ITEM No …6……..

REPORT TO: **PERFORMANCE AND AUDIT COMMITTEE – 22 SEPTEMBER 2020**

REPORT ON: **DISCHARGE MANAGEMENT PERFORMANCE UPDATE ON COMPLEX AND STANDARD DELAYS – QUARTER 1 2020/21**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC19-2020**

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 for the period up to Quarter 1 2020/21.

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 Transition 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.

4.1.6 The Quarter 3 Discharge Management Performance Report is attached as appendix 1. This report was prepared at the end of quarter 3 but has not previously been submitted to the PAC due to the cancellation of meetings during 2020.

5.0 CURRENT PERFORMANCE IN RELATION TO COMPLEX DELAYS

5.1 Complex Delays - Current Situation

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

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: NSS ISD Delayed Discharge Census

Chart 1 demonstrates the continued improvement in performance which has taken place in relation to code 9 complex delays for the 75+ group since 2016/17. The 'Discharge to Assess' model continues to prove successful in supporting discharge prior to major assessment decisions being made. As a result, fewer service users are being admitted to care homes following completion of community assessment. This has continued to support the aim 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.

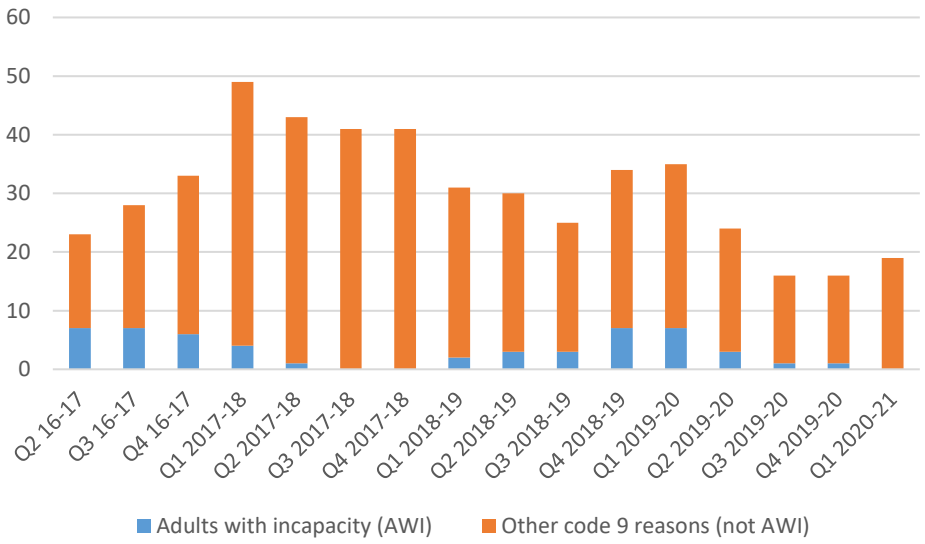
The Partnership has continued to invest in an additional Mental Health Officer post established within the Integrated Discharge Hub. This post specifically focusses on increasing clinicians' awareness of and confidence in the Adults with Incapacity legislation, as well as driving the Adults with Incapacity 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, perhaps contributing to the slight increase in complex delays more recently. Although there is a recognised shortage of Mental Health Officers nationally, posts within the community Mental

Health Officer team continue to attract interest, therefore contingency planning between the hospital and community teams is underway to ensure this work continues.

The increase during Quarter 1 in other complex delays (non AWI) in this older age group, can be attributed to the impact of COVID-19 on discharge planning. Discharge for patients who are existing care home residents has been frequently delayed due to the necessary closure of homes to admissions when test results are awaited. There has also been an increase in delays as a result of the halting of housing allocation during the lockdown period.

5.1.2 Chart 2 outlines the position for the 18-74 age group. Again, COVID-19 has delayed the completion of building work which would provide new purpose built housing for several patients delayed for complex reasons.

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



Source: NSS ISD Delayed Discharge Census

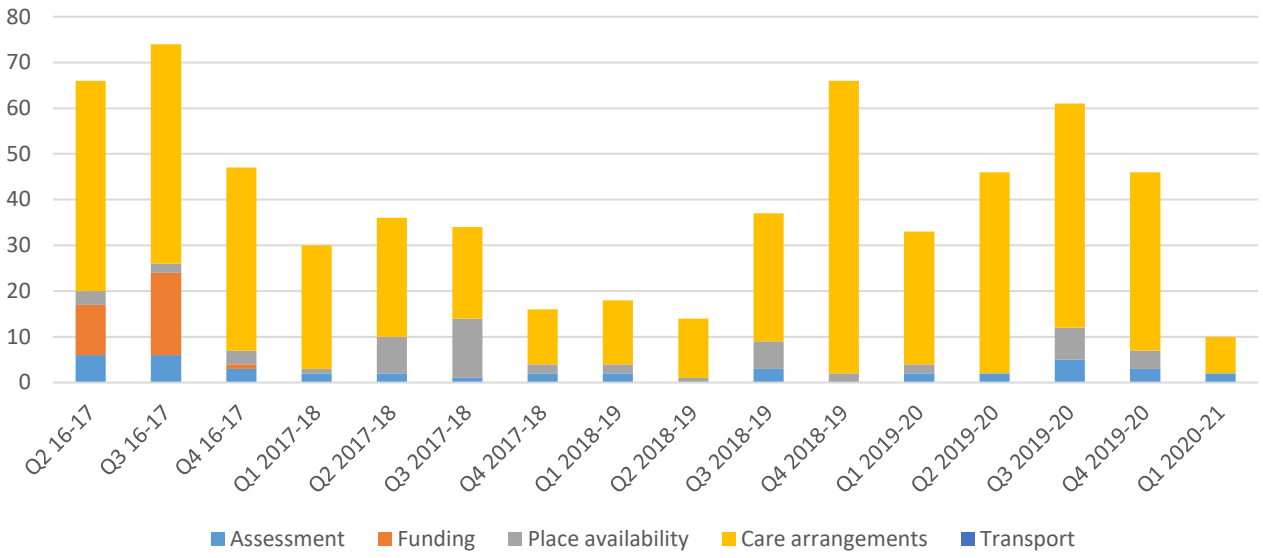
6.0 CURRENT PERFORMANCE IN RELATION TO STANDARD DELAYS

6.1 Dundee continues to perform well in relation to the 2015/16 benchmark and the 'Discharge to Assess' model aims to support the majority of patients to be discharged on their Planned Date of Discharge. Standard delays continue to be almost exclusively attributable to the non-availability of social care.

6.2 The significant improvement during Quarter 1 outlined in Chart 3 reflects the impact of the national and Scottish Government strategy employed in response to the COVID-19 pandemic. This led to a reduction in unscheduled admissions to hospital, therefore demand was reduced. Additionally, many families were more enabled to provide care and support due to the impact of lockdown restrictions, for example family members who had been furloughed.

6.3 The pandemic has provided some opportunities to build on the existing 'Discharge to Assess' policy, specifically a potential shift in the societal belief that hospitals are safe. The reduction in demand has provided an opportunity to accelerate the plans to move to a community-based rehabilitation model as outlined in section 7.

Chart 3: Standard Delayed Discharges by Principal Reason for Delay



7.0 IMPROVEMENT ACTIONS IDENTIFIED TO MAINTAIN PERFORMANCE AGAINST STANDARD DELAYS

7.1 Prior to the COVID-19 pandemic, the strategic plan was to reduce the intermediate care bed base from 28 to 16 as part of the gradual move to a more community-based rehabilitation model. Withdrawal from the intermediate care contract began earlier in 2020 and was scheduled for transfer to the reduced bed base in April. However, this transfer could not take place due to the impact of COVID-19 which has provided an opportunity to accelerate the strategic shift through the termination of the intermediate care contract and reinvestment of resource in a 'Home First' model.

7.2 Using the budget previously allocated to intermediate care, a whole systems strategic plan has been developed which will build on the existing 'Discharge to Assess' model and is badged as 'Home First'. This will incorporate improvement work already underway within the acute hospital to streamline unscheduled care pathways and processes, and will address the need to shift the balance of care further into the community in line with the NHS Tayside Remobilisation Plan.

7.3 Initial priorities for this strategic work will be contingency planning for winter, particularly as it is anticipated there may be further pressure on hospital and community services as a result of resurgence of COVID-19 cases. The national Reshaping Urgent Care Programme has been tasked with setting up community triage hubs in preparation for winter The Home First strategy will complement this by developing different ways of working for community-based services such as Enhanced Community Support nursing to support community based clinical assessment as a means of prevention of admission. For those service users identified as not requiring hospital admission, social care and rehabilitation services will work closely with clinicians to provide the necessary care and support to enable service users to remain in their own homes while they receive appropriate treatment.

7.4 COVID-19 restrictions have meant home working for many community-based staff. This provides an opportunity to remobilise these staff into locality based multi-professional teams which support and complement the work outlined above and provide a more seamless and efficient service.

7.5 Modelling of the Advanced Nurse Practitioner workforce continues to ensure the appropriate clinical support for community-based triage is available.

7.6 It is recognised that the loss of 28 intermediate care beds in addition to the loss of bed base as a result of the development of COVID/non-COVID pathways within the hospital, is likely to place additional strain on unscheduled flow. As a means of supporting the community Home First model, discussion is ongoing to develop community-based assessment beds for those service

users who do not require hospital admission, but who may require a more structured approach than can be provided in their own home.

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. Whilst there continue 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.

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 2 x Impact 5 = Risk Scoring 10 (High Risk)
Planned Risk Level	Likelihood 1 x Impact 5 = Risk Scoring 5 (Moderate 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

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.

Dave Berry
Chief Finance Officer

DATE: 24 August 2020

Lynne Morman
Integrated Manager

Lynsey Webster
Senior Officer

APPENDIX 1

REPORT TO: **PERFORMANCE AND AUDIT COMMITTEE – 22 SEPTEMBER 2020**

REPORT ON: **DISCHARGE MANAGEMENT PERFORMANCE UPDATE ON COMPLEX AND STANDARD DELAYS – 2019/2020 QUARTER 3**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC12-2020**

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 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.

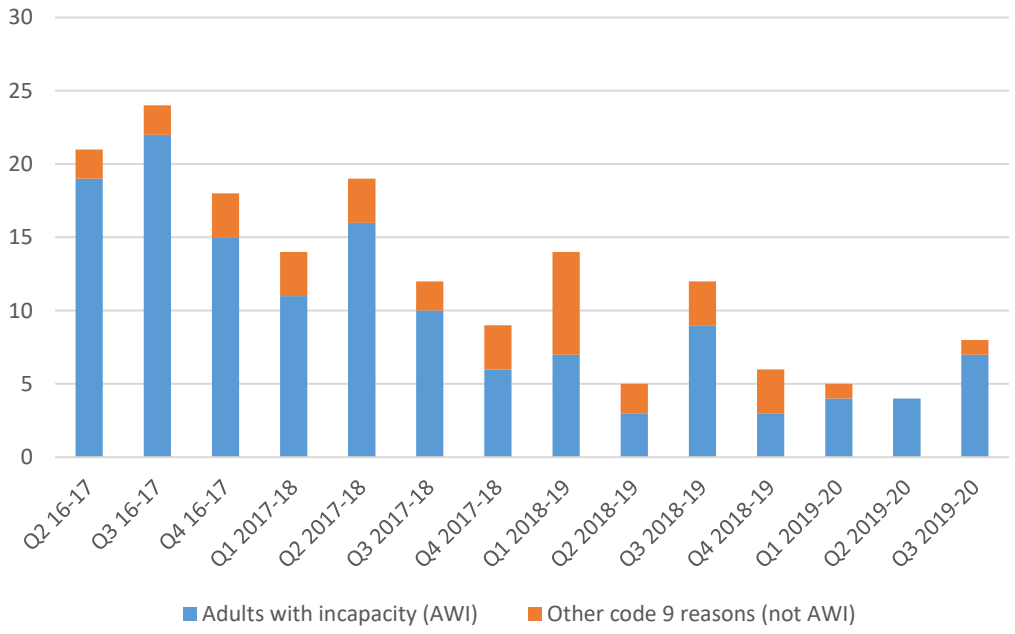
5.0 CURRENT PERFORMANCE IN RELATION TO COMPLEX DELAYS

5.1 Complex Delays - Current Situation

5.1.1 Complex delays can be split into 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:

Chart 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 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 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.

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, perhaps contributing to the slight increase in complex delays more recently. Although there is a recognised shortage of Mental Health Officers nationally, posts within the community Mental Health Officer team continue to attract interest, therefore contingency planning between the hospital and community teams is underway to ensure this work continues.

There 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. The remodelling of the care home provision will ensure older people with the most complex needs receive appropriate care and support.

5.1.2 Chart 2 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.

Chart 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

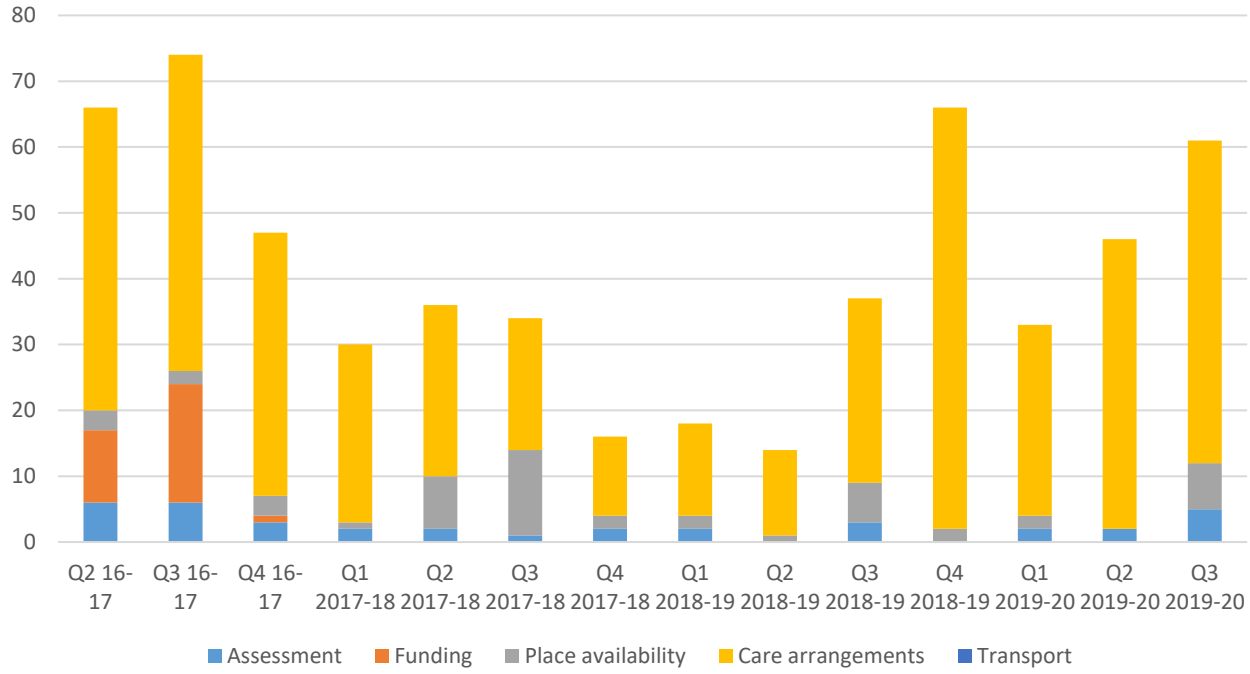
6.1 Although Dundee continues to perform well in relation to the 2015/16 benchmark, and has been amongst the top performing Partnerships in Scotland throughout this winter, there is a deteriorating picture regarding standard delays. During 2017/18, the introduction of the 'Discharge to Assess' model 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 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 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.

6.4 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



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 In order to improve outcomes for service users while maximising the use of resource, inpatient pathways for frail, older adults need to be simplified to support earlier discharge home for completion of assessment and rehabilitation.

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.

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.

7.5 Four additional occupational therapy posts have been recruited to expand the existing Community Rehabilitation Team and shift the focus of social care to supporting the rehabilitation process.

7.6 Although this report focuses on delayed discharge, the improvement measures are geared towards enhancing community services in order to prevent admission. Ongoing development of services such as Enhanced Community Support and Dundee Enhanced Community Support Acute (DECSA) will be crucial in supporting the developments in inpatient pathways. Work is ongoing to support development in these services.

7.7 Modelling of the Advanced Nurse Practitioner workforce continues to ensure efficiency of staff resource is maximised. Further recruitment is ongoing.

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

7.9 Substance Misuse Liaison Service is working in partnership with Community Integrated Substance Misuse Services, Pain Team, Pharmacy, and others to develop improved pathways and processes for patients affected by substance misuse. Additional resource is being sought to expand this work into Carseview.

7.10 Step down properties have been in place for approximately 3 years as a means of supporting discharge for patients who could not return to their own homes. Work with housing providers has identified additional social care availability within the step down properties which supports the use of these properties for earlier discharge when social care is not available elsewhere. A test of change is underway in partnership with Dundee Survival Group to provide housing with specialised support for people affected by substance misuse and/or homelessness.

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. Whilst there continue 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.

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

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.

Dave Berry
Chief Finance Officer

DATE: 24 March 2020

Lynne Morman
Integrated Manager

Lynsey Webster
Senior Officer