REPORT TO: **PERFORMANCE AND AUDIT COMMITTEE – 23 NOVEMBER 2022**

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

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC34-2022**

1.0 PURPOSE OF REPORT

1.1 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 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 9.

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 (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 as set out by the National Urgent and Unscheduled Care Collaborative. 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 Head of Health and Community Care for Angus Health and Social Care Partnership and the Associate Medical 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 Associate Locality Manager for

Acute and Urgent Care. Liaison between the local Board and the national team is undertaken by a Programme Manager within the NHS Tayside Improvement Team.

4.1.5 A large amount of weekly and monthly reporting is provided at management level to monitor, plan and make improvements. This includes:

- weekly 'RAG' snapshots across all sites;
- weekly Tayside level 'Discharge Without Delay' key measurement which is also used to populate the Local Oversight Reporting suite of measurement;
- monthly 'Planned Date of Discharge' report;
- weekly 'Discharge Without Delay' Data Template at Tayside level (Appendix 1); and,
- Discharge Without Delay Action plan updated weekly.

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 IN RELATION TO COMPLEX DELAYS

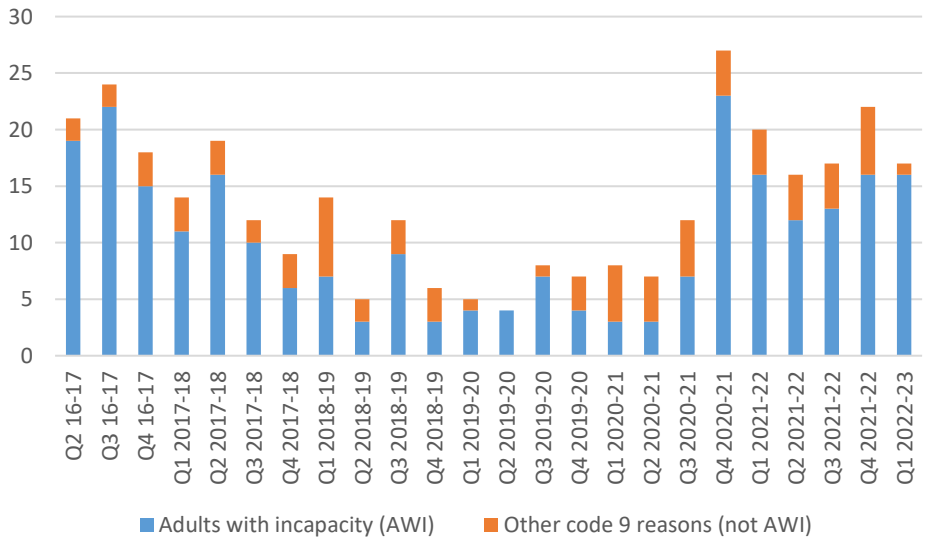
5.1 Complex Delays - Current Situation

5.1.1 A 'Complex Delay' (also known as a 'Code 9' delay) counts adults aged 18+ who have been delayed in their discharge from inpatient hospital care due to: waiting for a place in a specialist facility and no such facility exists in the partnership area and no interim option is appropriate; awaiting completion of complex care arrangements in order to live in their own home; Adults with Incapacity legislation requirements; or, people exercising their statutory right of choice where no interim placement is possible or reasonable.

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

The position in relation to the 75+ age 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

As previously reported, there was a significant improvement in performance in relation to complex delays for the 75+ group between 2016/17 and 2020/21. 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.

Delays linked to Adults with Incapacity guardianship applications in the 75+ age group began to rise during 2021 and they have remained high since. This is largely due to the impact of the COVID-19 pandemic, which increased hesitancy in the general population around the safety of care homes, at a time when the ability to recruit to social care reduced significantly and demand for social care rose sharply. These factors have led to a situation where there has been less resource available to continue with the 'Discharge to Assess' model and a consequent increase in the numbers of patients requiring to move directly to care homes from hospital.

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 the pandemic.

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 Dundee City Council Neighbourhood Services which was planned to release further housing stock throughout the second half of 2019/20, has been further delayed due to the pandemic. 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: NSS ISD Delayed Discharge Census

6.0 CURRENT PERFORMANCE IN RELATION TO STANDARD DELAYS

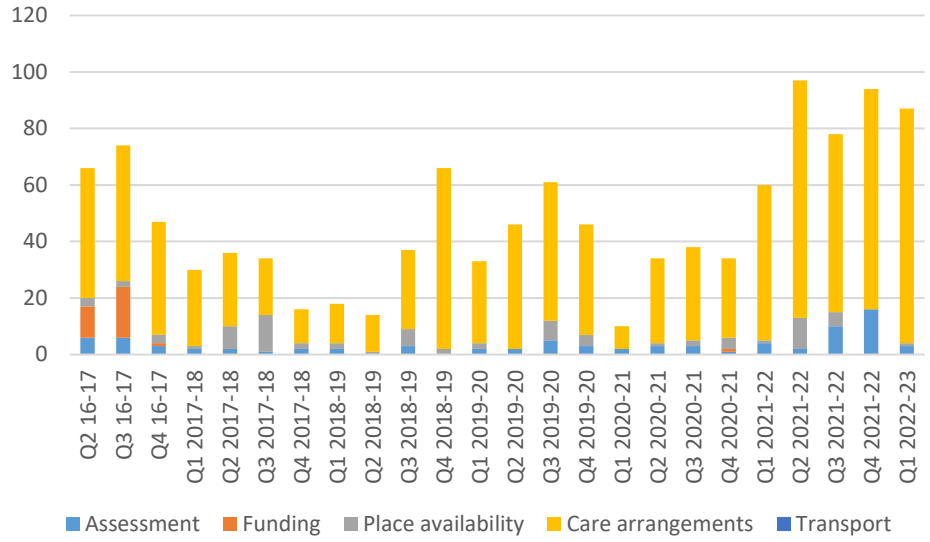
6.1 The position in Dundee regarding standard delays has continued to deteriorate over the previous 12 months as a result of the challenges noted above in relation to the matching of social care availability with rising demand. During 2017/18, the introduction of the 'Discharge to Assess' model enabled 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 Throughout 2021/22, local care agencies continued to experience recruitment challenges which has been the main contributor to the increase in standard delays. Although interim care home

placements have been offered to those patients awaiting social care packages to facilitate their discharge from hospital, many patients and their families have chosen not to accept this option.

6.3 As we remobilise post pandemic, social care recruitment is beginning to improve. Additionally, Dundee has entered into a new test of change with British Red Cross aimed at enhancing those improvement measures outlined in previous reports. As a result, a reduction in standard delays is anticipated during quarter 4 2022/23. 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 OCCUPIED BED DAYS DUE TO DELAYED DISCHARGE

Chart 4 Average daily delayed bed days occupied, age 18-74

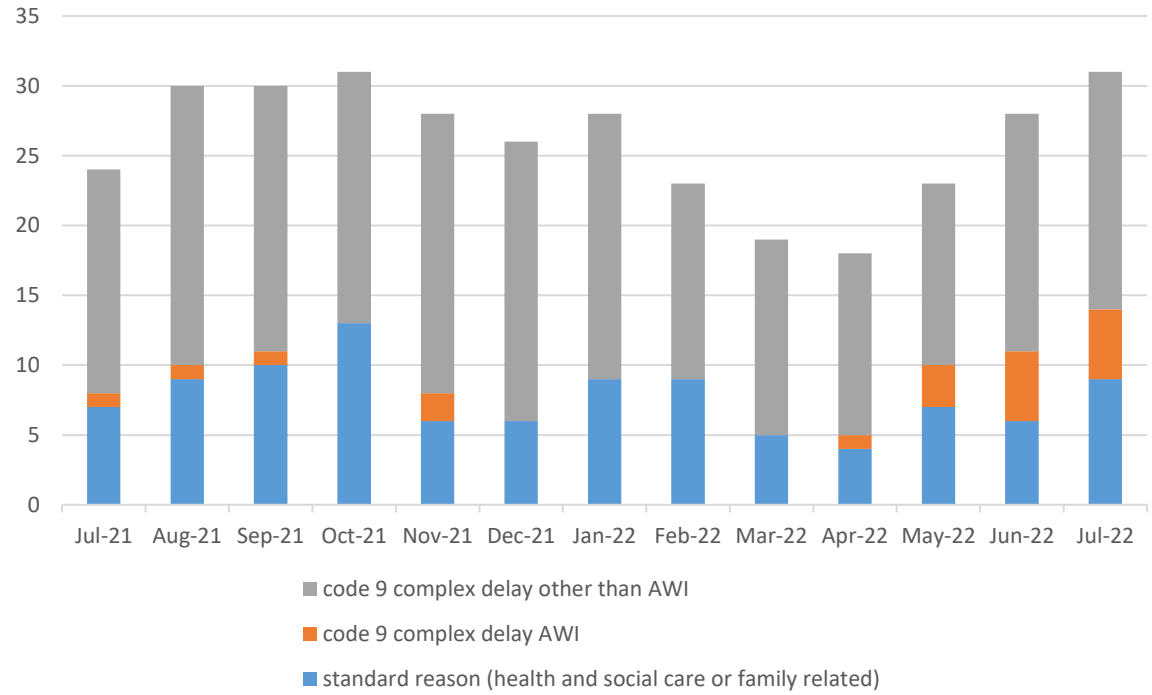
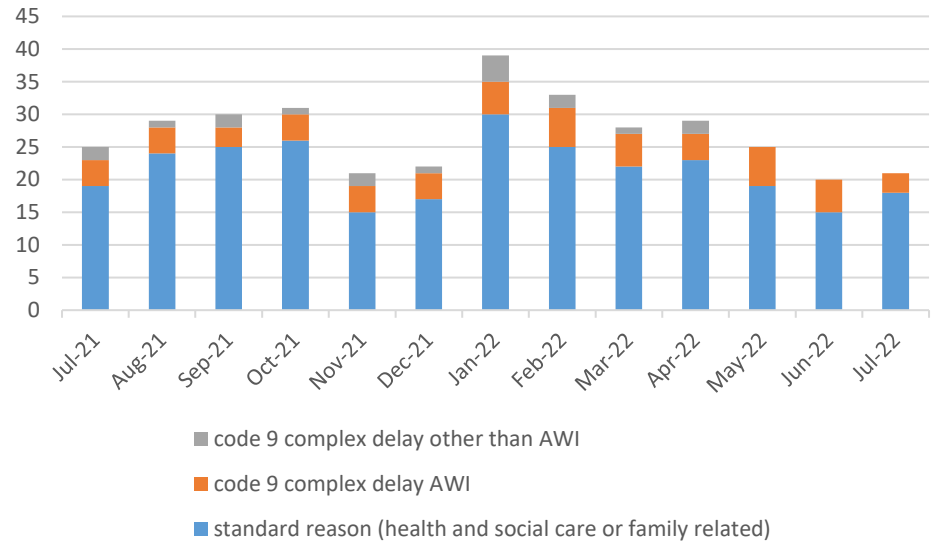
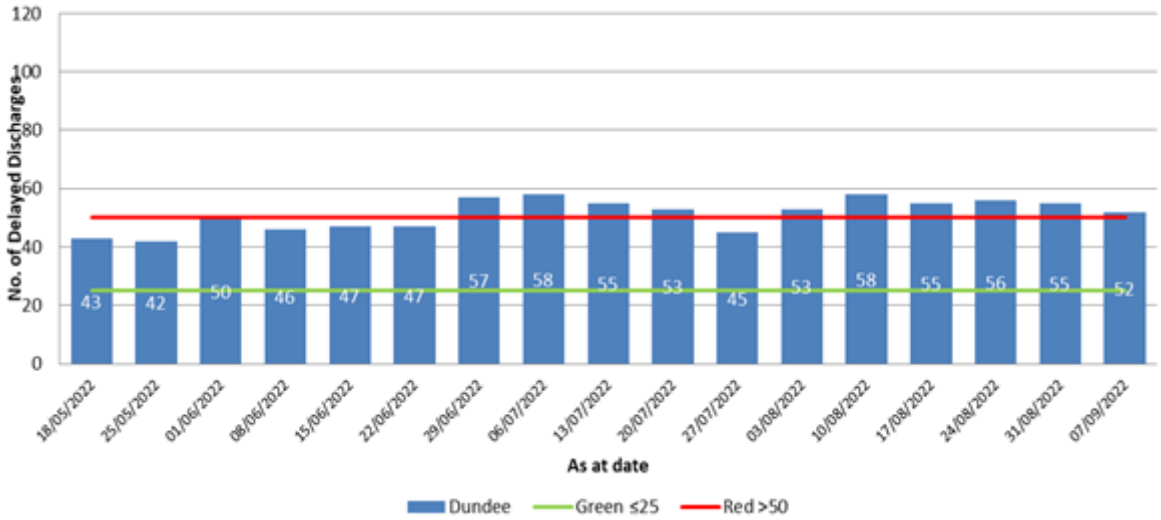


Chart 5 Average daily delayed bed days occupied, age 75+



It can be seen from charts 4 and 5 that the principle reason for delay in the 75+ age group is almost entirely attributable to the demand for social care as a means of supporting people to remain in their own homes.; both the average daily occupied bed days and the number of people delayed are high. whereas, delays for the younger adult age group continue to highlight a lack of availability of more specialised accommodation and support options predominantly for adults with complex mental health issues and/or learning disabilities. Both the average occupied bed days and the number of delays are high.

Chart 6 Dundee Delayed Discharges – Total including complex delays



The overall Tayside delay position is presented as part of the Board Business Critical Tayside level report for scrutiny at the Tayside Operational Leadership Group, which is chaired by the Medical Director and attended by senior representatives from each Tayside authority.
As part of the Tayside wide strategic approach, local targets with timescales have been set for each Health & Social Care Partnership both for overall reduction in delays and specifically reductions in standard delays within the acute hospital. Chart 6 above demonstrates the improving Dundee performance against the target set to reduce to AMBER status (<50 delays) by end of October 2022.

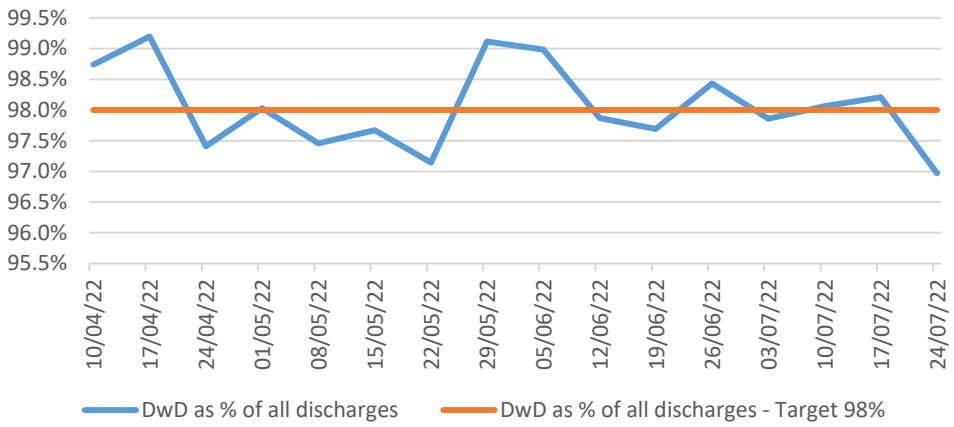
8.0 DISCHARGE WITHOUT DELAY (DWD)

8.1 In terms of the national and local urgent and unscheduled care targets, Tayside continues to perform well, sustaining 97% performance across all discharges at a time where we have seen an approximate rise of 20% in numbers of patients.

8.2 Work is ongoing to further improve this data, particularly relating to the roll out of Planned Date of Discharge, and targeted improvements relating to morning and weekend discharges. The Partnership's recent strategic commissioning work is beginning to demonstrate impact with a significant improvement in standard delays. In particular, we have embarked on a test of change with British Red Cross with the aim of reinstating the successful 'Discharge to Assess' model in place before the pandemic, but which has not been available throughout the past year due to social care recruitment issues as outlined above. If recruitment does improve, this model not only reduces bed days lost and total numbers of patients delayed, but also promotes improved outcomes for older people who are frequently more able to cope independently when assessed in their own homes.

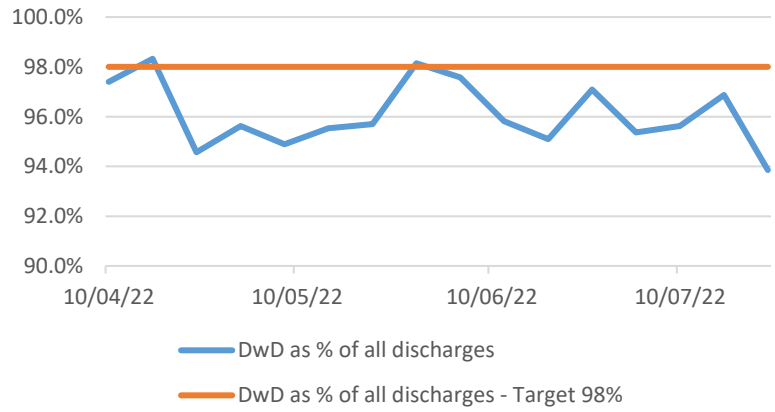
8.3 Charts 7, 8 and 9 demonstrate how the % of discharges without delay can vary by age group and specialty. Whilst overall, 97% of discharges were not delayed, performance particularly for the 65+ age group and Medicine for the Elderly specialty is more challenging due to the reasons already noted in sections 6 and 7 of this report.

Chart 7 % of DWD Discharges 18+ Dundee residents



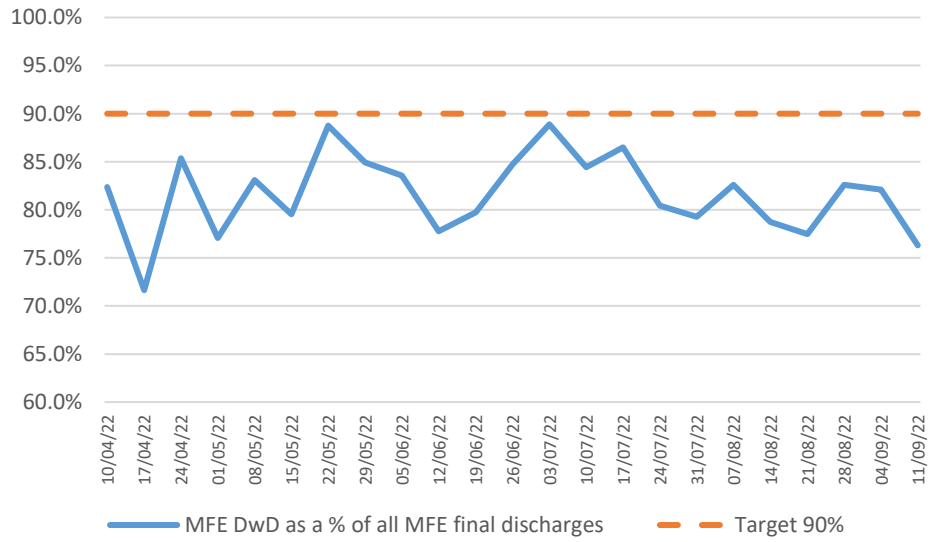
At July 2022 97% of discharges were without delay (target 98%) for the 18+ age group.

Chart 8 % of DWD Discharges 65+ Dundee Residents



At July 2022 94% of discharges were without delay (target 98%) for the 65+ age group.

Chart 9 - % of Medicine for the Elderly (MFE) DWD as a % of all MFE final discharges - Tayside



At 11 September 2022 76.3% of discharges were without delay (target 90%) in Medicine for the Elderly.

9.0 IMPROVEMENT ACTIONS IDENTIFIED TO ADDRESS INCREASE IN STANDARD DELAYS

9.1 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.

9.2 Building on the existing community urgent care services in Dundee, the Partnership has now launched the Dundee Enhanced Care at Home Team (DECAHT), aimed to work in a multidisciplinary way across a single frailty pathway which promotes patient focussed decision making and fewer barriers between stand alone services. The service is GP cluster focussed and multidisciplinary, drawing on the clinical expertise of the Hospital at Home clinicians as well as the cluster geriatricians who are based in inpatient settings but who will provide support and advice to the Advanced Nurse Practice led cluster teams. The service has a single point of access for GP practices, thereby simplifying the referral process and ensuring the patient receives the appropriate level of clinical assessment and input. The service will be supported by the developing Discharge to Assess social care service which will provide wraparound support for people in their own homes during periods of ill health as a means of avoiding hospital admission wherever possible and appropriate. Additionally, a Transitions Team comprising occupational therapy and physiotherapy staff has been developed which will functionally assess patients at the front door assessment areas of the acute hospital or within urgent care, and follow the patient to their own homes to embed the rehabilitation plan within the social care assessment package. Regular whole system multidisciplinary meetings will ensure the patient's care continues to be provided in the right place, at the right time by the right person. In order to make best use of the scarce social care resource, third sector partners are also involved in these discussions.

9.3 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.

9.4 The Acute Medicine for the Elderly Unit (AME) continues to support good quality frailty assessment and early discharge for frail older adults. The next phase of development will enhance the communication between AME, Emergency Department, Flow Navigation Centre and DECAHT with the aim of pulling patients appropriately from hospital settings and encouraging admission avoidance whenever possible.

9.5 The eight bedded unit within Turriff House has now been opened as a 'step down' alternative to inpatient psychiatric rehabilitation for older people.

9.6 In addition to the description of the DECAHT service above, alternative advanced practice models such as advanced paramedic roles, are also being explored with a view to the ongoing multidisciplinary development of the urgent care service.

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

9.8 The new stroke pathway has now been identified with the realignment of inpatient AHP staff to promote earlier discharge and community focussed rehabilitation. A programme of intensive improvement work is underway in mental health services, including the roll out of Planned Date of Discharge policy in those areas and the implementation of some processes which have been tested in the acute hospital as a means of promoting more effective and efficient discharge planning.

10.0 SUMMARY

10.1 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 continues 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.

11.0 POLICY IMPLICATIONS

11.1 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.

12.0 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.

13.0 CONSULTATIONS

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

14.0 BACKGROUND PAPERS

14.1 None.

Dave Berry
Chief Finance Officer

DATE: 3 November 2022

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Associate Locality Manager, Acute and Urgent Care

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Senior Officer

Appendix 1 Discharge Without Delay Data Template – Tayside Level

Measure 1A Patients in Delay - The number of acute, community and Mental Health inpatients with a Delayed Discharge code - Broken down by the partnership from which they reside.

	ALL DELAYS		
Partnership	**Acute**	**Community**	**Mental Health**
Angus	11	10	<10
Dundee City	29	30	16
East Lothian	<10	0	0
Fife	<10	0	0
Perth & Kinross	25	36	14

	Complex Delays		
Partnership	**Acute**	**Community**	**Mental Health**
Angus	<10	0	<10
Dundee City	<10	<10	15
Perth & Kinross	<10	<10	<10

Measure 1B Average Length of Stay (ALOS) of Delayed Inpatients - Average Trak (PAS system) LOS of inpatients in delay, acute, community and mental health (Tayside)

	ALOS - Total Delays	ALOS - Complex Delays
Community	117.7	157.8
Acute	73.8	185.9
Mental Health	977.5	1340.4

Measure 2 Inpatients Discharged Without Delay - The total number of patients discharged from an inpatient hospital stay and the total number discharged from an inpatient hospital stay who are were not in delay (Tayside)

	All sites
Total Discharges	1800
Total Discharged not in delay	1777

Measure 3 Proportion of Discharges by Hour - Proportion of patients discharged from acute inpatient hospital stay at three points in the day (Noon, 4pm, 8pm - cumulative) (Time in discharge lounge should be excluded) (Tayside)

	Pre Noon%	Pre 4pm %	Pre 8pm %
Monday	14.7%	48.0%	89.7%
Tuesday	14.6%	62.5%	95.0%
Wednesday	16.6%	57.6%	93.8%
Thursday	14.6%	51.9%	91.9%
Friday	12.9%	52.1%	95.2%
Saturday	19.6%	64.7%	93.5%
Sunday	21.6%	58.6%	92.8%
Weekly average	15.5%	55.6%	93.2%

Measure 4 Social Work / Social Care Referral Dates (Tayside)
This measure will look at the count of Patients who were discharged during the week who were in delay and will count:
1 - Have a Referral to SW/SC date before their R4D date
2 - Have a referral to SW/SC date equal to their R4D date
3 - Have a referral to SW/SC date after their R4D
4 - Have no referral made during their inpatient stay

	Acute	Community	Mental Health
Referral to SW/SC prior to R4D date	14	<10	0
Referral to SW/SC equal to R4D date	0	0	0
Referral to SW/SC following to R4D date	0	0	0
Have no referral made during their inpatient stay	<10	0	0

Measure 5a Planned Date of Discharge (PDD) Recorded - A total count of inpatients and a total count of inpatients with a PDD at the Midnight census point on the Sunday of the reporting week - Where there is no PDD field, and Estimated Date of Discharge (EDD) is utilised, this should be used if the field is used to record a PDD (Tayside)

	Acute	Community	Mental Health
Total number of inpatients	849	301	227
Number of PDD's recorded	457	163	86

Measure 5b PDDs lapsed over reporting period - The number of patients who have a PDD which has elapsed at the census point on the Sunday of reporting. (Tayside)
Where there is no PDD field, and EDD is utilised, this should be used if the field is used to record a PDD

Acute	Community	Mental Health
125	108	69

Measure 6a ALOS for delayed patients from time of admission to R4D - For acute patients who were discharged during the reporting week who were in delay: Average length of stay from date of admission to most recent date patient marked as R4D (Tayside)

	Acute Only
ALOS of DD Discharges - Admission to Ready for discharge	49.5

Measure 6b ALOS from R4D to discharge - delayed patients discharged in previous 7 days – For acute patients who were discharged during the reporting week who were in delay: average length of stay from the most recent time the patient is recorded as ready for discharge to the time the patient is discharged from Trak (PAS) (Tayside)

	Acute Only
ALOS of DD Discharges - Ready for discharge to discharge	18.3

Measure 7 Re-admission within 7 days of discharge - A count of all patients who were delayed at the point of discharge (From all sites) who went on to be re-admitted to an acute site within 7 days of discharge.(Tayside)

	Readmission
Readmissions	<10
Total delayed discharges from previous week	19

Measure 8 Discharge by day of the week - Number of delayed patients discharged by day of the week (Tayside)

	Total Delays
Mon	6
Tue	4
Wed	2
Thu	6
Fri	5
Total discharges for the week	23

Measure 9 Delayed days for current delayed inpatients - The total number of days patients spend delayed in hospital following their ready for discharge date to the census point at midnight of the Sunday reporting week. Total for Acute, Community and Mental Health patients. (i.e. the total number of delayed days for those patients identified in measure 1.a) (Tayside)

	Acute	Community	Mental Health
All Delays	2090	2162	5548
Complex Delays	780	557	5116