



REPORT TO: PERFORMANCE AND AUDIT COMMITTEE – 04 FEBRUARY 2026

REPORT ON: UNSCHEDULED CARE

REPORT BY: CHIEF OFFICER

REPORT NO: PAC5-2026

1.0 PURPOSE OF REPORT

1.1 To provide an update to the Performance and Audit Committee on Unscheduled Care Services and 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 and standard delays as outlined in sections 5-8.

2.2 Note the improvement actions planned to respond to areas of pressure as outlined in section 9.

3.0 FINANCIAL IMPLICATIONS

3.1 Dundee IJB's delegated financial resources continue to face a number of challenges in terms of in-year projected overspend and longer financial sustainability. Due to the current financial constraints, the IJB has had to approve a number of spend reduction proposals and implement financial recovery plans for 2025/26. As a result there is the risk that existing levels of activity and performance may not be able to be maintained.

3.2 While delegated community health and social care is a critical element of the overall unscheduled care pathways to support discharge without delay from hospital, the current levels of spend exceed the identified budgets and actions are being progressed to reduce overall spend levels. Whole-system efforts continue to be progressed to mitigate the impact on discharges for individuals through prioritisation of resources aligning to those of greatest assessed need.

4.0 MAIN TEXT

4.1 Background to Discharge Management

4.1.1 A delayed discharge refers to 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 for Dundee and Tayside, as well as ensuring all actions are designed in alignment with the national Operational Delivery Plan, in particular the principles outlined in the Discharge Without Delay Collaborative Programme. The focus of this work is to deliver care closer to home for citizens of Dundee and to minimize hospital inpatient stays wherever appropriate.
- 4.1.4 The Tayside Urgent and Unscheduled Care Board is chaired jointly by the Service Manager for Urgent & Unscheduled Care in Dundee Health and Social Care Partnership and the Associate 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 Service Manager for Urgent & Unscheduled Care. Liaison between the local Board and the national team is undertaken by a Programme Manager within the NHS Tayside Improvement Team alongside the Programme Leadership Team.
- 4.1.5 The programme of work is split across 4 key workstreams:
1. Optimising Access - Aimed at creating clear and seamless communication and referral pathways between community urgent services in order to create alternatives to hospital admission where appropriate.
 2. Performance 95 - Improving the flow through the Emergency Department in order to ensure the 4-hour national target is achieved.
 3. Integrated Health & Community Care - Linked closely to the Optimising Access workstream, this focuses on improving and expanding the role of Urgent Care services in the community setting. In Dundee, development of the Frailty at Home service has continued. This is an advanced practice led service with community and cluster geriatrician support which offers advanced clinical assessment and decision making for frail older patients in the community. This service is largely funded by Primary Care Improvement monies with the aim of supporting both GP practice and the acute hospital wherever appropriate. Increasingly funding has also gradually transferred from the Medicine for the Elderly medical budget into this initiative as part of the collaborative commitment to shift the balance of care into a community setting.
 4. Optimising Flow/Discharge Without Delay - This work continues to support improvement in capacity and flow management in every ward area across Tayside with the aim of improving patient outcomes as well as minimising delayed discharges. Dundee and Tayside remain committed to implementing the Discharge Without Delay principles as a means of supporting earlier discharge from frailty units to promote completion of long-term assessment at home. Budgetary constraints within social care continue to present challenges in fully achieving this aim.
- 4.1.6 These workstreams are closely linked to the aims contained within the NHS Tayside Annual Delivery Plan. As part of the collaborative working relating to this, each Health and Social Care Partnership in Tayside has agreed to work towards specific targets: achieving and maintaining GREEN RAG (Red / Amber / Green) status for delayed discharges against the locally set targets; and contributing to a 5% reduction in admissions.
- 4.1.7 Various reporting mechanisms are in place as well as datasets which supports the ongoing understanding of performance against the agreed targets.

This includes:

- Daily management and reporting of 'RAG' status across all sites;
- Weekly Dundee Oversight Report detailing performance across Partnership services including delayed discharge;
- Weekly Tayside level 'Discharge Without Delay' key measurement;

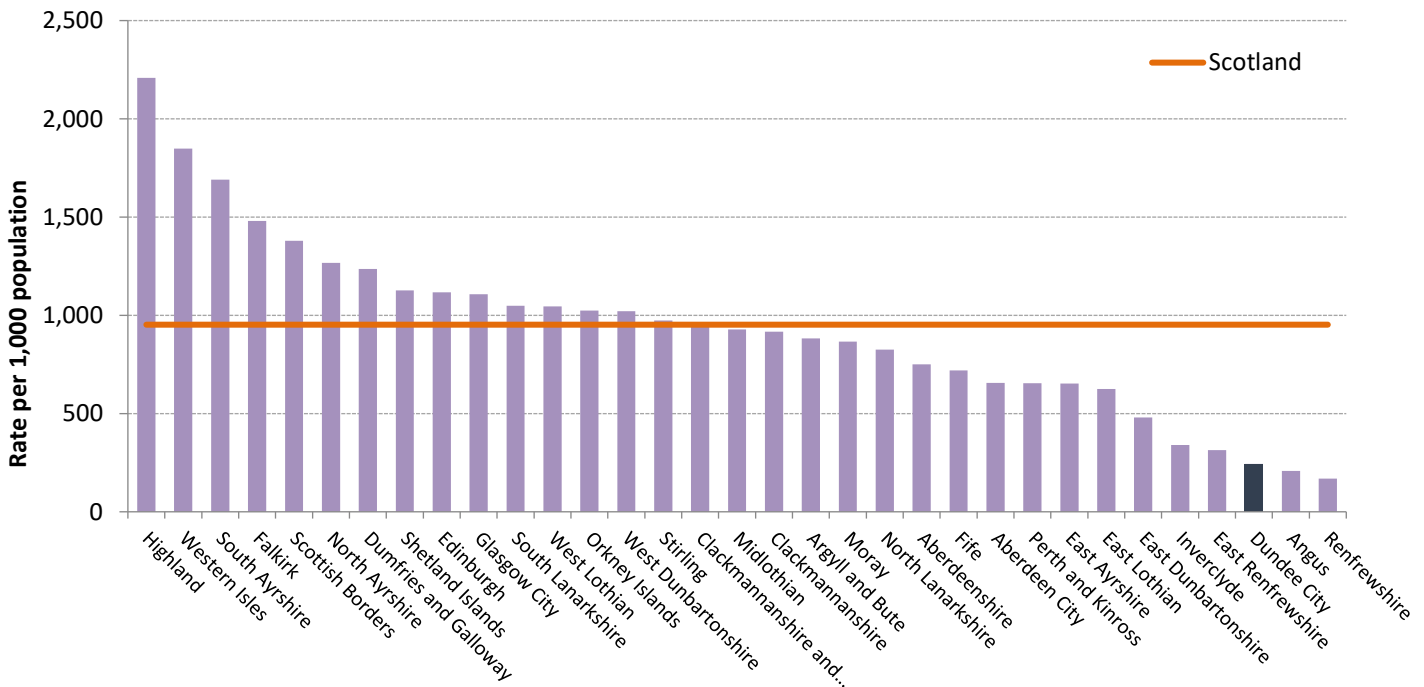
- New weekly community/access point performance report completed by Health & Business Intelligence Unit containing Dundee Frailty at Home data; and,
- Community hospital length of stay data pack monthly.

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.

5.0 CURRENT PERFORMANCE TOWARDS NATIONAL INDICATORS

5.1 The National Indicator is 'Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population' and the chart below presents the 204/25 annual performance for every HSCP.

Chart 1 Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population 2024/25



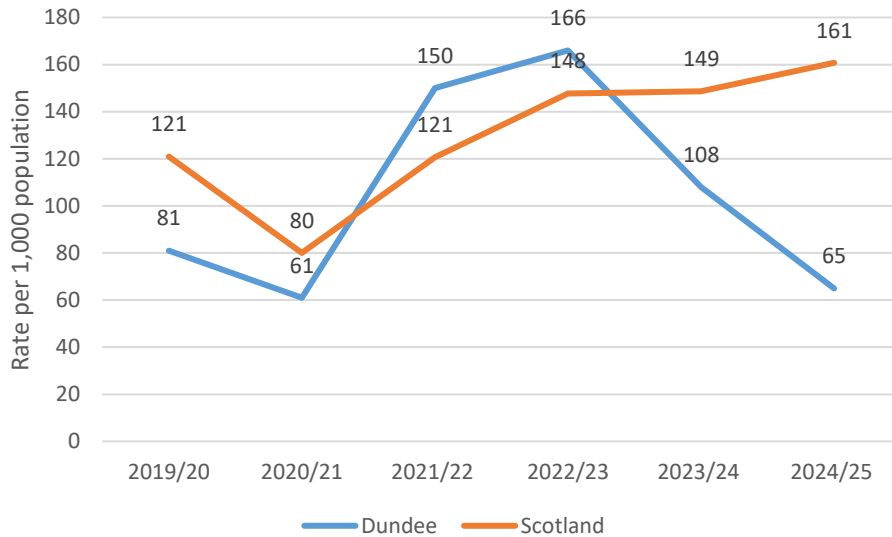
5.2 Dundee performs well against the National Indicator and is 3rd best in Scotland with a rate of 244.6 per 1,000 population compared with the Scotland rate of 952.3 per 1,000 population.

5.3 Longitudinally, Dundee performance has fluctuated but for every year except 2021/22 performance has been better than Scotland.

5.4 Dundee's performance broken down by Local Community Planning Partnerships and complex and non-complex delays is monitored quarterly and included in the PAC Quarterly Performance Reports.

5.5 In addition to the National Indicator, HSCPs are monitored against an Indicator agreed by the Ministerial Strategic Group and this monitors the rate of bed days lost per 1,000 of the 18+ population. This data is also monitored quarterly and included in the PAC Quarterly Performance Report.

Chart 2 Delayed Discharge Bed Days Lost per 1,000 18+ population



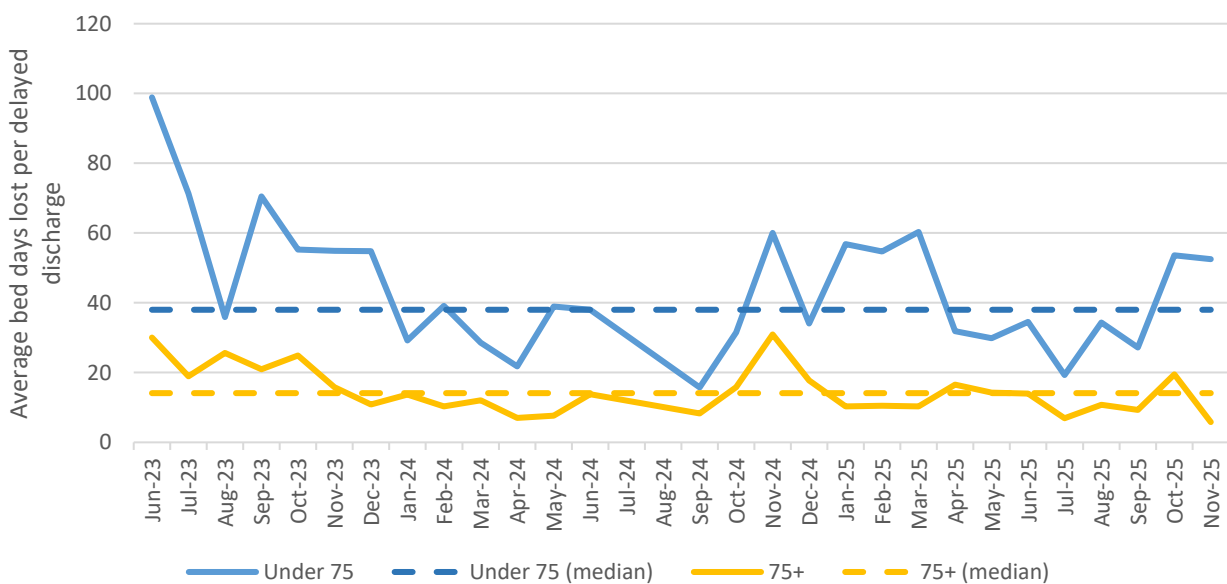
Source: NSS PHS Scotland

5.6 Comparing 2024/25 performance with the 2019/20 baseline shows an improved performance in Dundee whereas a poorer performance for Scotland as a whole.

6.0 Average Duration of Delay

6.1 As part of the further development of monitoring and reporting data, current analysis is focusing on the average duration of delay based on type, age group and location.

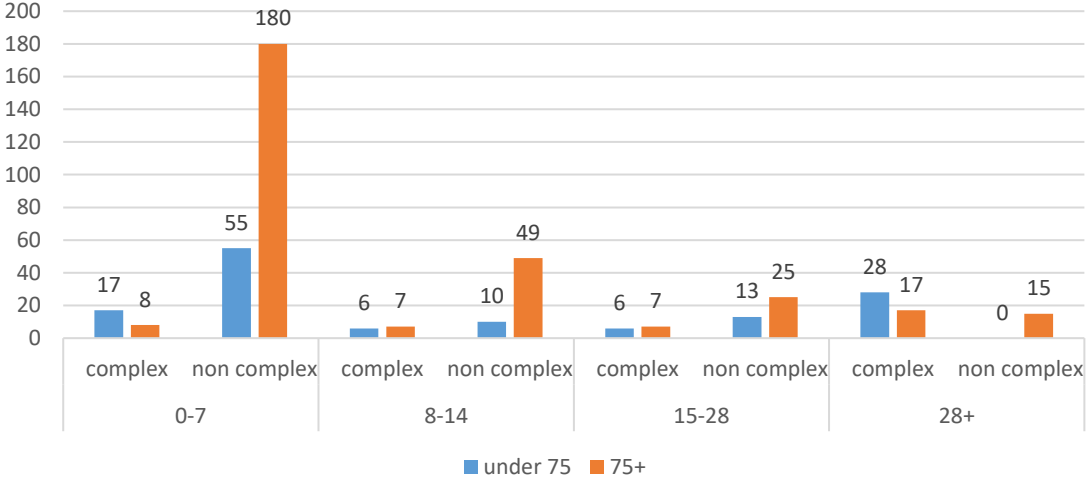
Chart 3 Average Duration of Delay by Age Group in Days



Source: Health and Business Intelligence Unit NHS Tayside

- 6.2 Chart 3 illustrates the average length of delay per month. Using the data available between June 2023 and November 2025, the median length of delay for people under 75 is 38 days. This reflects the complexity often associated in the younger adult inpatient population, particularly within General Adult Psychiatry and Learning Disability. Of note there also is an increase in younger adults in the acute hospital who have more complex needs and therefore longer delay.
- 6.3 The median length of delay for people over 75 is 14 days, reflecting the improvement work which has taken place to maximise capacity within social care services which largely supports discharge of older adults within the acute hospital. Of note will be the likely impact on this performance when the social care budget overspend is addressed.
- 6.4 Chart 4 illustrates that the majority of delays greater than 28 days are within the complex delay category, whereas non-complex delays tend to be shorter.

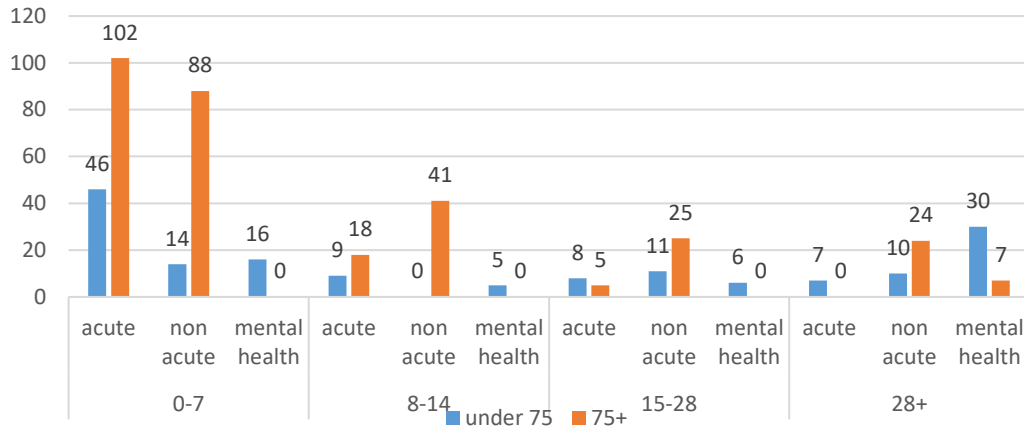
Chart 4 Average Duration of Delay by Type and Age Group September 2024 – November 2025



Source: Health And Business Intelligence Unit NHS Tayside

Note: Values <5 were rounded down to 0 for GDPR purposes

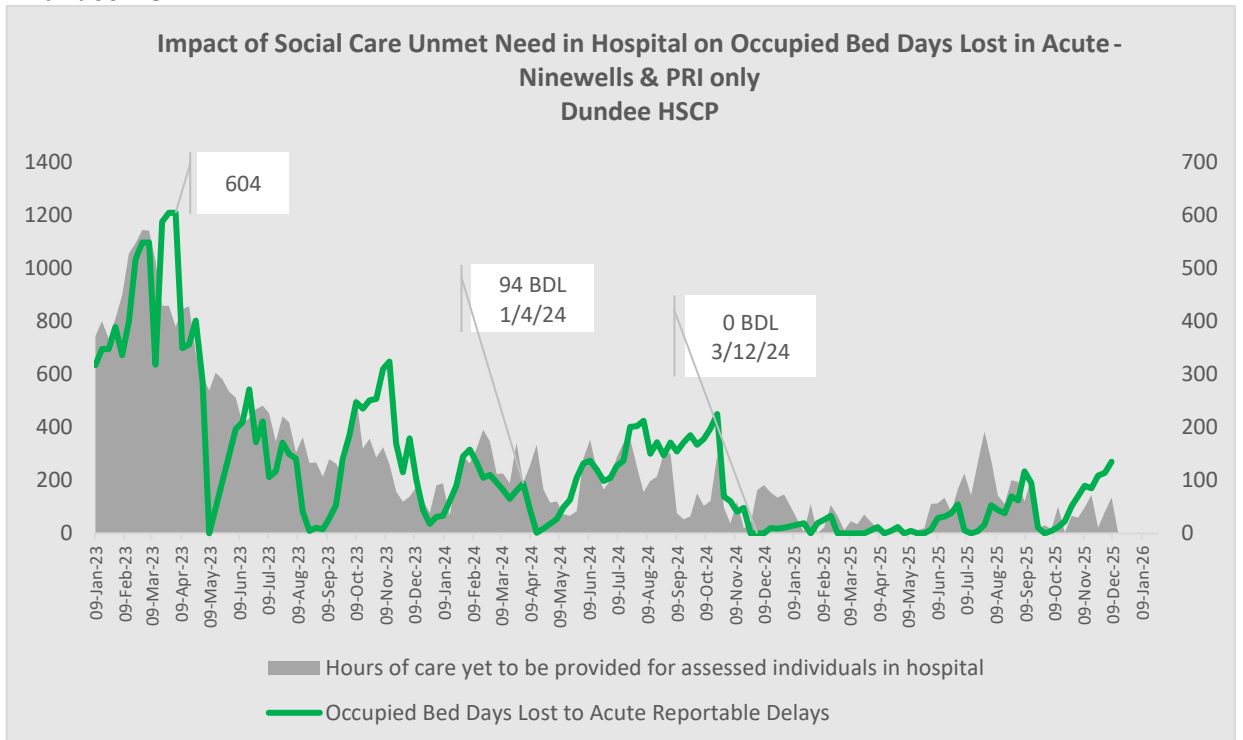
6.5 **Chart 5 Average Duration of Delay by Age and Location**



Source: Health and Business Intelligence Unit NHS Tayside
 Note: Values <5 were rounded down to 0 for GDPR purposes

7.0 As a result of the ongoing improvement work within DHSCP Care at Home services, the bed days lost due to delayed discharges demonstrates a longitudinal decrease. In April 2023, 604 acute bed days were lost due to reportable delays, compared to 94 in April 2024. This performance continued to improve to zero bed days lost in the acute hospital in early December 2024, however increases in unmet need have resulted in an increase in bed days lost.

Chart 6 Impact of Social Care Unmet Need on Bed Days Lost Delayed in Acute Hospital - Dundee HSCP

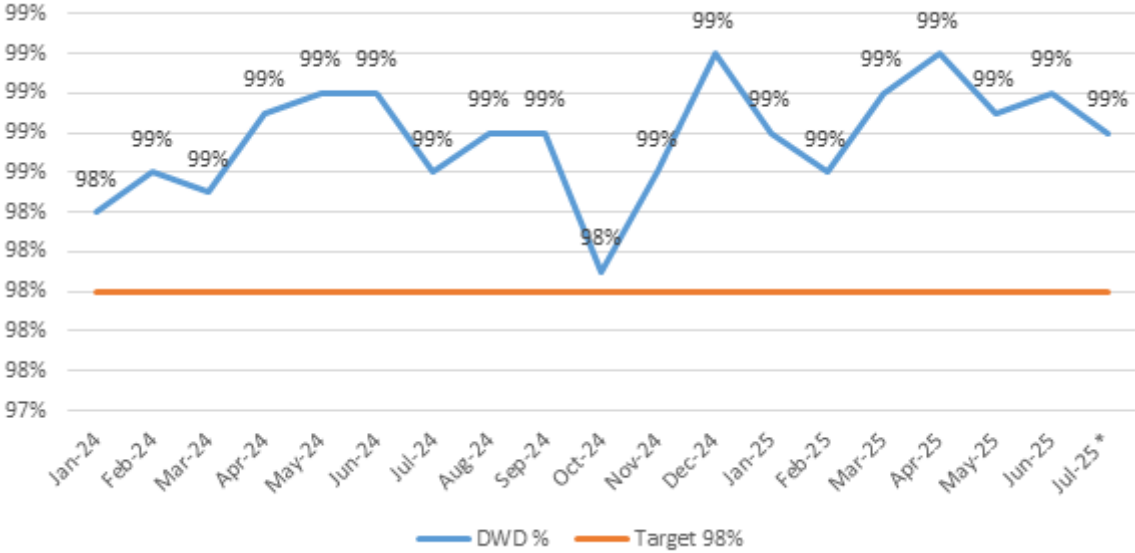


7.1 At 9 December 2025, there were 135 bed days lost to delayed discharges, showing the impact social care unmet need has on delays within the hospital system. However, efficiency gained through implementation of the Discharge Without Delay principles has continued to result in a slower deterioration in performance than the national position.

8.0 Discharge Without Delay

8.1 The majority of discharges across the whole system take place without delay. Chart 7 illustrates that Tayside has consistently performed at or above the 98% national performance target.

Chart 7 Discharge Without Delay (DWD) as a % of all Discharges (Tayside)



9.0 Key Outcome Focussed Actions

9.1 Partnership services are continuing to focus on the following areas to support further improvement:

- Continue to implement agreed actions identified within the Strategic Commissioning Plan.
- Expansion of Dundee Frailty at Home service with the aim of providing care closer to home in the form of advanced clinical assessment of frailty as an alternative to admission wherever appropriate. This will support (UUC) Board Optimising Access workstream aimed at reducing hospital presentations by 5%. This contributes to the wider Tayside Flow Navigation Centre Plus (FNC+) model in development.
- Continue to maintain and sustain GREEN RAG status for delayed discharge performance towards the suite of improvement measures across urgent and unscheduled care.
- Now that the Medicine for the Elderly Medical Team is aligned to GP clusters and Dundee Frailty at Home Team, there is a suite of improvement measures targeted at reducing harm caused by polypharmacy and creating ‘virtual wards’ to support primary care.
- Development of suite of performance measures for community urgent care services to track expansion progress in relation to the targets set by Scottish Government and to evidence quality indicators e.g. all patients within the service having a RESPECT conversation documented
- Targeted work to reinvigorate GP cluster meetings as a means of returning to ‘early intervention and prevention’ approach.

- Royal Victoria Hospital improvement plan in place and target of upper quartile length of stay set in all Medicine for the Elderly wards.
- Target Operating Model for Stroke Neuro Rehabilitation Unit now fully operationalised.
- Senior Nurse UUC leading on Optimising Flow workstream targeted at achieving upper quartile length of stay in all ward areas in Tayside.
- Frailty unit bed base has been increased and now provides opportunity for specialised frailty assessment for all frail patients in Dundee with developing links through Dundee Frailty at Home (DFAH) and into the GP clusters through virtual wards activity.
- Recruitment to additional inpatient Frailty ANPs to support the flow of frail older adults across the whole system pathway with the aim of reducing length of stay and promoting provision of care and treatment at home.
- Collaborative work across the acute, step down and community areas to develop a virtual advanced practice team approach to the management of capacity and flow, with the aim of 'right person, right place, right time'.
- Commissioned social care service (D2A) working with multidisciplinary team in Frailty Unit with aim of supporting early discharge and achieving zero delays in this area.
- Reinvigoration of Discharge to Assess model across the wider hospital as a means of minimising care home admissions and maximising social care efficiency/outcomes for people.
- Redesign of AHP services across whole system patient pathways
- Plan to add 2 Frailty Practitioners from an occupational therapy and physiotherapy professional background to the DFAH service
- Process mapping exercise commissioned and Centre for Sustainable Delivery improvement visit undertaken which will inform plans for further efficiency/improvement this year, particularly in relation to primary care.

10.0 POLICY IMPLICATIONS

10.1 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.

11.0 RISK ASSESSMENT

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| 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) | <ul style="list-style-type: none"> - Daily review of all delays. - 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 2 x Impact 5 = Risk Scoring 10 (High Risk) |

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| Approval recommendation | The PAC is recommended to accept the risk levels with the expectation that the mitigating actions are taken forward. |
| Risk 2 Description | Financial recovery plans for 2025/26 will impact on performance in relation to unscheduled care, including reduced levels of performance for delayed discharge. |
| Risk Category | Financial, Governance, Political |
| Inherent Risk Level | Likelihood 4 x Impact 5 = Risk Scoring 20 (Extreme Risk) |
| Mitigating Actions (including timescales and resources) | <ul style="list-style-type: none"> - Continuous monitoring of unscheduled care performance (as described in section 4). - A range of actions have been progressed by Care at Home Services to maximize the efficiency of the service. - The financial recovery plan for 2025/26 is subject of governance oversight, including risk assessment, meaning that impact on performance will be visible to IJB members. |
| 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. |

12.0 CONSULTATIONS

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

13.0 BACKGROUND PAPERS

13.1 None.

DAVE BERRY
CHIEF OFFICER

DATE: 19 DECEMBER
2025

Lynne Morman
Service Manager, Urgent & Unscheduled Care

Lynsey Webster
Lead Officer, Quality, Data and Intelligence

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