NHS Highland	

Meeting: **Highland Health & Social Care Committee**

Meeting date: **6 November 2024**

Title: **Position Paper – Delayed Discharges**

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1 Purpose

This is presented to the Group for:

- Awareness

This report relates to a:

- Government policy/directive

This report will align to the following NHS Scotland quality ambition(s):
Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

Start Well		Thrive Well		Stay Well		Anchor Well	
Grow Well		Listen Well		Nurture Well		Plan Well	
Care Well	X	Live Well		Respond Well	X	Treat Well	
Journey Well		Age Well		End Well		Value Well	
Perform well		Progress well					

2 Report summary

This report primarily applies to North Highland, the Highland Health and Social Care Partnership area. It is a briefing of our current activity and progress for Urgent and Unscheduled Care with a particular focus on reducing the level of delayed hospital discharges across the Highland Health and Social Care Partnership area.

2.1 Situation

NHS Highland continues to develop its response to Urgent and Unscheduled Care to ensure our communities health and social care needs are met by the right people, in the right place, at the right time, as close to home as possible.

Delayed discharges are a national concern and the Collaborative Response and Assurance Group (CRAG), which is a government led group of Health and Social Care Partnership's Chief Officers and NHS Chief Executives, has set a maximum level of delayed discharges of 34.6 per 100,000 adults. In practice, for the North Highland area to achieve this, a reduction of 65% in our delayed discharge total would be required. This is a challenging target for NHS Highland. Our interim aim, as submitted as part of our Urgent and Unscheduled Care funding return to Scottish Government is an initial reduction of 30% of people affected by standard delays in hospital. Further targets have also been set in relation to length of stay and emergency department performance. These are summarised in Appendix 1.

The Permanent Secretary asked NHS Highland to develop and deliver a 90-day recovery plan for Urgent and Unscheduled Care with the focus on reducing the number of people in delay. This plan is shown in Appendix 2.

2.2 Background

NHS Highland's Urgent and Unscheduled Care Programme has undergone several changes in leadership, structure and Scottish Government direction in recent years. The key areas of focus remain, generally, unchanged. These are:

- Management of urgent care needs in the community
- Development of alternative ways to manage urgent care needs which are unlikely to result in admission to hospital
- Conversion of unscheduled presentations to scheduled appointments/ admissions

Much of the focus has been at the "front door" of our services. It is now recognised that whilst improvements have been made, we are constrained by our onward discharge processes and capacity.

NHS Highland has continued to improve its discharge processes and is now setting planned discharge dates for all inpatients. However, these are often breached which indicates issues with timely review. Communication about discharges which will or may require social care has improved with the introduction of multi-disciplinary processes and the development of a discharge app to replace paper-based systems. However, these processes are still bedding-in and performance monitoring of implementation is in development.

A further constraint is the capacity within our social care sector in North Highland. From March 2022 to date, there has been significant turbulence within the independent sector care home market related to operating on a smaller scale, and the challenges associated with rural operation including recruiting and retaining staff in these localities, securing and relying on agency use, and the lack of available accommodation which compounds the challenges.

Between March 2022 and April 2024, 5 independent sector care homes have closed. During this period, the partnership also acquired a care home in administration to prevent the closure of this facility and a further loss of bed provision.

In 23/24, 3 in house care homes have also closed although two are closed on a temporary basis. The closures are in small rural and remote communities with closure due to acute staffing shortages.

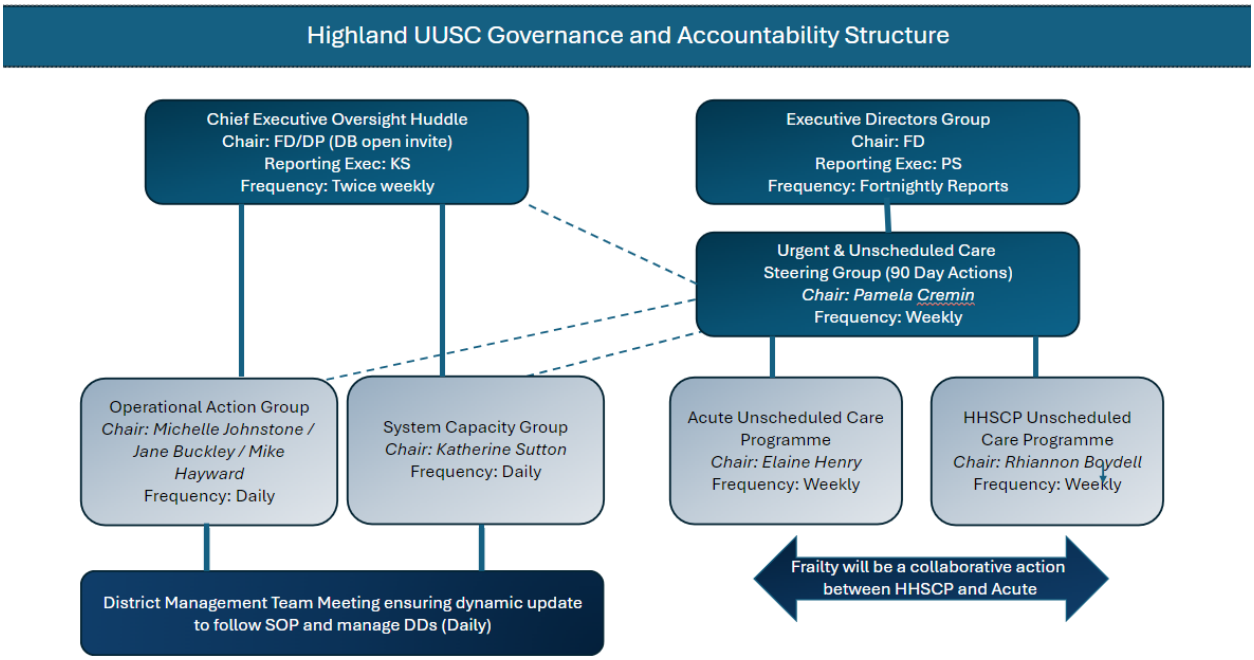
In total NHS Highland has lost 161 care home placements due to these 8 care home closures. This reduced care home bed availability is having an impact on the wider health and social care system, and in particular the ability to discharge patients timely from hospital.

In addition to a reduction in Care Home capacity, there are also fewer available Care at Home hours available to be allocated to individuals. At the end of April 2022 we were able to provide 14,497 hours of care each week between in house and external providers. This had reduced to 13,423 by the end of February 2024.

2.3 Assessment

Whilst there are capacity constraints within our system to respond to urgent and unscheduled care, and reduce people who experience delay in discharge from hospital, progress is being made.

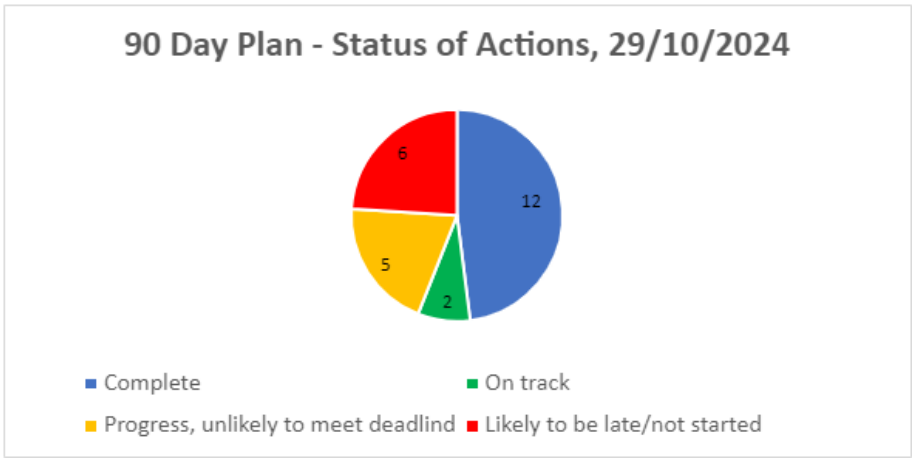
A refreshed governance structure for North Highland with direct accountability to the Chief Executive has been established as outlined in the image below.



Urgent and Unscheduled Care Steering Group

The Urgent and Unscheduled Care Steering Group is responsible for the oversight of the delivery of the 90 Day Plan in Appendix 2. The majority of actions are driven through the Acute and HSCP groups and reported into the Steering Group by the chairs for assurance.

Our initial 90 day plan in Appendix 2 is undergoing review. As of the 28th October, progress of actions can be summarised as follows:



	Reporting Group			
Action BRAG Status	**Acute UUC Group**	**HSCP UUC Group**	**Enabling Actions**	**Total**
B - Complete	2	5	5	**12**
G - On track		1	1	**2**
A - Progress, deadline unlikely to be met	1	3	1	**5**
R - Likely to be late/not started	4	1	1	**6**
Total	**7**	**10**	**8**	**25**

This progress against the data set gathered is being scrutinised by the Urgent and Unscheduled Care Steering Group with a view to being able to report on the action impact the plan has had.

Whilst this review is being undertaken, plans for the development of the next 90 day plan to support the recovery of Urgent and Unscheduled Care are underway. This is being managed through our Acute and HSCP Groups, reporting to the Steering Group. The focus is next step actions for the ones we have completed, roll over of actions not yet complete and the start of new actions. The focus is ensuring a positive position for winter where there is likely to be increased pressure in our system.

Winter Readiness

In previous years NHS Highland has developed a separate plan for winter, but as pressure across the system has increased, it has been necessary to develop plans which support year-round capacity management and response to pressure. NHS Highland has responded to the Scottish Government request to complete a Winter Readiness check list.

The checklist is made up of 4 sections. What these cover and the status for North Highland are detailed below:

- Section 1 Overall Status – Yes/Partially
    - General preparedness and resilience,
    - Communications
    - Step up step down
- Section 2 –Overall Status Yes/Partially
    - Urgent and Unscheduled Care
    - Planned Care

- Section 3 – Overall Status – Yes/Partially
    - Primary Care – including Adult Social Care, Primary Care, community Care Prisons
- Section 4 – Overall Status Yes/Partially
    - Infection Control and Prevention (including vaccination programme, and outbreak management),
    - Workforce,

A number of operational colleagues have been approached to provide the information to complete the checklist.

Most of the checklist is either fully in place or partially in place. Areas not yet or partially implemented requiring additional support will be considered for inclusion in the next 90 Day Plan (see previous section):

- Staff protection and outbreak resourcing
- Deployment of/additional volunteers to support capacity during winter

Outbreak resourcing

Despite best efforts, the ideal model of peer vaccination for staff is proving challenging. This model is preferred as staff can be vaccinated at their place of work which is likely to increase uptake.

A number of community clinics for the public are at risk of cancellation due to the need to divert staff to community clinics, adding more pressure.

Volunteers

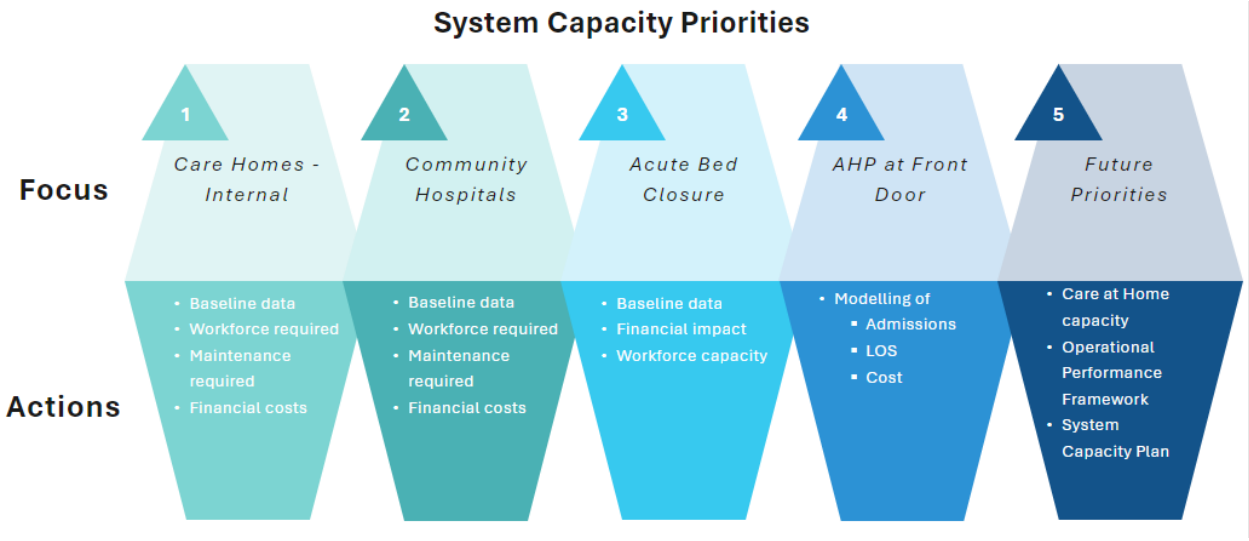
The Volunteer Co-ordinator is focused on supporting capacity within Acute services. Last year we were supported by the (paid) adult social care reserves. This capacity is no longer in place with the majority recruited now with permanent roles and the co-ordination capacity not available within the team.

Daily Operational Group

The Daily Operational Group was established in late August and is chaired by Operational managers from Acute and the HSCP. Districts attend weekly and present their delayed discharge position. The group provides a point of escalation for decision making and ensures best practice for discharge planning and that processes are followed at a district level.

System Capacity Group

The purpose of the system capacity group is to identify and action opportunities to optimise system capacity and ensure a shared understanding of capacity across our whole system at any time. The priorities of the group are shown in the image below.

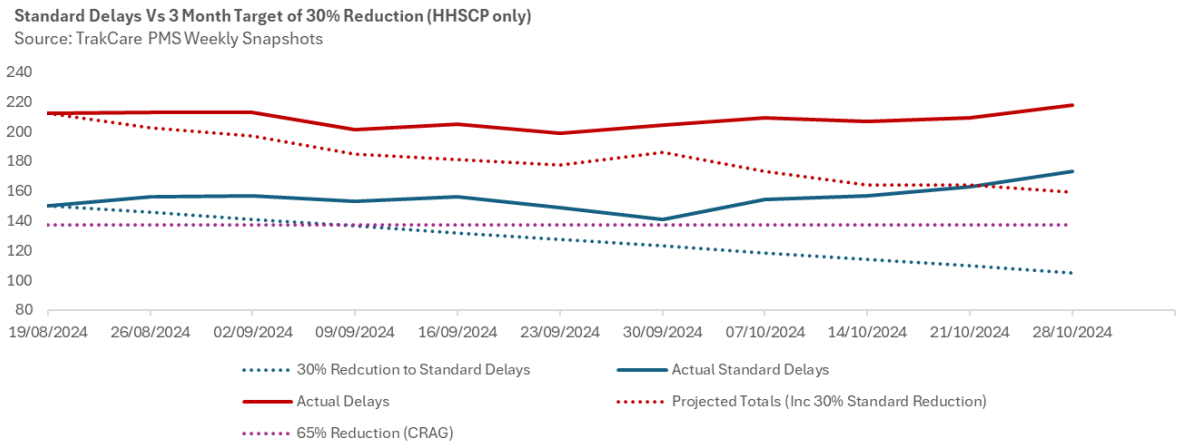


The group is developing and using capacity information across the independent and in-house sectors for Care Homes and Care at Homes and Community Hospitals to understand whole system capacity. In Care Homes, the group has identified potential for an additional 22 In House Care Home beds and approximately 10 self-funding beds if funding is allocated, and also efficiency, equity and quality benefits by centralising the care home bed allocation process. In Care at Home, the group has identified that changes to the way we commission Care at Home and improvements made to the CM2000 scheduling and Care at Home management tool, could produce similarly efficiency, equity and quality benefits.

Impact on Delayed Hospital Discharges

The current performance trajectories for Delayed Hospital Discharges have been embedded within internal reporting and there is a focus on trajectories. While there has been some progress in reducing the total numbers, actions are still to come to fruition within the 90-day UUC plans to achieve this.

The Delayed Hospital Discharges are subject to natural fluctuation. As of 28th October, our total number of Delayed Hospital Discharges for the Highland area only was 218 as shown in the graph below.



As mentioned previously, the SG performance trajectory is to reduce standard delays by 30%. This excludes code 9 delays, which are defined as complex patients who may require guardianship or may be delayed due to infection control.

It is anticipated that the actions outlined through the System Capacity Group to secure additional capacity within the Care Home and Care at Home services will help to move closer to the agreed trajectory and the 30% reduction. Our current performance is outlined below.

Urgent & Unscheduled Care Trajectories

					TRAJECTORY TARGETS			PREVIOUS RESULTS		CURRENT RESULTS	
Measure	**Aim***	**Target***	***Base line***	**Split Baseline**	**AUG**	**SEP**	**OCT**	**Aug-24**	**Split Results (Aug-2024)**	**Sep-24**	**Split Results (Sep-2024)**
A&E attendances completed within 4 hours: Percentage (%) of 'unplanned' attends at Emergency Departments that are admitted, discharged or transferred within 4 hours.	**Maximise**	**78.5%**	*74.8%*	**74.8% NHSH**	**76.0%**	**77.3%**	**78.5%**	**75.3%**	**75.3% NHSH**	**74.9%**	**74.9% NHSH**
				72.0% HHSCP					72.2% HHSCP		72.4% HHSCP
				93.3% A&B					95.5% A&B		89.5% A&B
Total A&E attendances lasting more than 12 hours: Total of 'unplanned' ED attends that are admitted, discharged or transferred more than 12 hours after arrival in ED.	**Minimise**	**24**	*106*	**106 NHSH**	**104**	**102**	**101**	**179**	**179 NHSH**	**145**	**145 NHSH**
				105 HHSCP					178 HHSCP		144 HHSCP
				1 A&B					1 A&B		1 A&B
Reduce the number of patients in Acute & Community Hospital beds with a LOS >14 day by 5% by end Oct-24 #	**Minimise***	**443**	*349*	**332 NHSH**	**343**	**337**	**332**	**329**	**329 NHSH**	**339**	**339 NHSH**
				294 HHSCP					276 HHSCP		299 HHSCP
				40 A&B					53 A&B		40 A&B
Reduce the number of **non-delayed** patients in Acute & Community Hospital beds with a LOS >14 days by 5% by end Oct-24 #	**Minimise***	**292**	*182*	**182 NHSH**	**179**	**176**	**173**	**167**	**167 NHSH**	**195**	**195 NHSH**
				158 HHSCP					129 HHSCP		169 HHSCP
				24 A&B					38 A&B		26 A&B
Reduce the number of patients in Acute & Community Hospital beds affected by **standard delays** by **30%** by end Oct-24 #	**Minimise***	**176**	*167*	**167 NHSH**	**150**	**134**	**117**	**162**	**162 NHSH**	**144**	**144 NHSH**
				151 HHSCP					147 HHSCP		130 HHSCP
				16 A&B					15 A&B		14 A&B
Reduce the average LOS in ED for patients that get Admitted to Hospital after arriving between the hours of 5.00pm to 5.00am (Overnight) by 5% by end Oct-24. Reported in minutes.	**Minimise***	**352**	*409*	**409 NHSH**	**403**	**396**	**389**	**405**	**405 NHSH**	**379**	**379 NHSH**
				388 HHSCP					449 HHSCP		410 HHSCP
				220 A&B					168 A&B		210 A&B
Reduce the average LOS in the ED for patients that get Admitted to Hospital after arriving between the hours of 5.00am to 5.00pm (Day Time) by 5% by end Oct-24. In mins.	**Minimise***	**329**	*390*	**390 NHSH**	**383**	**377**	**370**	**362**	**362 NHSH**	**344**	**344 NHSH**
				360 HHSCP					393 HHSCP		362 HHSCP
				223 A&B					195 A&B		232 A&B

Baseline is Mar-2024 apart from # which is Mon 03-Jun-2024

* Target set by Centre for Sustainable Delivery (CfSD)

The table above shows the August and September positions against the measures which have been submitted to Scottish Government as part of the Urgent and Unscheduled Care funding submission for 24-25. Additional measures include the

Emergency Department 4 hours performance and number of breaches over 12 hours. These measures are based on the improvement areas identified by the Centre for Sustainable Delivery (CfSD) for NHS Highland. Baselines are set as March 2024, except the delayed discharge figures which are based on patient totals on Monday 3 June 2024.

At 30th September, the number of standard delays was 144, which is below the 30% reduction trajectory number of 147 (see next section). This demonstrates some progress however caution needs to be given as to whether this was natural seasonal variation. Data updates are pending on whether performance against this trajectory at the end of October is on track to meet the required downward trajectory.

Continued engagement through EDG and CRAG will further develop NHS Highland's plans to respond to the current U&UC mission to reduce Delayed Hospital Discharges, while considering the longer-term strategic models required to transform services.

3 Impact Analysis

3.1 Quality/ Patient Care

Performance measures are indicators of quality and patient care and therefore, engagement to deliver the plan and improve our position is required. However, there are wider systemic issues across the health and care services nationally that make this challenging. This includes available resources, especially workforce.

There is increased risk of experiencing adverse harm if remaining in hospital longer than is required. This is why tackling delayed hospital discharges is a priority.

3.2 Workforce

Continued pressure on staff resulting in issues with engagement and progress. The impact of recruitment and retention of staff across the health and care sector also results in unsustainable services with both Care Home and Care at Home capacity reducing considerably in the last two years.

3.3 Financial

NHS Highland is awarded Urgent and Unscheduled Care funding each year. In 24/25, the funding of £2.117m is expected to improve our position against the trajectories in Appendix 1. Funding has been allocated in North Highland to:

- AHPs at the front door in ED (Raigmore) to support turnaround home/reduce length of stay
- Discharge lounge to improve hospital flow (Raigmore)

- Further development of our discharge app (whole system)
- Discharge co-ordination (Belford & Caithness General)
- Community capacity – MacKenzie Centre
- Rehab services – Badenoch & Strathspey
- Community Respiratory Nursing to support care for people in their own homes

The remaining NRAC share is in the process of being allocated within Argyll & Bute.

3.4 Risk Assessment/Management

Risks are being identified by senior responsible officers and managed by the Urgent and Unscheduled Care Steering Group. Operational risks are identified and managed through local risk processes.

3.5 Data Protection

N/A

3.6 Equality and Diversity, including health inequalities

Older people are disproportionate users of urgent and unscheduled care health and wider social care services, so failures of these services have a disproportionate impact on this group.

3.7 Other impacts

N/A

3.8 Communication, involvement, engagement and consultation

Communications priorities have been identified as part of the 90 Day plan. Development of these plans is being led by the Communications team.

3.9 Route to the Meeting

Update presented at Executive Directors Group.

4 Recommendations

Paper for awareness only.

List of appendices

Appendix 1 – UUC Trajectories

Appendix 2 – UUC 90 Day Plan

Appendix 1 – UUC Trajectories

The trajectories connected to the funding award are:

- Reduce the number of patients in Acute & Community hospital beds with a LOS >14 day by 5% by end October

- Reduce the number of non-delayed patients in Acute & Community hospital beds with a LOS >14 days by 5% by end October

- Reduce the number of patients in acute and community hospital beds affected by standard delays by 30% by end October

- Reduce the average LOS in the Emergency Department for patients that get admitted to hospital after arriving between the hours of 5pm to 5am (Overnight) by 5% by end October

- Reduce the average LOS in the Emergency Department for patients that get admitted to hospital after arriving between the hours of 5am to 5pm (Day Time) by 5% by end October

Additional trajectories required by Scottish Government are:

- Improve the percentage of attendances within 4-hours by 5% by end October
- Number of attendances lasting more than 12-hours by 5% by end October

Appendix 2 – UUC 90 Day Plan

21/08/24 – 90 Day Plan on a Page - Urgent & Unscheduled Care (August – October 2024)

AMBITION – IN PARTNERSHIP

Create value by working collaboratively to transform the way we deliver health and care

STRATEGIC OUTCOMES

Care Well	Respond Well
Work together with health and social care partners by delivering care and support that puts our population, families and carers experience at its heart	Ensure that our services are responsive to our populations needs by adopting a "home is best" approach

PLANNING FOR SUCCESS - STRATEGIC TARGETS

Reduce standard DDs by 30% by end October 2024	Increase A&E attendances complete within 4 hours by 5% by end October 2024	Reduce A&E attendances lasting more than 12 hours by 5% by end October 2024	Reduce the time spent in A&E for people admitted to hospital - day time and overnight by 5% by end October 2024	Reduce LOS for delayed and non-delayed people by 5% by end October 2024	Increase the amount of people discharged on their PDD date	Reduce Social Care waiting lists and C@H unmet needs hours	Decrease numbers of times OPEL status is at levels 4/5	Reduce inappropriate occupancy for our population

Area	What do we want to do?	What priority 1 actions will we take?	How will we know we have achieved?
Respond	Respond quickly to support our population across our system who are vulnerable or in crisis	•Implement sector agreed proposals to stabilise provision and increase C@H capacity •Ensure consistent application of standard work for AWI •Develop community urgent response to crisis from ED •Maximise capacity of In reach social work team to Raigmore •Care Home Capacity and resilience	1.Reduced delayed discharges 2.Equitable access to hours of care at home 3.Increased flow of assessment 4.Reduction in <1 day admissions
Rapid	Facilitate rapid discharge and support to embed the "home is best" approach	•Implement PDD improvement and compliance plan •Review length of stay for all non delayed discharges. Targeted conditions •Whole system OPEL •Community hospital specification and agreed pathways •TEC solutions to enable social care assessment at home •Pre-noon discharge plan	1.PDD compliant discharges 2.Reduction in length of stay to peers 3.Increased flow through community hospitals 4.Reduced black status
Reduce	Reduce occupancy and avoidable admissions and identify at risk population by working collaboratively	•Hospital at Home Framework •Implement frailty standards and pathway •Root cause analysis of ED performance •Review all MIU pathways •Review higher volume medical admission pathways	1.Hospital at Home Framework 2.Reduced admissions in >65 years 3.Increased ED performance 4.Increased hospital at home activity
Redirect	Redirect inappropriate attendance to suitable services so emergencies are seen quickly	•Scope opportunity to develop our Community Urgent Care Response •Choice guidance utilisation monitoring •Research current impact and causes of inappropriate attendances at A&E and develop a campaign to reduce them. •Pilot a campaign to increase use of Pharmacy First	1.FNC utilisation 2.Call before you convey 3.Choice guidance applications