ITEM No …10…

REPORT TO:	**PERFORMANCE AND AUDIT COMMITTEE – 24 SEPTEMBER 2019**
REPORT ON:	**DISCHARGE MANAGEMENT PERFORMANCE UPDATE ON COMPLEX AND STANDARD DELAYS**
REPORT BY:	**CHIEF FINANCE OFFICER**
REPORT NO:	**PAC37-2019**

1.0 PURPOSE OF REPORT

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

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, and in relation to standard delays as outlined in section 6.

2.2 Note the improvement actions planned to respond to areas of pressure as outlined in section 7.

3.0 FINANCIAL IMPLICATIONS

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 (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 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 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 Further improvement actions are discussed and agreed through the Tayside Unscheduled Care Board, chaired jointly by the Head of Health and Community Care for Dundee Health and Social Care Partnership and the Associate Medical Director for Medicine for the Elderly.

4.1.5 On a weekly basis, an update is provided to the Dundee Health and Social Care Partnership Chief Officer, the NHS Tayside 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.

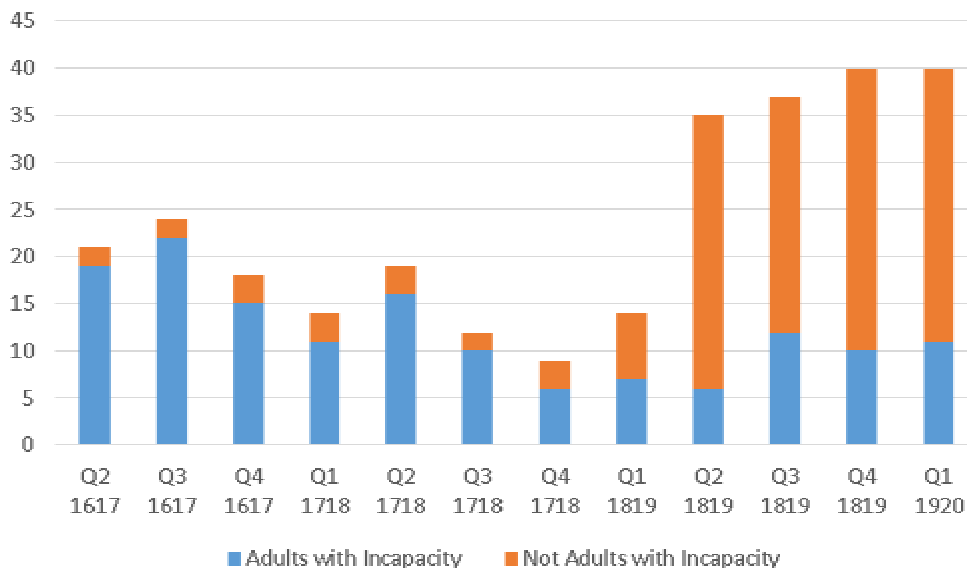
5.0 CURRENT PERFORMANCE IN RELATION TO COMPLEX DELAYS

5.1 Complex Delays - Current Situation

5.2 Complex delays can be split into 2 main age groupings, and specific approaches to improvement have been adopted for each.

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

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



Source: NSS ISD Delayed Discharge Census

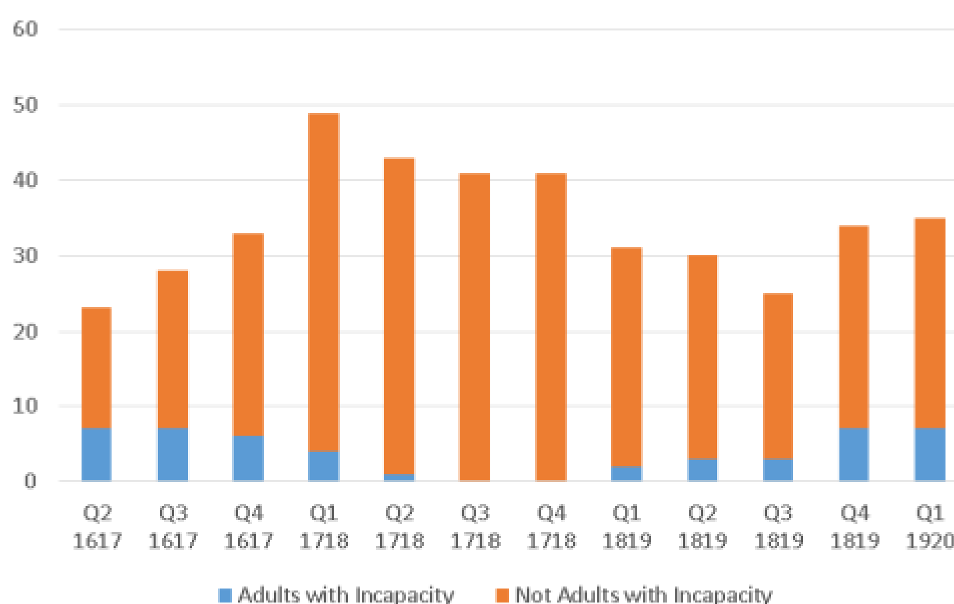
This highlights the improvement in performance which has taken place in relation to code 9 complex delays for the 75+ group over 2016/17 and 2017/18. In part, this can be attributed to the 'Discharge to Assess' model which promotes discharge prior to major assessment decisions being made. The aim of this is to reduce the numbers of patients moving to care home from hospital, and therefore reduces the demand for guardianship applications under the Adults with Incapacity legislation.

In addition, there has been investment in an additional Mental Health Officer post established within the Integrated Discharge Hub specifically focussed on increasing clinicians' awareness of and confidence in the legislation, as well as driving the Adults with Incapacity process when necessary to reduce the bed days lost for each individual. This post has been vacant for a few months during which there has been an increase in delays as a result of Adults with Incapacity processes. This demonstrates the impact being made by the inclusion of this post in the Discharge Hub.

During 2018/19 there has been an increase in code 9 complex delays where the reason for delay was not due to Adults with Incapacity. This can be attributed to 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. This is being addressed through the remodelling of the local authority care home resource which will ensure those older people with the most complex needs receive appropriate care and support.

5.3 Table 2 below outlines the position for the 18-74 age group. This demonstrates the impact of the long term improvement work being undertaken between the Partnership and Neighbourhood Services in terms of identifying appropriate accommodation and support services for this group. Further housing stock is scheduled to become available throughout the second half of 2019 which will reduce these delays further.

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



Source: NSS ISD Delayed Discharge Census

6.0 CURRENT PERFORMANCE IN RELATION TO STANDARD DELAYS

6.1 Although Dundee continues to perform well in relation to the 2015/16 benchmark, there is a deteriorating picture regarding standard delays. 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.

6.2 The greater accuracy of this assessment has enabled more patients to remain in their own homes on a long term basis and demonstrated a reduction in the need for care home placements. However this has also resulted in an increased requirement for social care.

6.3 Table 3 below shows the deteriorating position in relation to standard delays. Table 3 also demonstrates that standard delays are now almost exclusively attributable to the non-availability of social care.

Table 3 Standard Delayed Discharges by Principal Reason for Delay

Source: NSS ISD Delayed Discharge Census

7.0 IMPROVEMENT ACTIONS IDENTIFIED TO ADDRESS INCREASE IN STANDARD DELAYS

- Implementation of eligibility criteria which will ensure services are only provided in response to a critical or substantial level of need, in order to ensure people receive the right support at the right time in the right place;
- Development of a rehabilitation focussed social care pathway, linking community rehabilitation services with the enablement service to ensure the focus is on promoting independence;
- Test of change using ring fenced Red Cross 'discharge to assess' service to target same day discharge in the Acute Medicine for the Elderly Unit;
- Continue to promote the 'discharge to assess' model;
- Continued locality modelling in relation to workforce planning to ensure the statutory social care review function is maintained adequately;
- Ongoing development of community based models such as Enhanced Community Support and Dundee Enhanced Community Support Acute to prevent admission to hospital;
- Development of 8 bedded step down unit within Turriff House as a community alternative for older adults experiencing mental health issues;
- Continued exploration of the current step down model to create efficiencies which will support earlier discharge;
- Recruitment to Advanced Nurse Practitioner posts across the existing community services to build more robust support in community teams;

- Consideration of the use of frailty scoring tools by third sector domiciliary care providers as a means of targeting review activity more accurately; and,

- Promote the use of technology to support assessment whenever possible and appropriate.

8.0 SUMMARY

8.1 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.

9.0 POLICY IMPLICATIONS

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

10.0 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 PAC is recommended to accept the risk levels with the expectation that the mitigating actions are taken forward.

11.0 CONSULTATIONS

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

12.0 BACKGROUND PAPERS

None.

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DATE: 16 September 2019

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