Item No: 17

Meeting Date: **Wednesday 27th September 2023**

Glasgow City Integration Joint Board

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Update on Actions to Mitigate Delayed Discharges – Acute

Purpose of Report:	To brief the IJB on the Health and Social Care Partnership's ongoing performance related to delayed discharge, to note the improvement work plan, and the Health and Social Care Partnership's planning for winter.

Background/Engagement:	The report reflects the commitment from across the HSCP in relation to managing delayed discharges. Input from colleagues contributed to this report. The key partner agencies remain committed to sustaining continuous improvement in this complex service area.

Governance Route:	The matters contained within this paper have been previously considered by the following group(s) as part of its development. HSCP Senior Management Team ☒ Council Corporate Management Team ☐ Health Board Corporate Management Team ☐ Council Committee ☐ Update requested by IJB ☐ Other ☐

Recommendations:	The Integration Joint Board is asked to: a) Note the current position pertaining to acute delayed discharges; b) Note the actions underway to reduce acute delayed discharges; and c) Note the actions for winter planning 2023/24.

Relevance to Integration Joint Board Strategic Plan:

This paper aligns with Glasgow City IJB Strategic Plan 2023-26 in particular, partnership priorities two and three; Supporting greater self-determination and informed choice and supporting people in their communities.

Implications for Health and Social Care Partnership:

Reference to National Health & Wellbeing Outcome(s):	The effective day to day management of delayed discharges requires a robust and proper response to ensure that the most vulnerable in society are prioritised to ensure they can access the care and support they need when leaving hospital. This is in keeping with all outcomes but, outcomes 2, 3, 4 and 5 in particular.
Personnel:	None
Carers:	None
Provider Organisations:	None
Equalities:	None
Fairer Scotland Compliance:	None
Financial:	None
Legal:	None
Economic Impact:	None
Sustainability:	None
Sustainable Procurement and Article 19:	None
Risk Implications:	
Implications for Glasgow City Council:	Glasgow City Council have the lead role (Social Work) to carry out a statutory assessment for those requiring care and support when leaving hospital. Lengthy delays for social care patients can lead to a deterioration in their health and wellbeing.
Implications for NHS Greater Glasgow & Clyde:	The NHS Greater Glasgow & Clyde have a legal duty to identify an individual who is medically fit for discharge. This is critical to identify patients early who will require ongoing care and support; thus, ensuring patient flow across acute sites.

Direction Required to Council, Health Board or Both	
Direction to:	
1. No Direction Required	☒
2. Glasgow City Council	☐
3. NHS Greater Glasgow & Clyde	☐
4. Glasgow City Council and NHS Greater Glasgow & Clyde	☐

1. Purpose

1.1. To advise the Integration Joint Board (IJB) on the progress in relation to delayed discharges and the performance of Glasgow City Health and Social Care Partnership (HSCP), as well as outline the range of measures currently deployed within the partnership to manage the ongoing challenges related to this complex agenda.

2. Background

2.1. The reduction of acute delayed discharges remains a challenge for the organisation. Previous briefings / reports to the IJB and the Finance, Audit and Scrutiny Committee have noted and supported targeted work aimed at reducing and maintaining delays at a lower level. Scrutiny of delays across Scotland is a high priority for the Scottish Government and the HSCP is committed to support a reduction in delays.

2.2. This paper identifies the data analysis around delays and notes the scrutiny in place both internally within the Partnership and ongoing work with acute colleagues to mitigate delays, whilst recognising significant challenges across the wider health and social care system. This paper also presents the key actions being progressed to continue the focus on reducing delays

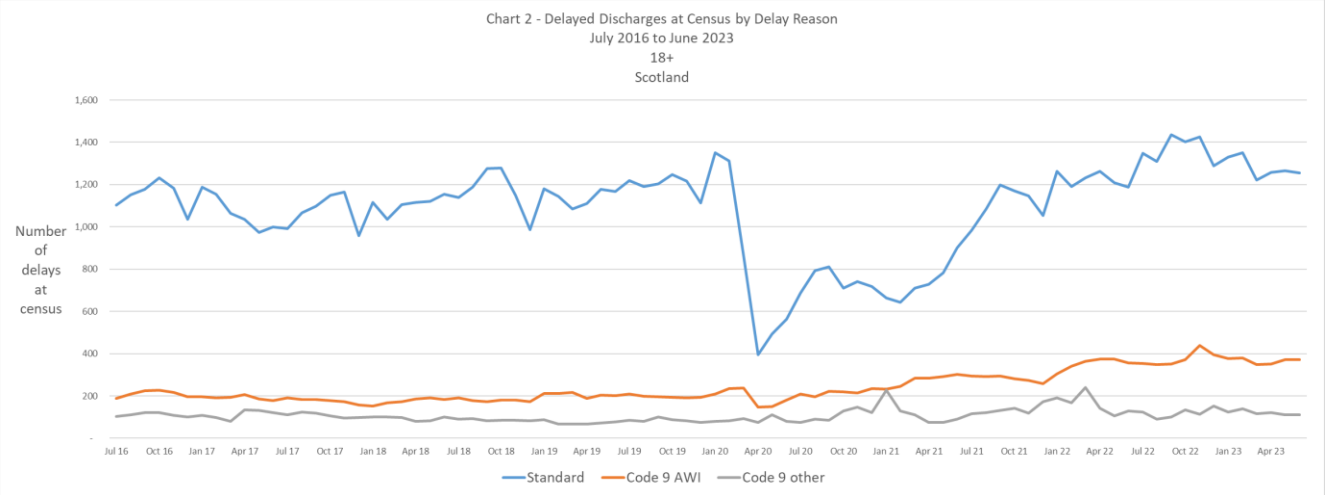
2.3. A delay occurs *"when a hospital patient who is clinically ready for discharge from in-patient care continues to occupy a hospital bed beyond the date they are ready for discharge"* All delays are recorded and monitored through the Trackcare Patient Information System, with information presented via the Microstrategy dashboard platform to present the information on a timely basis for operational and monitoring purposes. A monthly census occurs mid-month and forms the basis of the data returned nationally from all Partnerships and Boards. These figures are published by Public Health Scotland June 2023 figures.

2.4. Delays are measured and analysed in terms of numbers of delays and the associated bed days used by patients who are defined as delayed discharges. In addition, the reasons for delay are also reviewed. The summary of delays and bed days shows a high level that reduces during the pandemic and an increasing level of delays post pandemic. Graph 1 reflects total delays reported by GCHSCP (Including Acute / Mental Health / Older People Mental Health / Learning Disability & Forensic). This shows the delays split by standard / Adults with Incapacity and other complex delays.

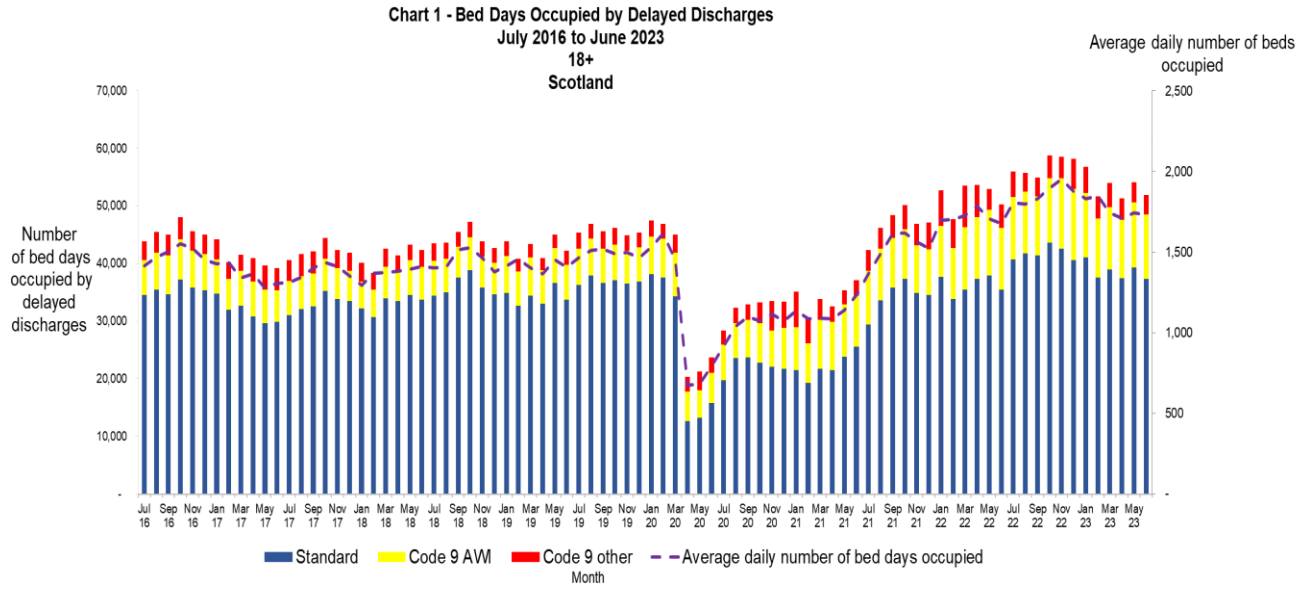
2.5. Graph 2 shows the bed days associated with delays, again reflecting the total delay reported for GCHSCP showing standard / Adults with Incapacity (AWI) and other complex delays. In this graph it also shows the trend of average bed days for delays.

2.6. The data below reflects the overall reduction in delays during the pandemic (April 2020 to December 2021) and pinpoints an increase in Adults with Incapacity.

Graph 1

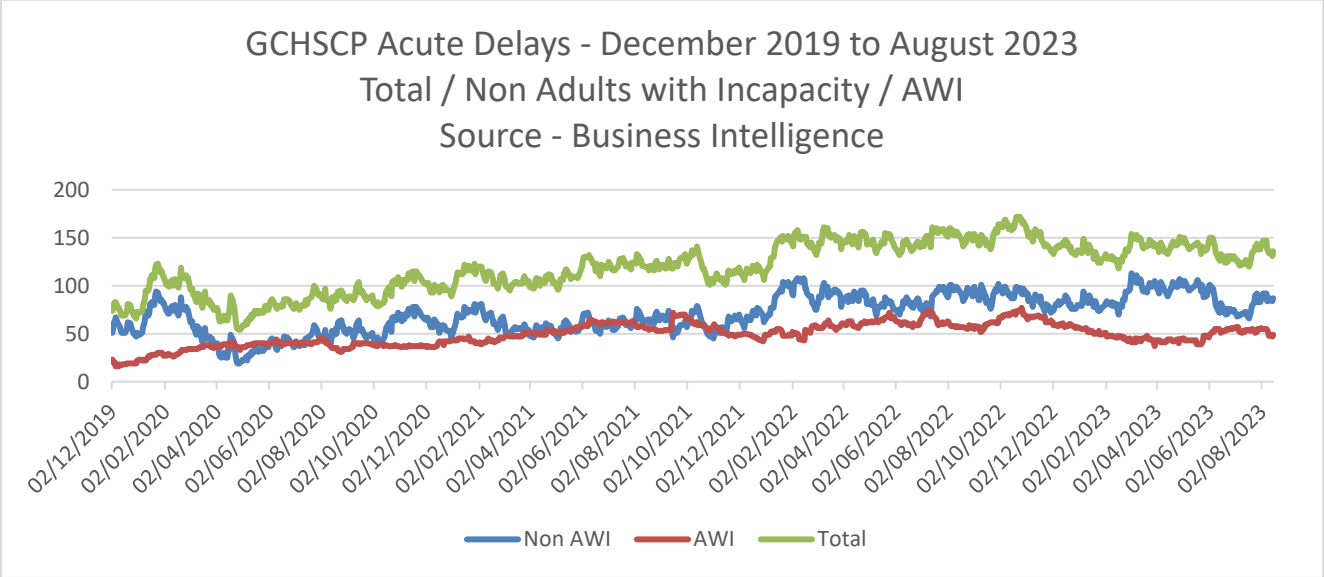


Graph 2 – Bed Days associated with delays



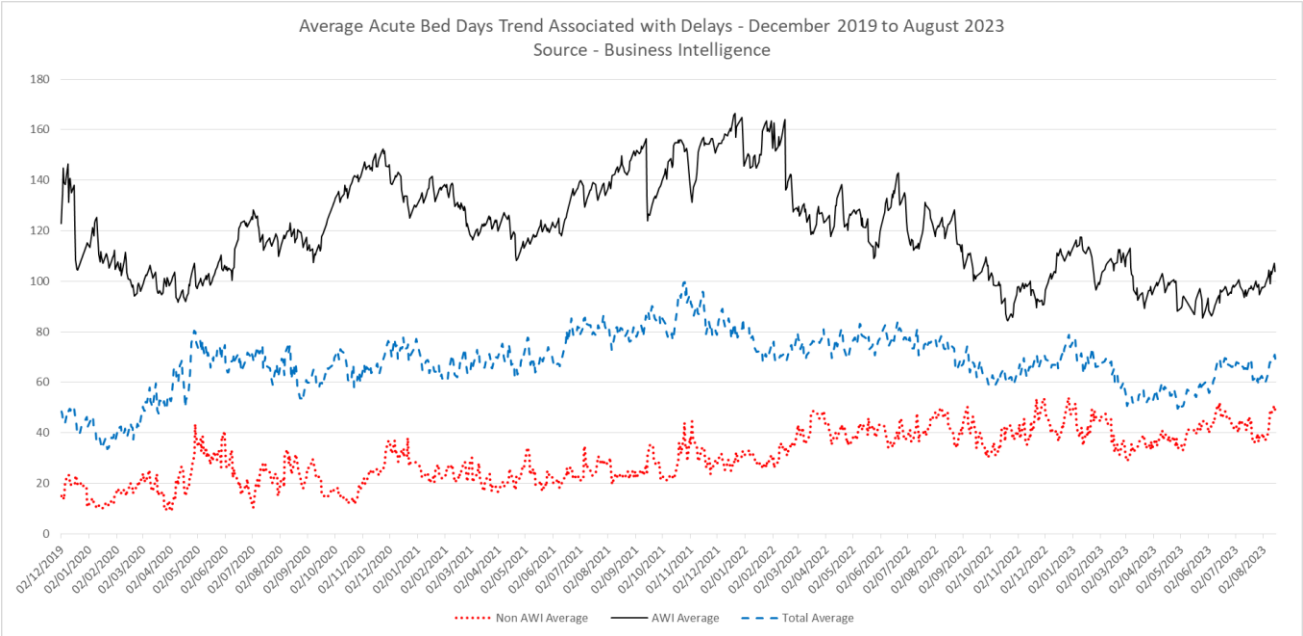
2.7 Acute delays represent a significant proportion of the total delays reported. Graph 3 shows the acute specific delay numbers December 2019 to date, reflecting the same position for the pandemic and the change in AWI numbers.

Graph 3



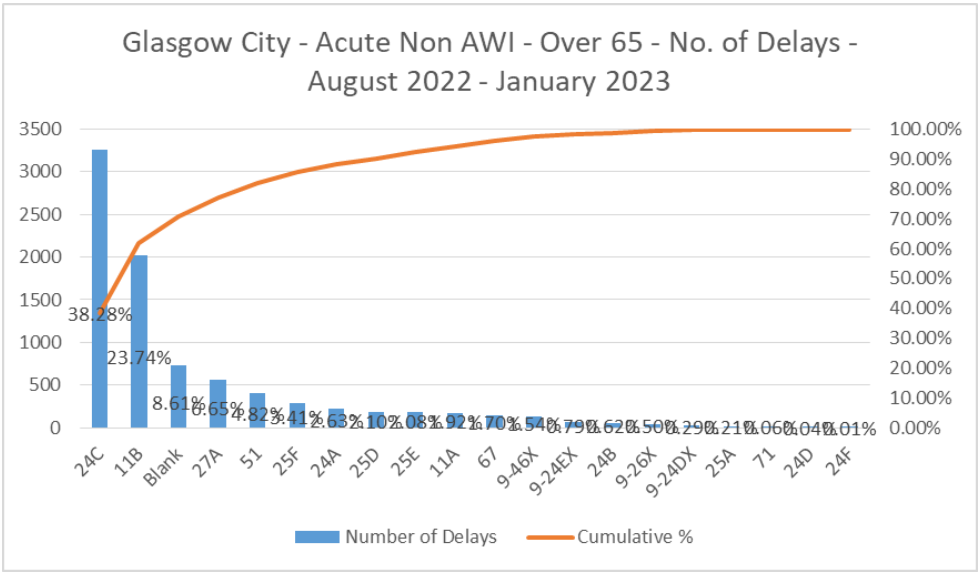
2.8 The impact of delays noted in terms of acute bed days associated with the delays is also used to understand changes over time. Graph 4 below shows the average acute bed days over the period December 2019 to August 2023 as a calculation of the total bed days and numbers of patients in the grouping of total delays, Non AWI and AWI delays. This reflects the impact of AWI which contributes significantly to the total bed days but has seen a 36% reduction from March 2023 following targeted activity. The evidence shows a reduction in associated bed days overall since a peak in January 2022. Within the non AWI cohort, the aged under 65 group contribute considerably to this due their complexity and a lack of available placements for complex adults.

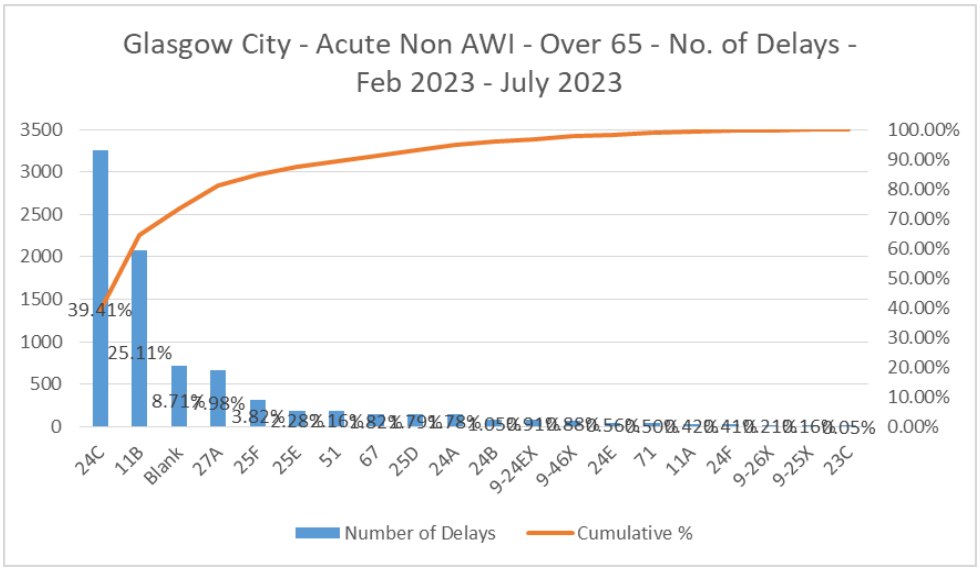
Graph 4

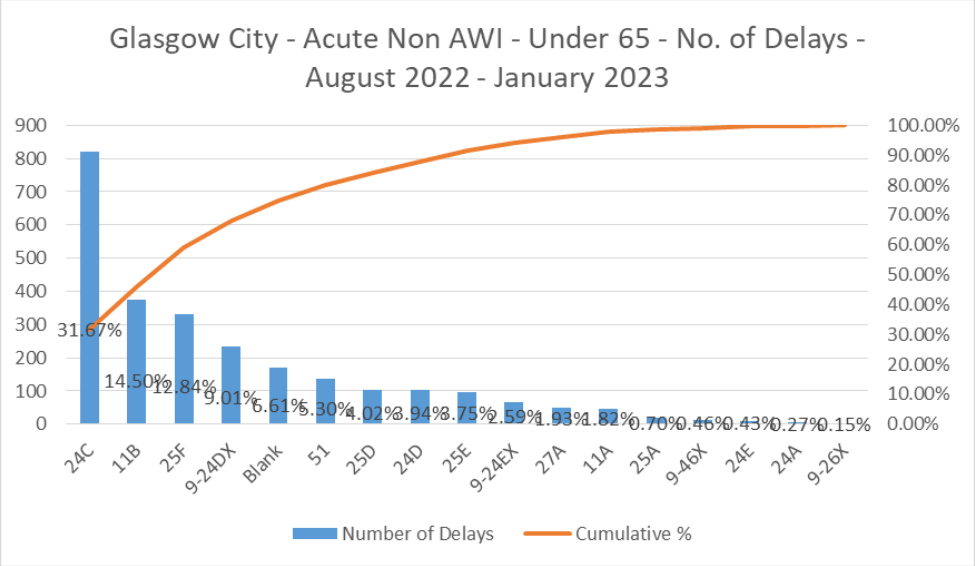


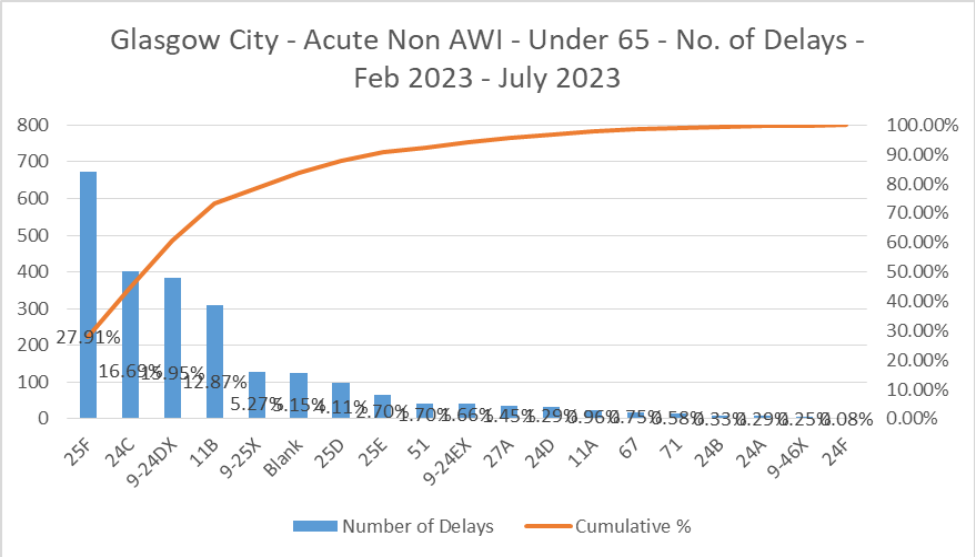
2.9 A key element of the understanding of delayed discharges is identifying the reasons for delay. There is a national coding system used consistently across Scotland. A summary of this is attached as Appendix A. The following graphs use a pareto analysis to understand which reasons for delay contribute to both delay numbers and bed days. The graphs show two recent 6-month periods where patient numbers were reviewed – Excluding AWI - (Aug 22 – Jan 23, & Feb 23 – July 23 - inclusive) split by age under and over 65. The first set reflects the patient numbers, and the second set notes the analysis of the bed day contribution by reason. Code 24c (Awaiting care home placement) is consistently the main reason for delay to nursing care. 24d (awaiting specialist placement) is a complex code featuring frequently in the under 65 age group. 'Blank' represents patients awaiting assessment and features in the patient numbers but does not contribute significantly to bed days (typically 2 days).

Patient Numbers contribution by reason – Over 65 and Under 65 (Excluding AWI)

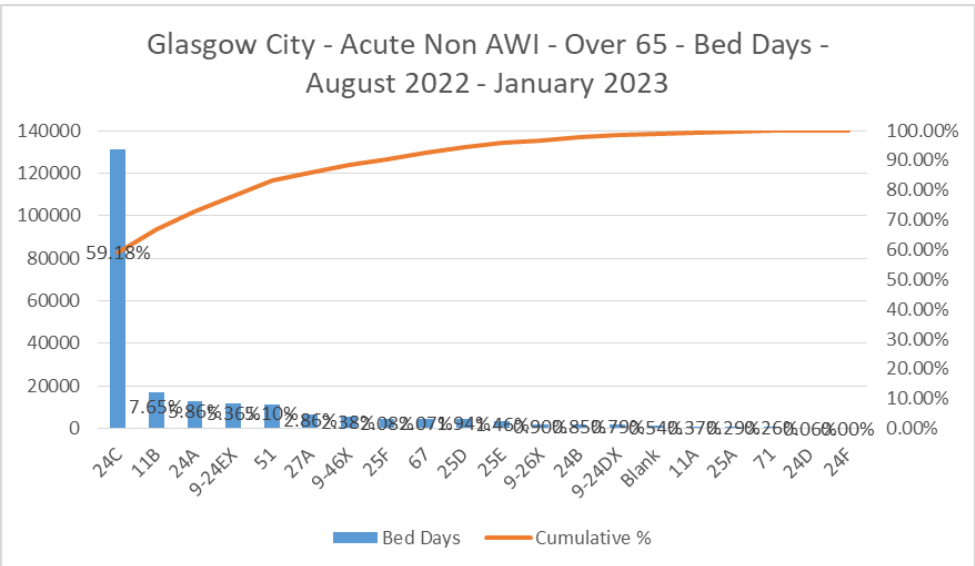




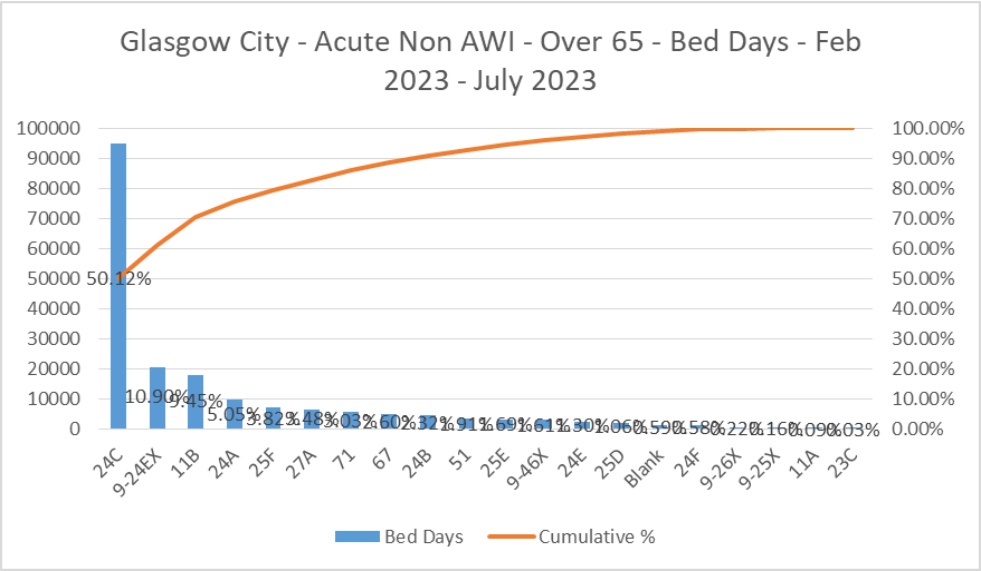


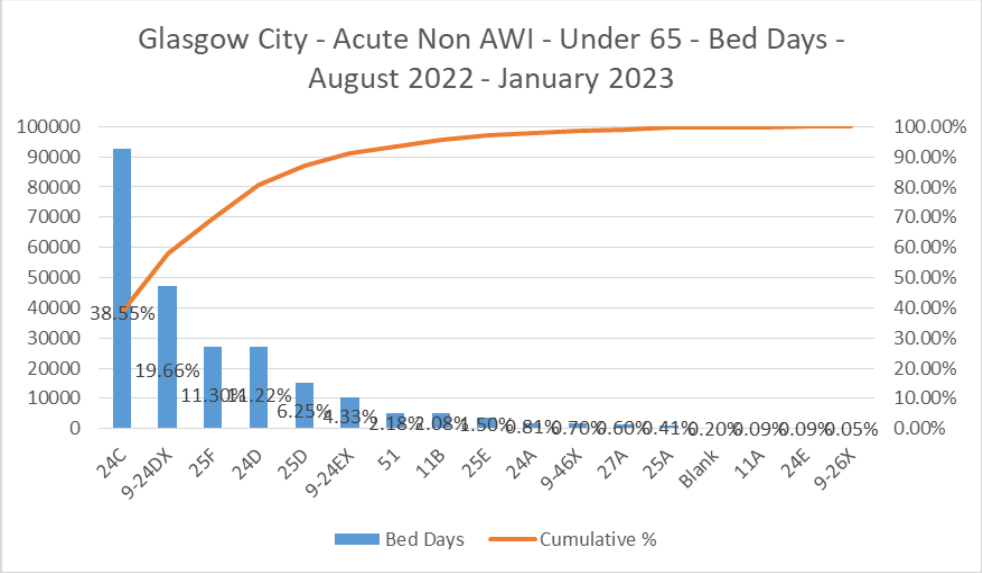


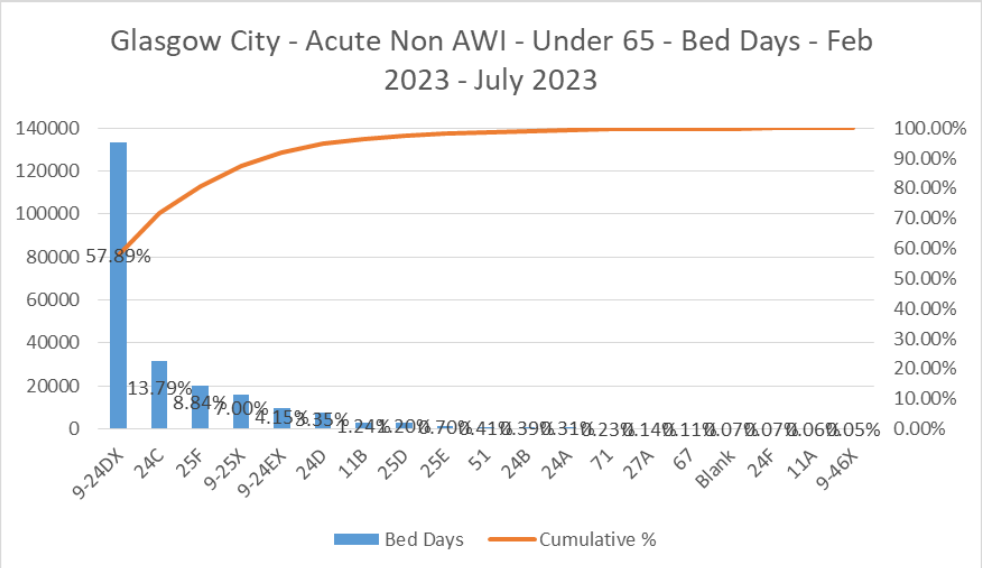
Bed Days contribution by delay reason (Excluding AWI) Over and Under 65



24C (Nursing care home)

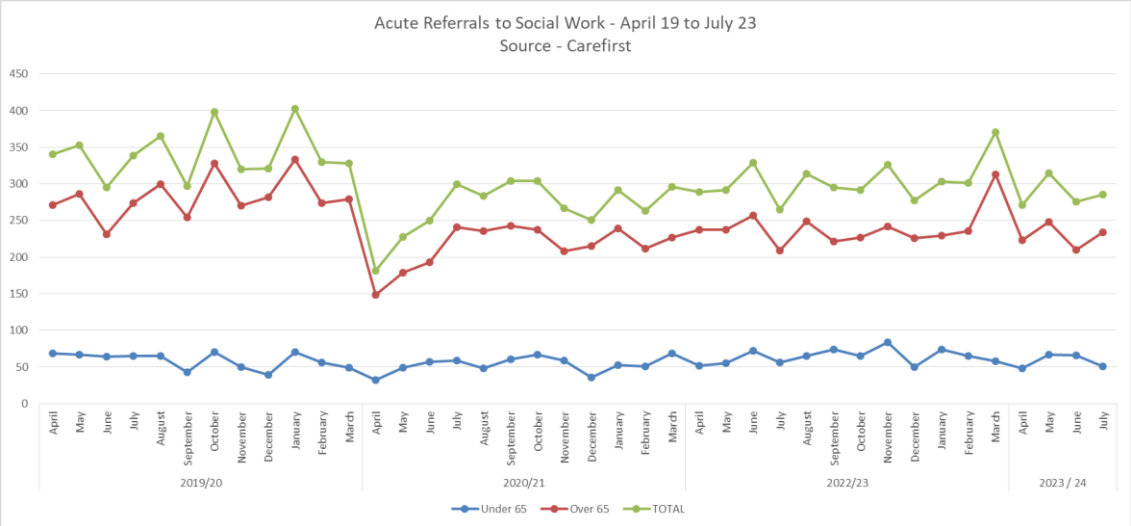

Glasgow City - Acute Non AWI - Over 65 - Bed Days - Feb 2023 - July 2023
100000
90000
80000
70000
60000
50000
40000
30000
20000
10000
0
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
50.12%
10.90%
9.45%
5.05%
24C
9-24EX
11B
24A
25F
27A
71
67
24B
51
25E
9-46X
24E
25D
Blank
24F
9-26X
9-25X
11A
23C
Bed Days
Cumulative %


Glasgow City - Acute Non AWI - Under 65 - Bed Days - August 2022 - January 2023
100000
90000
80000
70000
60000
50000
40000
30000
20000
10000
0
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
38.55%
19.66%
11.30%
11.22%
6.25%
4.33%
24C
9-24DX
25F
24D
25D
9-24EX
51
11B
25E
24A
9-46X
27A
25A
Blank
11A
24E
9-26X
Bed Days
Cumulative %


Glasgow City - Acute Non AWI - Under 65 - Bed Days - Feb 2023 - July 2023
140000
120000
100000
80000
60000
40000
20000
0
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
57.89%
13.79%
8.84%
7.00%
4.15%
9-24DX
24C
25F
9-25X
9-24EX
24D
11B
25D
25E
51
24B
24A
71
27A
67
Blank
24F
11A
9-46X
Bed Days
Cumulative %

2.10 There are a range of additional areas of analysis undertaken by the planning and operational teams including hospital and ward reviews, identifying the location of delays and which wards contribute the most. In addition, there is a Multi-Disciplinary Team (MDT) 'Huddle' which conducts a daily review of referrals to the Partnership from acute. Referrals to the Hospital Social Work Team remain high with many requiring longer-term assessment.

2.11 Peaks of activity have a significant impact on patient flow with higher volumes of referrals. The average weekly referral rate was 79 in January to May 2023, with March and April being the highest referral periods (85 p/w).



2.12 Anticipation and prevention of delays is a major part of the work of the HSCP along with partners in acute services. A reduction in admissions means less risk of delays along with the early intervention to identify barriers which pose a risk to delay and onward discharge.

2.13 GCHSCP discharge on average 180 patients per week requiring further support, of which 25-35 are complex and an average of 150 leave hospital through a discharge process for home. These patients are supported by rehabilitation options and homecare, 23% of which are discharged in 4 hours with no delays.

2.14 Prevention of admissions is an aspect of activity that is growing over time as part of both mainstream, unscheduled care development, and winter planning. The development of Hospital at Home even as a small service has managed 418 patients in the community and saved at least 2000 bed days, who would be at a higher risk of delay if they were in an acute location. Other key work such as the Home First Response Service, the use of the Flow Navigation centre and work to support care homes have all contributed to reduce admissions to hospital.

2.15 Early referral to the Hospital Social Work Team is also essential to commence assessment and to identify options for progressing discharge. The quality of referrals is important to reduce delays in starting this process and preventing duplication. GCHSCP and acute colleagues are committed to a joint improvement plan for Discharge without Delay, which is a Scottish

Government national programme aiming to improve patient flow from acute sites.

The increase in diagnoses of issues affecting mental capacity such as dementia, within the general population is reflected in the hospital population. There is a serious challenge where Power of Attorney (POA) or Guardianship is not in place. The risk around AWI delays is significant, as a complex legal process is required to enable patients to be placed in the most appropriate location. This legal process must be adhered to whilst the individual is within the acute estate as they cannot be placed elsewhere; unless alternative legislation can be enacted through the Social Work Scotland Act (Section 13za) which cannot always be utilised.

2.16 A decision previously made in 2019 removed the use of alternative placements whilst the AWI legal process was followed. The availability of Mental Health Officer (MHO) Social Workers is a rate limiting factor given their role in the overall AWI process and the fact that they also operate across mental health and community services.

2.17 In winter 2022 / 23 GCHSCP secured additional funding to recruit two extra solicitors to support private solicitors who deal with 60% of AWI guardianship applications. Often private solicitors:

- Struggle with complex families.
- The legal process and court proceedings for AWI.
- MHO assessments.

These targeted resources have improved GCHSCP 'Bed Days Lost' performance for AWI delays by 36% in the last 8 months

2.18 Supporting people at home remains a priority for the partnership, although onwards placements for individuals with complex needs are required to support many of the patients who are designated as delayed discharges. The availability of these placements is therefore an important factor in discharging patients from hospital. Intermediate care has been a resource within GCHSCP for many years. There are currently 4 units providing a total of 60 places across the city, this support is delivered within a care home as part of a commissioned service. Maximising throughput within these units is essential to ensure the flow of patients. Recent evidence shows a higher level of occupancy at 98%.

2.19 Care home placement remains a key feature of the delay profile with an average of 80% of delays pending a placement outcome. There is also evidence of increased overall acuity of patients post covid and the complexity / frailty of the cohort of patients in care homes.

2.20 There is recognition of the challenges within the care home sector such as the National Care Home Contract, challenges to care homes to sustain their business model and a shift in the availability of care home places due to staff recruitment and retention. The current economic crisis in the UK has impacted on the financial viability of several providers, whether third or private sector. This will have to be closely monitored throughout the winter period.

2.21 A range of actions are underway across the Partnership to address the level of delayed discharges within the acute estate. This includes a heightened level of scrutiny and escalation to senior managers within the organisation and a range of improvement opportunities to manage demand, flow, capacity, and activity throughout the partnership.

The following table notes the level and scale of scrutiny:

Meeting Name:	**Attended by:**	**Frequency:**
Strategic Overview DD	Chief Officer, ACOs, Commissioning, CSWO	Weekly
Delayed Discharge/Acute	Chief Officer, ACO	Fortnightly
DD Weekly Review	ACO, Service Manager	Weekly
AWI Strategic Work Plan	City-wide group	4 weekly
AWI Legal Issues	ACO, GCC Senior Solicitor	4 weekly
Long Delays/Commissioning/Complex Care	ACO, Service Manager, Head of Commissioning	Weekly
Citywide RAG – Delayed Discharges	All HOS	Weekly
Unscheduled Care	ACOs	4 weekly
Discharge Without Delay (DWD) National Group and GG&C	ACO/ Service Manager	4 weekly
Acute Review Meeting – Patient Queries	Service Manager Delayed Discharges	Fortnightly
Winter Planning – Delayed Discharge	Chief Officer, ACOs	4 weekly
Day Of Care Audit (DOCA) Board-wide Group	ACO, Service Manager	4 weekly
Hospital Discharge Relationship Meeting – Care at Home	ACO, HOS & Acute	**2 weekly**

2.22 The following table lists a range of improvement initiatives underway to support the ongoing activity to mitigate delays as the partnership prepares for winter 23 / 24.

Adults With Incapacity - AWI representing around 30% of GCHSCP delays
• The use of a tracker system to map progress of individuals against key milestones in the journey of Local Authority or Private applications – Reviewed daily. • Additional investment in council legal services to progress cases and liaise across solicitors and other key stakeholders.

- Improvements to allocation of Mental Health Officers to progress applications.
- Impact of activity to date reflecting a 36% reduction in bed days lost.
- AWI Citywide improvement plan.

Housing

- Housing Options to support progression where tenancy is an issue including the use of Clustered Supported Living.
- Homecare – facilitation of an average of 180 discharges per week supported by homecare 23% of which are discharged within 4 hrs.
- Review of housecleans to mitigate delays of patients returning to their own home.

Throughput in Intermediate Care

- New contract with providers to support flow through units - occupancy currently 98% (60 beds available across 4 sites).
- IMC Improvement program to remove any delays to progressing individuals through the units.
- Daily huddles to review activity.

Hospital Social Work Team

- Improvement plan to improve pathway, improve referral process, reduce unnecessary steps, speed up decision making & support areas with higher levels of delays – measurable success already in terms of quality of referrals and liaison between acute and Partnership services.

Supporting the Discharge Without Delay Agenda (national program)

- Promoting & scrutinising Planned Date of Discharge.
- Providing a social work presence in high referring wards.
- Promoting Discharge to Assess.
- Promoting rehabilitation options through homecare and community. rehabilitation services (100% screening of all patients for reablement potential).

Wider winter plan started in June 2023 for Glasgow HSCP. Additional joint planning with Acute

- Pre-planning for peak demand – public holidays and December to March.
- Mitigating delays with use of transport using additional capacity commissioned through a third sector partner.
- Scaling up services to mitigate admission and risk of delayed discharge including use of Flow Navigation Centre, Hospital at Home, Home First Response Service.

Financial monitoring – IJB budget reductions 23 / 24

- Monitor the capacity which has been reduced in the following discharge pathways from hospital:

- Home care
- Care home beds
- SDS
- Intermediate care.

- Escalation to executive-leadership team.
- Monitor care home sector - the provision of care home beds is vulnerable to the current economic crisis in this social care sector.
- The Scottish Government winter funding is yet to be confirmed for 23 / 24.

3. Recommendations

3.1. The Integration Joint Board is asked to:

a) Note the current position pertaining to acute delayed discharges;
b) Note the actions underway to reduce acute delayed discharges; and
c) Note the actions for winter planning 2023/24.

Appendix A – Delay Code Reason Summary

Appendix D - Reason for delay codes

Health and Social Care Reasons		
Assessment	11A	Awaiting commencement of post-hospital social care assessment (including transfer to another area team). Social care includes home care and social work OT
	11B	Awaiting completion of post-hospital social care assessment (including transfer to another area team). Social care includes home care and social work OT
Funding	23C	Non-availability of statutory funding to purchase Care Home Place
	23D	Non-availability of statutory funding to purchase any Other Care Package
Place Availability	24A	Awaiting place availability in Local Authority Residential Home
	24B	Awaiting place availability in Independent Residential Home
	24C	Awaiting place availability in Nursing Home
	24D	Awaiting place availability in Specialist Residential Facility for younger age groups (<65)
	24DX*	Awaiting place availability in Specialist Facility for high level younger age groups (<65) where the Facility is not currently available and no interim option is appropriate
	24E	Awaiting place availability in Specialist Residential Facility for older age groups (65+)
	24EX*	Awaiting place availability in Specialist Facility for high level older age groups (65+) where the Facility is not currently available and an interim option is not appropriate
	24F	Awaiting place availability in care home (EMI/Dementia bed required)
	26X*	Care Home/facility closed
	27A	Awaiting place availability in an Intermediate Care facility
	46X*	Ward closed – patient well but cannot be discharged due to closure
Care Arrangements	25A	Awaiting completion of arrangements for Care Home placement
	25D	Awaiting completion of arrangements - in order to live in their own home – awaiting social support (non-availability of services)
	25E	Awaiting completion of arrangements - in order to live in their own home – awaiting procurement/delivery of equipment/adaptations fitted
	25F	Awaiting completion of arrangements - Re-housing provision (including sheltered housing and homeless patients)
	25X	Awaiting completion of complex care arrangements - in order to live in their own home