ITEM No …6……..

REPORT TO: **PERFORMANCE AND AUDIT COMMITTEE – 26 MAY 2021**

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

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC11-2021**

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

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 (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 the 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

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

The position in relation to the 75+ 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

Chart 1 highlights the improvement in performance which has taken place in relation to code 9 complex delays for the 75+ group since 2016/17. 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 number of patients moving directly to a care home from hospital, and therefore reduces the demand for guardianship applications under the Adults with Incapacity legislation.

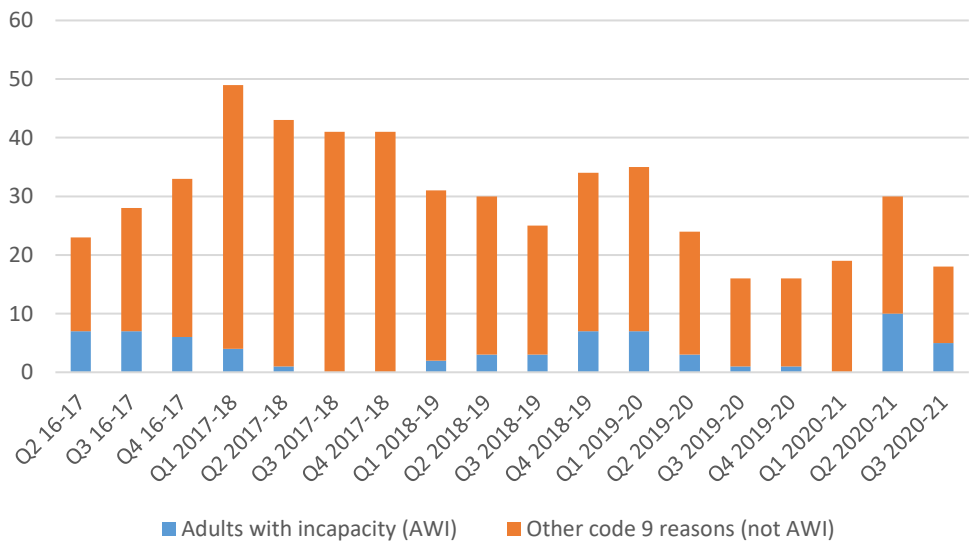
As previously reported, there has been investment in an additional Mental Health Officer post established within the Integrated Discharge Hub specifically focussed on increasing clinicians' awareness of and confidence in the legislation, as well as driving the Adults with Incapacity process when necessary to reduce the bed days lost for each individual. The positive impact of this post is reflected in Chart 1, specifically since Quarter 3 2018/19 when delays as a result of Adults with Incapacity reduced significantly. This post is currently vacant and it has not been possible to recruit which perhaps has contributed to the slight increase in guardianship delays throughout the past year. Societal fears regarding the impact of care home admission during the COVID pandemic have undoubtedly also increased the numbers of patients requiring guardianship orders to facilitate discharge.

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.

There are plans to remodel local authority care home provision which will ensure older people with the most complex needs receive appropriate care and support, however progression of this has been delayed due to COVID.

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

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



Source: PHS Delayed Discharge Census

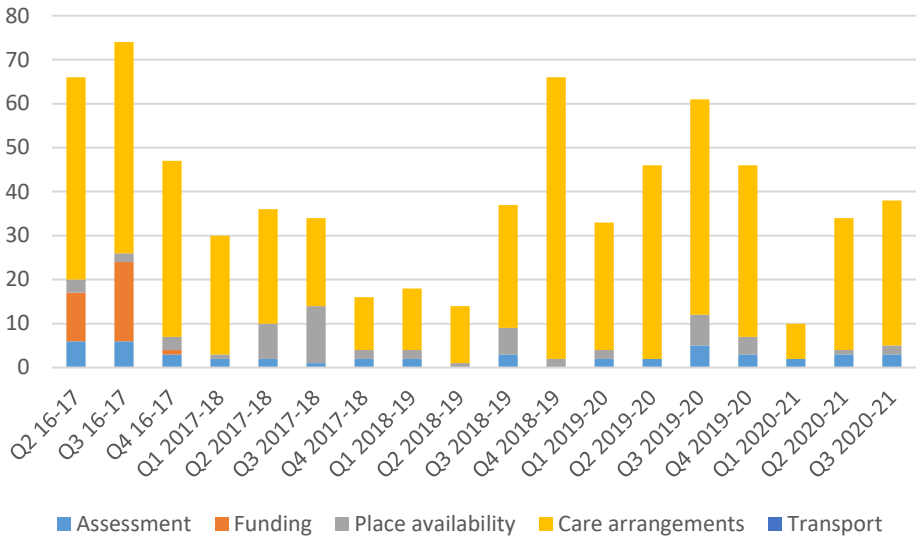
6.0 CURRENT PERFORMANCE IN RELATION TO STANDARD DELAYS

6.1 Although Dundee continues to perform well in relation to the 2015/16 benchmark, and has been amongst the top performing Partnerships in Scotland throughout this winter, 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 community-based 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 services and supports.

6.3 Chart 3 shows the deteriorating position in relation to standard delays and 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



6.4 In order to address this, there is a need for a further improvement in discharge pathways which maximise the resources available and promote better outcomes for patients. These measures are outlined in section 7.

7.0 IMPROVEMENT ACTIONS IDENTIFIED TO ADDRESS INCREASE IN STANDARD DELAYS

7.1 Since the last report, 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.

7.2 The Home First strategic programme is now underway. This aims to reduce barriers between urgent care services in the community and create a whole systems pathway for frail older people which ensures they can receive care and treatment in community settings wherever possible. This will support reduction in hospital admission, and will expand the Dundee Enhanced Community Support Acute model into a Hospital at Home service. This pathway will be focussed on community rehabilitation in order to promote independence and has replaced the previous 28 bedded Intermediate Care Unit which was closed in March 2020.

7.3 The implementation of the Eligibility Criteria for social care is now complete and staff across the Partnership have been briefed. This will provide a clearer framework for allocation of social care resource with the aim being to only provide this service to people with a critical or substantial need. In tandem with the developing community rehabilitation focus through the development of the Independent Living Review Team, as well as stronger links with the Third Sector, this is designed to reduce reliance on traditional social care services over time.

7.4 Winter Pressures monies were used to expand the existing 'Discharge to Assess' model over the winter. The success of this model has provided evidence that earlier discharge from hospital and minimal moves whilst an inpatient, creates better outcomes particularly for frail, older adults. Now that this approach is fully embedded, the next stage of development is to target inpatient rehabilitation alongside this resource within the acute hospital to ensure patients can return home safely on their Planned Date of Discharge. Whilst this may slightly increase the length of stay within acute, the aim is to reduce whole system length of stay while improving outcomes for individuals. The Acute Medicine for the Elderly Unit continues to support good quality frailty assessment and early discharge for frail older adults, and the Home First project is now focussed on developing a similar model in the community.

7.5 Following a delay due to COVID, the 8 bedded unit within Turriff House has now been opened as a 'step down' alternative to inpatient psychiatric rehabilitation for older people.

7.6 Advanced practice models are now being developed to support the community hospital and urgent care services in the community. This will complement the Primary Care Improvement Plan, specifically in relation to the proposal to develop urgent care around the existing GP cluster model.

7.7 The Care Home Team continues to undertake development work with local care homes as a means of preventing admission to hospital when appropriate and a further Nurse Consultant post is in the process of recruitment to support this.

7.8 Frailty assessment is now fully embedded within the Surgical and Orthopaedic inpatient pathways which is contributing to reduced length of stay, however will initially impact on demand for services to support discharge.

7.9 Ongoing development work on the stroke pathway for both younger and older adults has just commenced with the aim of reducing length of stay for this patient population over the next six-month period.

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 completed, ongoing and proposed actions summarised in section 7 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 in section 7, it is important to note that Dundee's 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.

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

11.0 CONSULTATIONS

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

12.0 BACKGROUND PAPERS

12.1 None.

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DATE: 08 April 2021

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