PERTH & KINROSS INTEGRATION JOINT BOARD

26 October 2022

DISCHARGE WITHOUT DELAY

Report by Head of Health
(Report No. G/22/161)

PURPOSE OF REPORT

To provide an update to the IJB on the complexity, ongoing challenges, and current position in relation to delayed discharges in Perth and Kinross. This is set out in the context of demographic pressures, declining workforce, and the impact of the pandemic on older people. The report also describes the current redesign of integrated discharge pathways and the work being taken forward within the Discharge Without Delay improvement programme.

1. RECOMMENDATION(S)

It is recommended that the Perth and Kinross Integrated Joint Board (IJB)

(i) notes the complexity, ongoing challenge on the current position of delayed discharges in Perth and Kinross; and
(ii) endorses the direction of travel within the Discharge Without Delay improvement programme to achieve longer term and sustained progress in reducing delays in hospital for people who are fit for discharge to home or a suitable homely care setting.

2. SITUATION/BACKGROUND / MAIN ISSUES

The Scottish Government's Integrated Urgent and Unscheduled Care Collaborative (IUUCC) is an initiative which has a broad range of aims and objectives working across multiple stakeholders. Together with the NHS Tayside *Unscheduled Care Board* (USCB), the collaborative has ambitions towards "*a more radical rethink about what new models of care and services would look like if we were to design them from scratch to meet the needs of our population*".

In response to the escalating delayed discharge issue, the IUUCC and USCB have placed "*Discharge without Delay*" as a core sub-strategy within a suite of whole- system commitments to support end to end urgent and unplanned patient journeys.

For Perth and Kinross HSCP this means:

- Adopting a *Home First* approach across the whole patient journey;
- Implementing a Frailty at Front Door Approach within Perth Royal Infirmary;
- Implementing a Planned Date of Discharge Approach across all inpatient areas and adopting a 7-day discharge process.
- Reducing length of stay by discharging patients on planned day of discharge; and
- Improving patient experience by simplifying the discharge process;
- Optimising flow by aligning capacity with demand.

Significant improvement work within our inpatient services is underway to refine processes, further integrate teams and to simplify the patient's journey from admission through to discharge and return home with support in the community through locality teams.

The Older Peoples Strategic Delivery Plan 2022:2025 (OPSPD), approved by the IJB in March 2022, sets out the significant success of the **Phase 1** of the redesign between 2016 and 2021 to shift the balance of care and improve capacity and flow across the system. The IJB prioritised investment in Care at Home capacity, establishment of the Locality Integrated Teams and a new respiratory service which are all aimed at early intervention and prevention of admissions to hospital. This investment led to a significant reduction in beds days occupied or avoided which equates to £2m (20 beds) per annum. This was achieved through delivery of efficiency savings across delegated services with no additional investment from NHS Tayside or Perth & Kinross Council.

The strategy had proven itself effective prior to the pandemic. However, since remobilisation the combination of staff absence and turnover, increased demand and acuity has presented unprecedented challenges. **Phase 2** of the OPSDP aims to deliver the necessary capacity and system redesign to address this. The *Discharge without Delay* improvement programme complements the OPSDP by prioritising *Early Intervention*; *Shifting the Balance of Care*; and *Improving Capacity and Flow*. All of these relate to the complex array of factors that influence delayed discharges and aim to support patients to return home as soon as possible.

Perth and Kinross has a growing and rapidly ageing population. This demographic in combination with the exponential relationship between conditions such as frailty and dementia increases the likelihood of unplanned hospitalisation. For older people, the detrimental effects of prolonged hospital stay have long been recognised. These include enhanced risks relating to falls, muscle atrophy, hospital-acquired infections, and cognitive decline, and ultimately early/premature admission to long-term care. Delays in hospital discharge for older people must be avoided.

The resurging delayed discharge problem is recognised locally and nationally with Scotland as a whole experiencing an increasing trend. Prior to the pandemic, there were around 3,000 people delayed in Scottish hospitals every day. Daily lost bed days are now around 20% higher nationally suggesting a systemic difference associated with the pandemic.

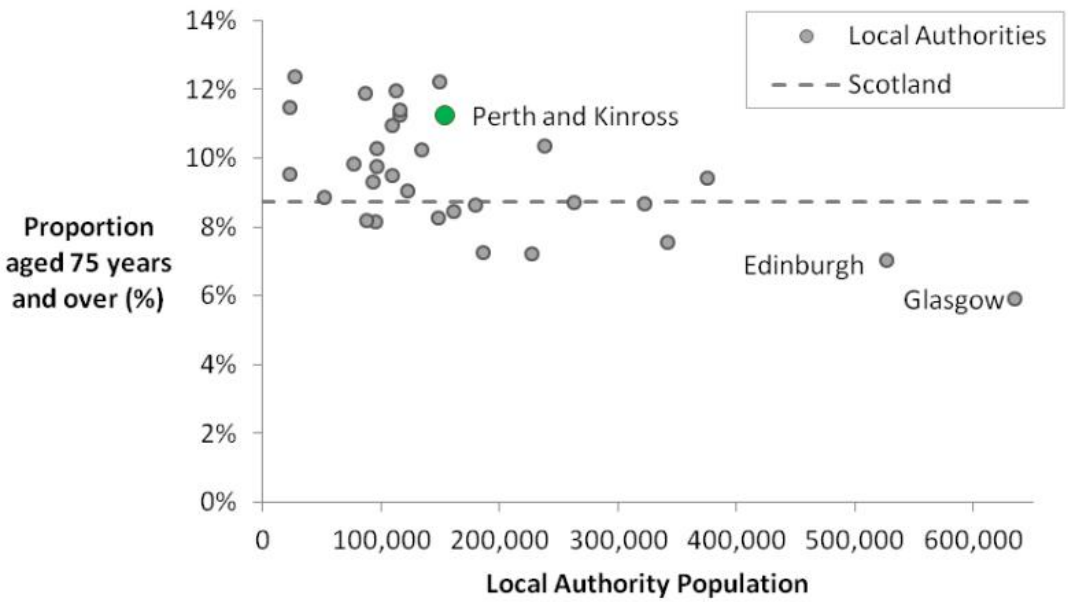


Figure 1 Proportion of population aged 75+ years versus population size for Scottish Local Authority areas (*Source: NRS mid-year population estimates data for 2021)*

Perth and Kinross has a relatively large and elderly population (Figure 1). This renders the HSCP susceptible to mismatches in demand for older people's services and our capacity to respond due to a declining workforce. When accounting for our age structure, Perth and Kinross generally mirrors Scotland-wide delayed discharge rates with our trends largely following the national pattern as below (Figure 2).

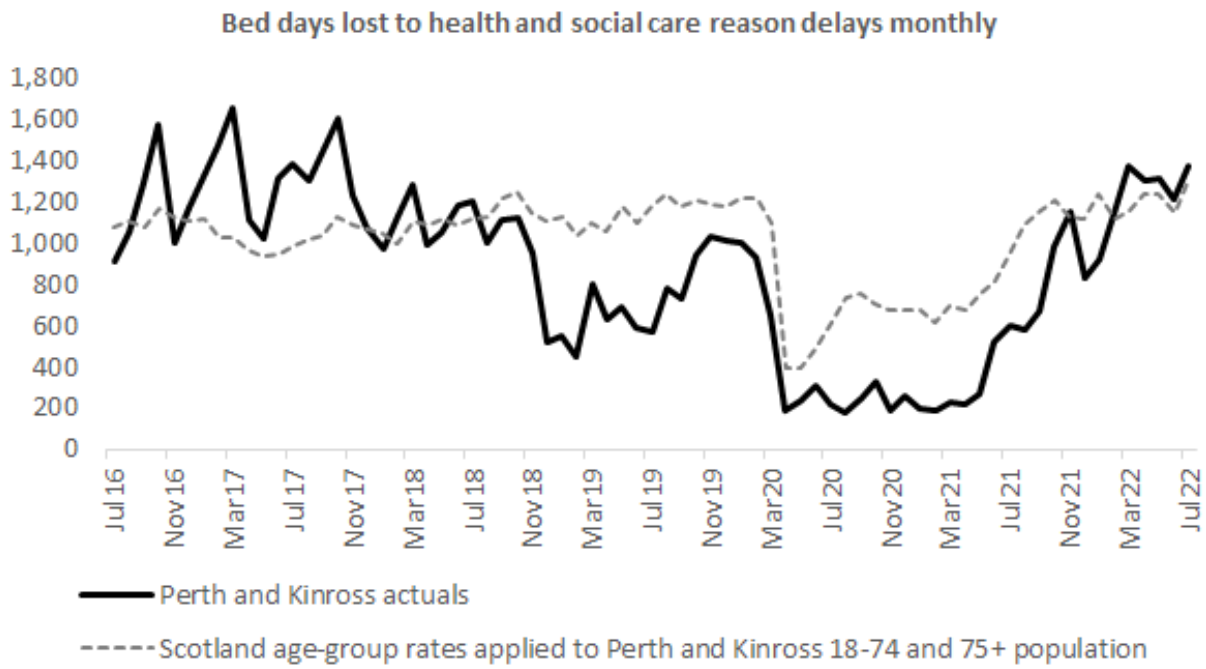


Figure 2 Bed days lost to health and social care reasons monthly: Perth and Kinross actual versus Scotland age group-specific rates applied to Perth and Kinross age groups (18-74, 75+) *(Sources: PHS (delayed discharge data), NRS (mid-year population estimates data))*

The rapid demographic change, combined with service capacity constraints, declining workforce and the aftermath of Covid translate into a significant increase in the scale and complexity of needs presenting to community and inpatient services. Frailty and dementia modelling supports the experience reported by practitioners and suggests that people are presenting at each stage of care with increasing complexity and acuity. The impact on community teams, inpatient services and GP practices is unmatched, with services experiencing significant challenges in maintaining whole-system capacity and flow.

In the face of our particular demographic pressures, we have previously demonstrated significant delayed discharge performance improvements. In 2019 we saw a 40% reduction in average monthly lost bed days from around 1,500 during 2016/17 to less than 1,000 during 2019. Following a “winter pressures” increase in late 2019, pandemic management led to an all-time-low, typically under 500 lost bed days per month for much of the remainder of 2020. However, since late 2020 (as also reflected nationally) there has been a rising trend, which has now taken our monthly total above the previous highs of 2016/17.

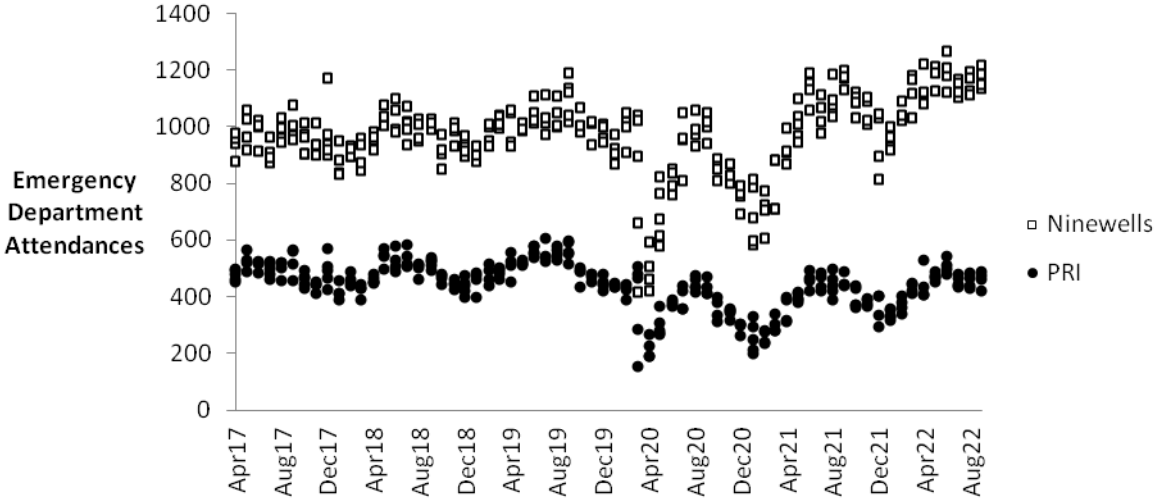
Nationally, the health and social care sector is experiencing continuing issues in relation to recruitment and provider sustainability. Workforce availability acts as a fundamental capacity-limiting factor. From a social care perspective, minimising unmet demand by using agency staff and the creative management of internal service capacity is not sustainable. We are addressing this demand-capacity mismatch in several ways, including through

significant investment and approaches through the Older Peoples Strategic Delivery Plan. Through secured funding and enhanced remuneration packages, we continue to develop the *Living Well* Teams and our Alliance Contract development activity to increase assessing and reviewing capacity and reduce unmet need. A recruitment event has recently been carried out within Perth City to attract potential staff into caring roles.

While the total Care at Home delivered hours is expected to increase greatly over the next year, this is as a result of increasing complexity of need rather than increasing numbers of people requiring care at home.

The capacity of a hospital system is the safe rate of outflow when final discharges are unhindered. If the flow into the system (admission rate) exceeds the capacity, then inpatient services will increase. This is also the case if patients are delayed in hospital when their inpatient treatment is complete. Managing inpatient capacity and flow relies on measuring and understanding the demands and capacity for each component of the system, and for the system as a whole. Paradoxically, increasing hospital capacity through inpatient process improvements may simply result in patients joining the "discharge queue" even sooner and translate into a perception of reduced performance. As such, we are seeking to tease out the causal factors for the steady increase in delayed patients over the recent period across the whole system.

First, we consider the influence of flow at the front door. Since our delayed discharges numbers began to rise in early 2021, emergency inpatient stay admissions for Perth and Kinross residents aged 18 and over have increased by almost 25%. That said, compared with the summer of 2019, the rate is currently “only” approximately 6% higher (note that these values are derived from live system data and require verification). In addition, combined emergency department attendances for Ninewells and PRI are comparable with 2019 rates and the attendance rate at PRI is lower than during 2019.



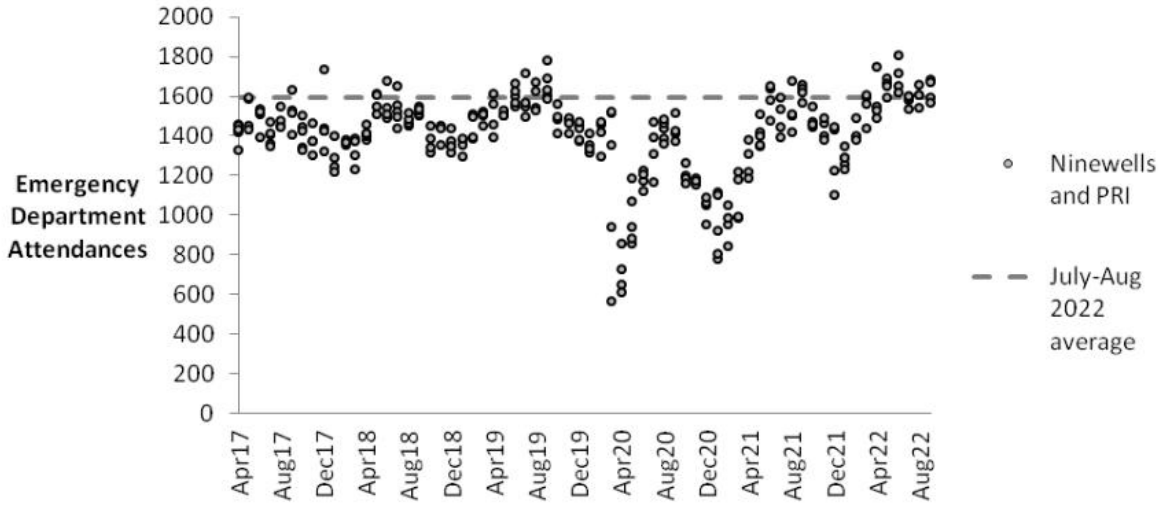


Figure 3 NHS Tayside Emergency Department attendances – April 2017 to September 2022 (*source: PHS*)

The inflow shows modest increases in relation to the rate of increase in delayed discharge occupancy. However, these numbers do not necessarily demonstrate to the *totality of need* presenting at hospital and it is this that consumes hospital capacity.

The rate of discharges from delay provides a proxy for the rate at which patients "join the queue" to leave hospital.
Figure **4** shows that the rate is now comparable to that of 2019 and considerably below the preceding years. So, patients are not "joining the queue" at a particularly high rate.

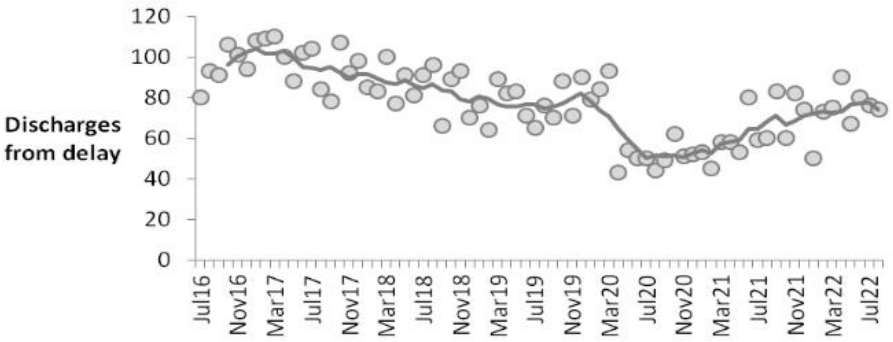


Figure 4 Discharges from delay for 18+ Perth and Kinross residents (*source: PHS*)

Figure **5** indicates that it is the typical length of delay experienced by patients that is the main driver of lost bed days.

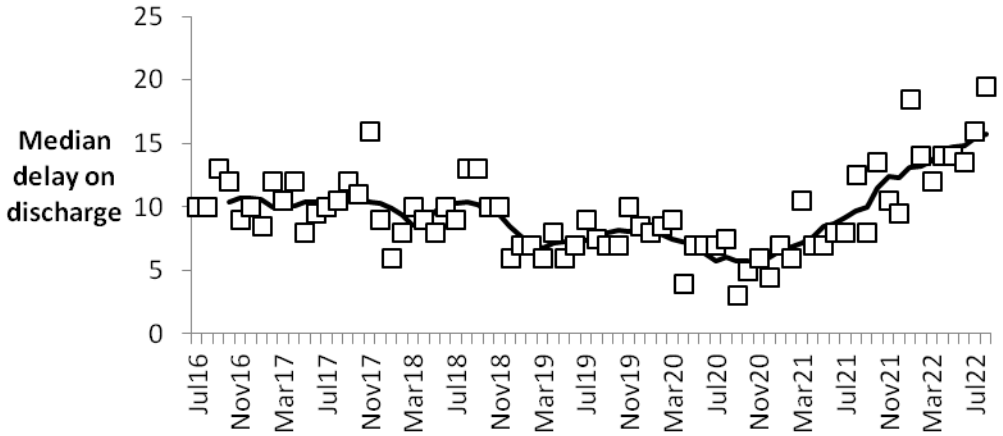


Figure 5 Median number of days delayed on discharge from delay for 18+ Perth and Kinross residents (*source: PHS*)

We cannot assume that the recent surge in delayed discharges is due to a relative change in the capacity of post-discharge community services and support. It is also due to increased levels of complex need (hence demand) for those services. A dramatic increase in needs is entirely plausible, driven by the impacts of the pandemic – directly by COVID but also indirectly due to reduced preventative/universal service access and health behaviours generally.

The heat map in Figure 6 clearly illustrates that while the under-65 population shows signs of relative stability, the older population groups continue to rise, and we have yet to experience the peak of population ageing (see also Figure 7).

	Age Group																		
Year	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90+
2001	7,178	7,941	8,653	7,929	6,050	6,849	9,007	10,470	9,932	9,457	10,161	8,686	7,543	7,039	6,444	5,252	3,295	2,040	1,024
2002	6,992	7,940	8,451	7,765	6,138	6,431	8,818	10,476	10,178	9,647	9,729	9,374	7,772	7,106	6,418	5,304	3,574	1,984	1,033
2003	6,907	7,935	8,402	7,689	6,210	6,211	8,539	10,517	10,427	9,743	9,686	9,869	8,065	7,229	6,458	5,327	3,767	1,939	1,040
2004	6,919	7,888	8,534	7,304	6,315	6,213	8,268	10,438	10,671	9,958	9,737	10,207	8,181	7,491	6,481	5,333	4,049	1,846	1,067
2005	6,904	7,892	8,710	7,098	6,671	6,360	7,946	10,070	11,105	10,013	9,745	10,438	8,426	7,571	6,623	5,435	3,970	1,987	1,096
2006	6,810	7,975	8,616	7,303	6,941	6,654	7,527	9,929	11,238	10,264	9,811	10,561	8,835	7,567	6,629	5,500	3,987	2,141	1,092
2007	6,909	7,794	8,748	7,554	7,232	7,068	7,220	9,720	11,298	10,532	10,011	10,117	9,537	7,788	6,705	5,541	4,032	2,303	1,031
2008	7,014	7,602	8,808	7,858	7,505	7,562	7,070	9,411	11,322	10,862	10,138	10,016	9,990	8,035	6,853	5,612	4,027	2,412	1,033
2009	7,143	7,491	8,655	8,215	7,552	7,890	7,066	9,054	11,178	11,122	10,301	9,941	10,308	8,073	7,058	5,639	4,106	2,557	1,021
2010	7,244	7,422	8,683	8,633	7,391	8,000	7,319	8,661	10,850	11,539	10,341	9,933	10,512	8,224	7,141	5,801	4,228	2,538	1,140
2011	7,377	7,226	8,667	8,744	7,487	8,103	7,581	8,289	10,659	11,724	10,574	9,982	10,597	8,584	7,184	5,864	4,369	2,589	1,250
2012	7,367	7,296	8,427	8,861	7,734	8,079	7,875	7,884	10,426	11,792	10,799	10,169	10,049	9,328	7,250	5,950	4,435	2,688	1,331
2013	7,239	7,400	8,112	8,767	7,804	8,046	8,086	7,664	9,982	11,689	11,031	10,210	10,006	9,660	7,498	6,038	4,456	2,682	1,400
2014	7,158	7,587	7,984	8,668	8,197	7,932	8,357	7,670	9,591	11,548	11,333	10,418	9,971	9,975	7,537	6,224	4,544	2,738	1,498
2015	7,272	7,665	7,913	8,577	8,409	7,766	8,596	7,830	9,149	11,192	11,796	10,504	10,005	10,266	7,659	6,317	4,660	2,825	1,529
2016	7,181	7,899	7,708	8,450	8,284	7,931	8,571	8,191	8,785	10,947	11,972	10,769	10,076	10,338	8,038	6,299	4,710	2,928	1,603
2017	7,064	7,976	7,832	8,223	8,029	8,101	8,503	8,478	8,372	10,753	12,059	10,954	10,241	9,901	8,691	6,453	4,752	3,012	1,706
2018	6,897	7,956	7,954	8,043	7,710	8,235	8,534	8,677	8,185	10,320	12,014	11,289	10,277	9,914	9,023	6,638	4,845	3,054	1,725
2019	6,799	7,841	8,152	7,941	7,432	8,473	8,400	8,986	8,214	9,999	11,797	11,540	10,542	9,875	9,300	6,697	5,048	3,112	1,802
2020	6,551	7,869	8,124	7,870	7,474	8,479	8,174	9,103	8,445	9,466	11,439	11,986	10,613	9,859	9,610	6,742	5,124	3,167	1,815

Figure 6 Heat map illustrating demographic structural change for Perth and Kinross 2001-20 *(Source: NRS mid-year population estimates)*

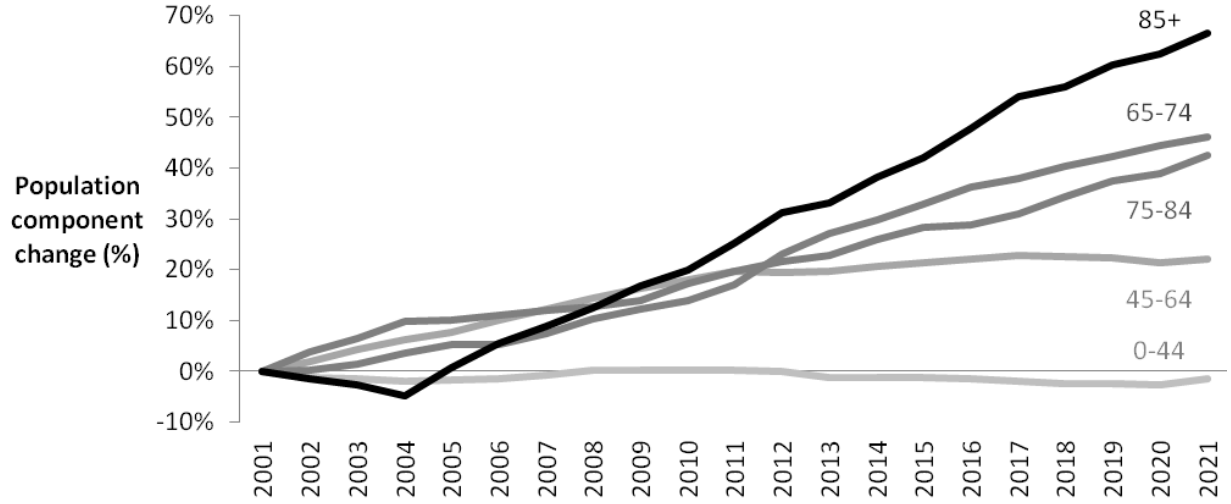


Figure 7 Perth and Kinross population age-group component change against 2001 baseline *(Source: NRS mid-year population estimates)*

Translating this population structural change into the context of changes in the nature of need and the human and financial resources required to meet those needs is complex. We know that the quantity of need will increase relative to the available workforce and infrastructure. Applying established condition prevalence models to official Perth and Kinross population projections warns us of a substantial year-on-year increase in the number of people living with frailty and/or dementia. These are among the conditions that we associate with high levels of unplanned care – areas already under extreme pressure.

3. PROPOSALS

Our vision is that the people of Perth and Kinross are supported by a single integrated team, working in the best interest of them, their family, and carers. The right people, delivering the right care, in the right place, at the right time, and proactively ensuring an unhindered pathway that enables optimal outcomes and the best possible experience across their entire care journey and beyond.

We are driving towards this vision through the “Discharge without Delay”. The programme seeks to simplify discharges by applying a “pathway-based” planning approach and fully embrace the principles of “Home First”, which encourages all health and care professionals to ask the questions “why not home, why not now?” at every stage of the hospital journey, from the front door, through admission, to discharge. To evaluate our progress, we are developing a set of SMART objectives supported by a suite of outcome indicators.

The following key workstreams have been set up to deliver core components of the Discharge without Delay programme.

Frailty at the Front Door

People are frail when they lack the resilience to recover from illness/injury. With the right care, support come opportunities to improve independence, quality of life and reduce reliance on health and social care resources. An integrated frailty at the Front door model is being developed within Perth Royal Infirmary that will make connections to the Locality Integrated Care Teams and Social Work Teams. This 'front door' intervention is intended to provide urgent, wrap-around care that seeks to identify the best pathway for frail patients. The PRI team are working towards their future ambition of a dedicated 7-day frailty service, which will enhance the current frailty model. This includes changes to patient pathways, staffing/workforce and hospital infrastructure.

Integrated Discharge Hub

The Integrated Discharge Hub will support wards with safe and appropriate patient discharge. This multi-disciplinary approach puts health and social work professionals at the heart, communicating with families, integrating with board rounds, and liaising with community staff. A discharge coordinator will act as an integral, single point of contact, supporting the team towards the timely completion of all discharge related tasks with staff adopting a 'day before' approach. Early referral options will continue to support carers to obtain advice earlier on in relation to Guardianship where there is potential for delays in complex circumstances.

Planned Date of Discharge

"Planned Date of Discharge" is the date when the Multi-Disciplinary Team along with patient and family considers that a patient can be safely discharged from the acute hospital setting in a coordinated way. Setting the best date and time is integral in supporting existing teams with demand and capacity, and ensuring that there is enough time to plan, prepare and communicate with patients, family members, carers & other teams. The requirement to set a Planned Date of Discharge has been agreed as a priority focus within the Unscheduled Care Board Improvement Plan, and an Operational Lead has been appointed to carry out observations and training (Tayside Wide).

The work stream is progressing well, with a priority focus on:

- Morning and weekend discharges (which are usually the best for patients and carers)
- The development of a risk assessment tool for setting the best date and time of discharge.
- Team participation in the NHS Tayside's *Quality Improvement Programme*, with a practitioner level course delivered by the Improvement Academy team.

Interim Care Home Placement

Interim placements can be used to assist timely discharge from hospital when individuals have been assessed as being clinically fit for discharge, but an appropriate care package and/or accommodation is not immediately available. Interim placements are successfully reducing some delayed discharges in hospital. A reablement and asset-based approach continues to be taken forward, with Live Active and RVS being part of the delivery model, along with strong participation of the Locality Integrated Care Teams and Social Work Teams. The current financial framework will support this until March 2023.

Programme management

Our Perth and Kinross programme works collaboratively as part of a Tayside-wide best practice approach. The Perth and Kinross Discharge without Delay Steering Group is developing a programme implementation plan with agreed completion dates overseen by a project manager.

4. CONCLUSION

This report highlights the Partnership's strategic challenge in minimising the incidence and detrimental impact of delayed hospital discharges. There are challenges in meeting increased levels of need associated with our growing and ageing population, alongside a declining workforce and budget constraints.

People who become delayed in hospital are more likely to experience and increasing need for unplanned care and increasing dependence so being able to move to a preventative and proactive approach is essential.

While the reduction in delayed discharges associated with the pandemic led to what may have felt like a "fresh start", the delayed discharge problem has returned and we face as big a challenge as ever exacerbated by the health and wellbeing impacts associated with the pandemic.

The Discharge without Delay programme will drive fundamental process improvement processes and redesign, while tackling cultural change to enable people to be ready for discharge at the best planned date and time. A Home First approach will mean that people will be assessed in their home and promote access to support and restorative services for the best outcomes and to avoid further crisis. Our performance framework will evaluate our success.

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NOTE: No background papers, as defined by Section 50D of the Local Government (Scotland) Act 1973 (other than any containing confidential or exempt information), were relied on to any material extent in preparing this report.

ANNEX

1. IMPLICATIONS, ASSESSMENTS, CONSULTATION AND COMMUNICATION

Strategic Implications	
HSCP Strategic Commissioning Plan	Yes
Transformation Programme	Yes
Resource Implications	
Financial	Yes
Workforce	Yes
Assessments	
Equality Impact Assessment	No
Risk	Yes
Other assessments (enter here from para 3.3)	
Consultation	
External	No
Internal	Yes
Legal & Governance	
Legal	No
Clinical/Care/Professional Governance	Yes
Corporate Governance	No
Directions	
Communication	
Communications Plan	No

1. Strategic Implications

1.1 **Strategic Commissioning Plan**

By simplifying discharges via a fully integrated, 'pathway-based' planning approach; and by embracing the principles of "Home First", as detailed within this paper, we will support the objectives set out within the Perth & Kinross Strategic Delivery Plan:-

1 prevention and early intervention,
2 person centred health, care and support
3 work together with communities
4 inequality, inequity and healthy living
5 best use of facilities, people and resources

2. Resource Implications

2.1 **IJB Approved Recurring Investment Plan 2022/23**

In March 2022, PKIJB approved investment of £6.40m in Older Peoples Services as part of the OPSDP. Table 1 below sets out the key investments approved.

Table 1 2022/23 Recurring Investment in Older Peoples Services

	Approved investment (£m)	Forecast slippage (£m)
Care at Home Redesign	2.76	1.44
Community Alarm	0.53	0.11
Social Work Capacity	0.66	-
Locality Integrated Care Team	1.20	0.31
AHP Staffing	0.20	-
Hospital at Home	0.53	0.06
Urgent Care	0.31	0.17
Care Home Nursing Staff	0.21	0.02
Total	6.40	2.11

A level of slippage is now anticipated with the full year impact of this investment now expected in 2023/24.

Unplanned Inpatient costs 2022/23

The unanticipated level of admissions and acuity of patient's has led to a significant and unplanned increase in costs across the PKHSCP inpatient bed base in 2022/23. Table 2 below sets out the unplanned forecast overspend on inpatient beds at Month. This includes savings not deliverable due to the level of current admissions.

Whilst £1.25m of forecast costs have been attributed directly to Covid and are being funded from covid reserves the £1.96m balance is only able to be managed as a result of the slippage in investment set out at (2) above. For 23/24, this level of spend is projected to continue and will have a significant impact on any remaining IJB winter resilience reserves.

Table 2 Forecast overspend 2022/23 PKHSCP Older People Inpatient Beds

	Forecast Overspend (£m)
Medicine for the Elderly	1.08
Psychiatry of Old Age	1.18
Community Hospitals	0.21
Unachieved rehabilitation bed savings	0.74
Total	**3.21**
Covid Offset	(1.25)
Net Overspend	**1.96**

2.2 Workforce

Human Resources and Partnership Representatives will be consulted directly on any future proposals that may contain workforce implications pertaining to the Discharge without Delay programme, in particular, any contractual

implications associated with 7-day working and organisational change processes that may need considered across the partnership

3. Assessments

3.1 Risk

Capacity and flow currently sits as a red risk on the strategic risk register of the HSCP and further risk management approaches will be causally explored and prevention and mitigation strategies identified using standard risk management methods. Risk assessment exercises will be carried via risk workshops. Risk owners will be appointed who will be responsible for developing and implementing risk reduction strategies operationally and strategically.

4. Consultation

4.1 External

Patient/Service user feedback will be obtained during the course of the Discharge without Delay programme via various methods, including online feedback (Care Opinion).

4.2 Internal

This paper has been prepared in conjunction with PKHSCP Executive Management Team, Integrated Management Team & Partnership Representatives.

4.3 Impact of Recommendation

By simplifying and streamlining the discharge process, a patient's overall experience will be enhanced and their length of stay reduced. Patients will receive the right care, in the right place and consequentially, unnecessary deterioration will be prevented. Additionally, optimising flow by aligning capacity with demand will have a positive impact on the whole system.

5. Legal and Governance

There are no specific legal or governance issues at this stage.

6. Directions

As no decision is being made by the IJB at this stage, no direction is required.

7. Communication

N/A

8. BACKGROUND PAPERS/REFERENCES

N/A

9. APPENDICES

N/A