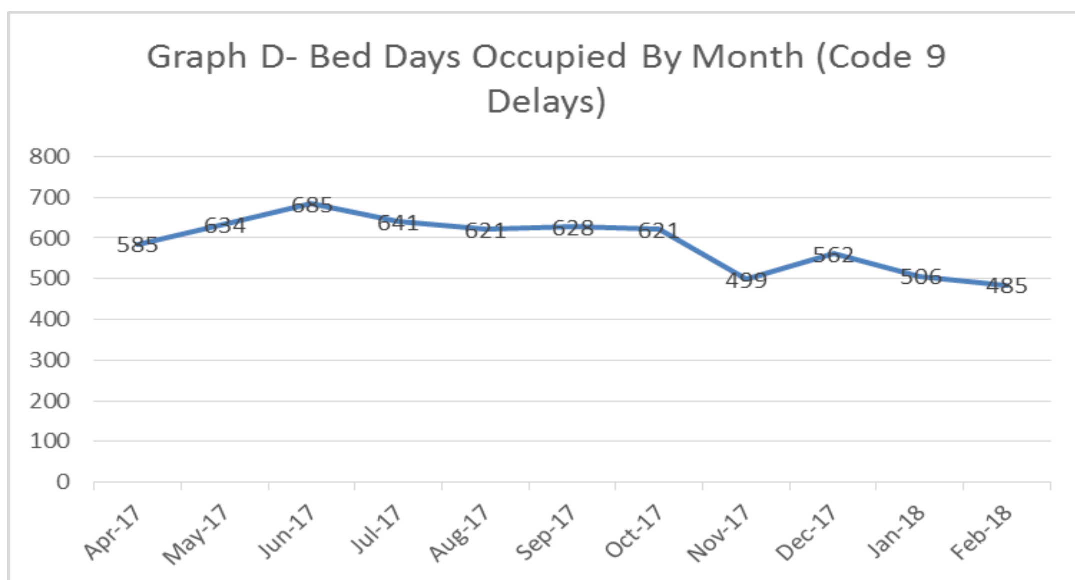
2.3 National Health and Wellbeing Outcome Indicator 19: Performance Against Number Of Days People Spend In Hospital When They Are Ready To Be Discharged.

2.3.1 This indicator counts the number of bed days occupied for all Patients (aged 18 years and over) who have met the criteria for a delayed discharge for each month.

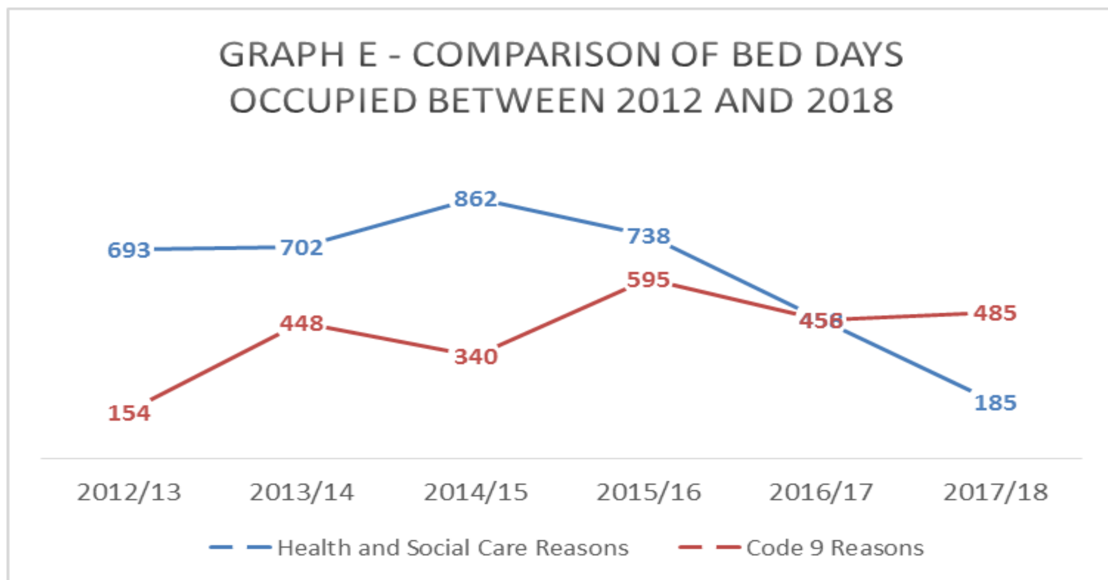
2.3.2 Graph C provides information about number of days people spend in hospital when they are ready to be discharged where the standard maximum delay period of 72 hours applies. This indicator highlights an increase in number of bed days occupied during period April 2017 – February 2018.



2.3.3 Graph D below provides information about number of days people spend in hospital when they are ready to be discharged where patients have a complexity of personal circumstances. The data indicates a deterioration in relation to our performance during period April 2017 – February 2018 where patients are ready to be discharged and who have a complexity of circumstances.



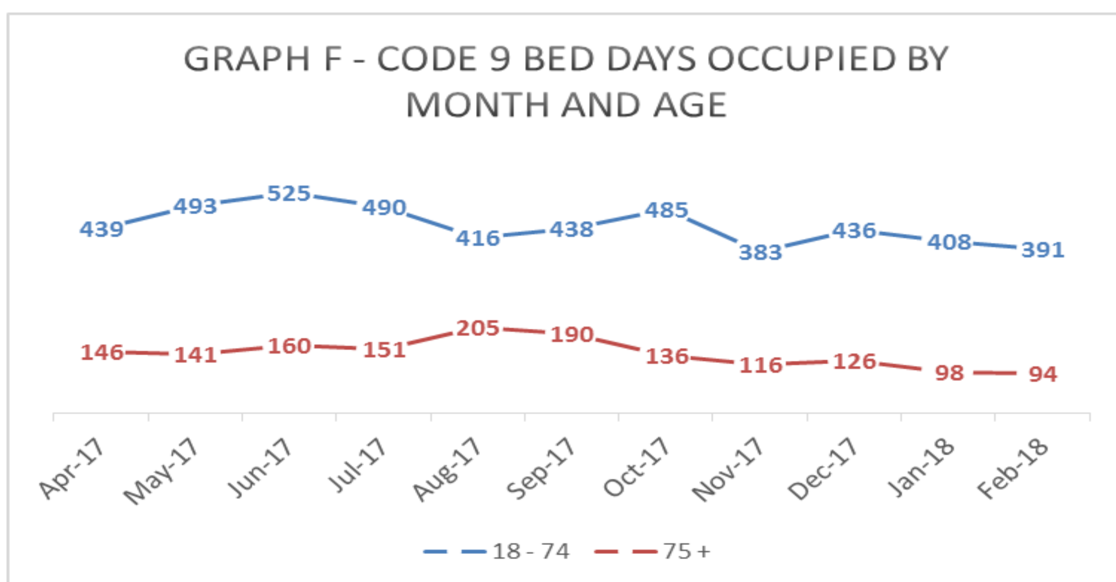
2.3.4 Graph E below provides information about number of days people spend in hospital when they are ready to be discharged as a comparison between health and social care reasons and where patients have a complexity of personal circumstances. This highlights the positive trend towards reducing standard delays.



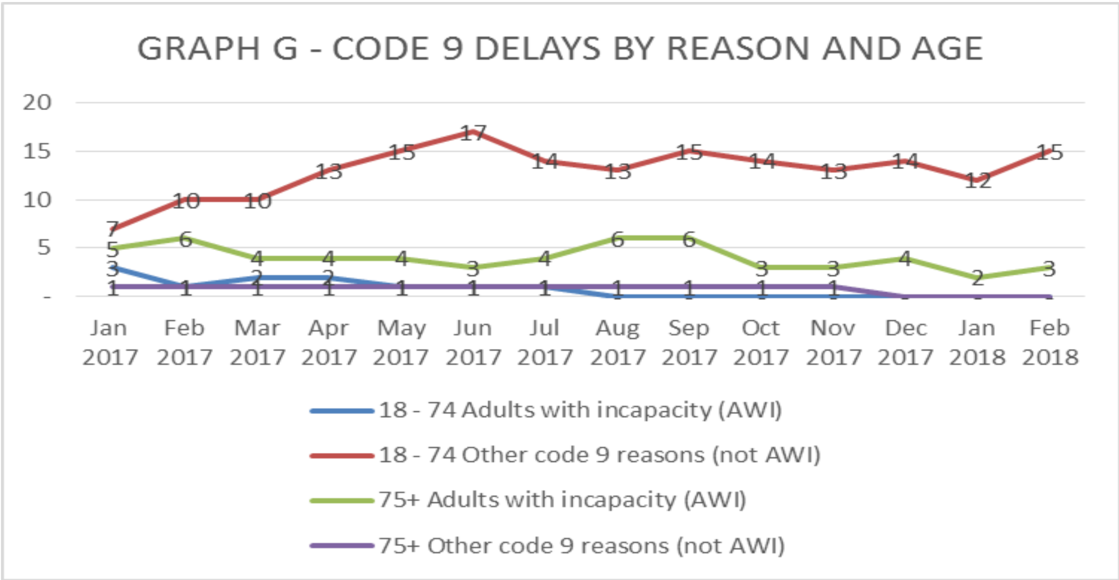
2.4 Complex Delays Information

2.4.1 Graph F highlights code 9 bed days occupied by month and age. This graph demonstrates that a positive trend relating to complex delays where people are aged over 75 and a positive trend for people aged between 18 - 74. This data, however, indicates that further work is required across all age groups to support a reduction in complex delays.

Graph F – Code 9 Bed Days Occupied by Month and Age



2.4.2 Graph G highlights comparison of Code 9 delays by Reason and Age for the period January 2017 – February 2018. This is split between delays due to adults with incapacity processes and delays due to people awaiting a specialist facility and awaiting completion of complex care arrangements. The Graph evidences that the main reason for delay in adults aged 75+ continues to be due to adults with incapacity processes and the main reason for delay in adults aged between 18 –74 is due to awaiting specialist facility or complex care arrangements.



2.4.3 Graph H demonstrates comparison of number of bed days occupied due to complex reasons for people aged 75+ between the period April 2017 to February 2018 against the target set in the Measuring Performance Under Integration submission. This data indicates that Dundee is exceeding the monthly targets within safe margins.