Meeting of South Ayrshire Health and Social Care Partnership **Held on**	**Integration Joint Board** **14th June 2023**
Agenda Item:	**7**
Title:	**Delayed Discharge and Hospital Occupancy Action Plan**

Summary:

The purpose of this report is to provide an update on the actions taken by South Ayrshire HSCP to minimise delayed transfers of care and reduce hospital occupancy.

Author:	**Billy McClean, Head of Community Health and Care Services**

Recommendations:

It is recommended that the IJB note the actions taken and endorse the recommendations in this report.

Route to meeting:

Health and Care Governance.

Directions:		**Implications:**	
1. No Directions Required	☐	Financial	☐
2. Directions to NHS Ayrshire & Arran	☐	HR	☐
		Legal	☐
3. Directions to South Ayrshire Council	☐	Equalities	☐
		Sustainability	☐
4. Directions to both SAC & NHS	☐	Policy	☐
		ICT	☐

DELAYED DISCHARGE AND HOSPITAL OCCUPANCY ACTION PLAN

1. PURPOSE OF REPORT

1.1 The purpose of this report is to provide an update on the actions taken by South Ayrshire HSCP to minimise delayed transfers of care and reduce hospital occupancy.

2. RECOMMENDATION

2.1 It is recommended that the Integration Joint Board note the actions taken and endorse the recommendations in this report.

3. BACKGROUND INFORMATION

3.1 Winter is challenging for the Health and Care system every year, but winter 2022/23 was considerably more so due to short-term seasonal demand for unscheduled care due to a high incidence of flu, Covid-19, and other respiratory infections. This placed exceptional pressure on an already strained system that was working hard to rebuild following the pandemic and striving to address the 'backlog' and meet high levels of demand for elective procedures. Additionally, we have been responding to the deconditioning of those who either were waiting for care or had their care delayed due to fear of Covid-19 and/or a wish not to add to the strain on the health and social care system.

3.2 13th March 2023 Scottish Government wrote to all NHS CEOs and IJBs setting out a Health and Social Care Delayed Discharge and Hospital Occupancy Action Plan. This plan sets out the actions that are needed to deliver a step change to support the system reset after a particularly difficult winter period.

3.3 The actions set out within this plan, builds on best practice from across the country that has an evidenced impact on creating the necessary headroom in hospital occupancy to ensure system resilience.

3.4 Scottish Government are seeking assurances from local systems that the actions are being fully implemented through a variety of means including national oversight and support of Professional Advisors to local systems.

3.5 Due to the significant numbers of delayed transfers of care in South Ayrshire, the CEO of NHS Ayrshire and Arran approached Scottish Government to request specific support. The Senior Team in South Ayrshire have engaged with Scottish Government colleagues and agreed that an in-depth assessment of whole system improvement interventions would provide a good starting point and identify areas to target further improvement activity.

3.6 This report provides the outcome of an initial self-assessment against the Health and Social Care Delayed Discharge and Hospital Occupancy Action Plan.

4. REPORT

4.1 **Getting the Basics Right To Prevent Delayed Discharge And Improve Flow**
The action plan sets out twelve actions aimed at preventing delayed transfers of care and improving flow. These actions and our progress against each of the actions are set out in table 1 below:

Table 1: Progress Against "Getting the Basics Right" Action Plan

Area of Improvement	Description	Progress
Admission avoidance and front door	Implement admission avoidance, locality rapid response wrap-around models, care management, multiagency input at the front door approaches. Whole-system input at an early point in the first 48 hours of admission to engage patient/family/carers in discharge discussions and prevent deconditioning of patients.	Hospital at Home is funded and although not at full capacity, is preventing admissions. Intermediate Care Team have a presence at the front door, but this can detract from their community focussed work and other models of AHPs at the front door are being explored. To support Whole system input, at an early point (within the first 48hours of admission), several initiatives have been introduced at UHA to engage the MDT in early discharge planning to minimise any foreseeable delays. These include: • The development and introduction of the Discharge without Delay planner (Zockey). This tool enables the MDT to collaboratively identify minimum goals for discharge (within 48 hours of admission) and to set realistic PDDs based on the identified time frames. This initiative was first piloted at Station 4 on 26th Feb and was rolled out to all medical wards on 14th March as part of the fire break event. • Hospital at Home and ICT services are collaboratively working with the home first team, to facilitate early reviewing of patients identified for these services. Patient reviews are being completed on a daily

		basis, and plans are being set in place for their prompt discharge.
Social care assessment	Ensure the social care needs of patients are considered on every ward and that there is social work input into wards with high frailty and ongoing care needs. Service managers/care at home managers should attend ward rounds (this may be virtually) to understand/challenge referrals, manage and mitigate risk or perceived risk, provide expert advice and engage in planning and preparation for discharge as part of wider MDT discussions.	Social work and Reablement are on site daily at Ayr Hospital and attending virtual Multi-disciplinary Team meetings daily at Crosshouse, Biggart and Girvan Hospitals.
Planned date of discharge	All systems should implement Discharge without Delay principles to plan together as the patient recovers, and jointly set a Planned Date of Discharge – using the PDD bundle to aid implementation and reliable and consistent practice. Every patient must have a planned date of discharge, reviewed daily and this be used to plan and prepare in real time.	Improved use of planned date of discharge, however some variation in practice remains and the accuracy to support planning continues to be a challenge. This approach continues to be refined through the Whole System Interventions.
Senior decision making	Senior decision-making should happen with multi-agency teams, with regular communication and visibility of the plan. Daily senior oversight	Principal Social Worker attends daily huddles. There is daily senior oversight of data within the HSCP through the 3min brief and sitrep. Regular senior escalation as required and weekly DTOC and complex MDT meetings with Senior

	and escalation in both Health Boards and HSCPs/LAs should be in place to prevent/resolve delay-causing issues. Utilise performance data to apply continuous improvement to any emerging systemic issues.	Decision Makers and Managers with a focus on the most complex discharges and those who have waited the longest. Due to staffing challenges across the MDT, there are some challenges affecting consistency of the teams attending MDT meetings. To ensure continuity of discharge planning, Home first practitioners are bridging this gap by relaying all essential information to social workers and other MDT members for their input. Weekly MDT meetings are currently being held at some wards and are being gradually introduced to the rest of the wards at UHA. A complex MDT is being held every two weeks to review all complex patients and escalate them as needed.
Structured ward rounds	Structured ward rounds or white board assessment 7 days per week to ensure there is a plan for every day, which sets out tasks for the day and agrees the ward round priority order (sick, discharges, others) alongside parameters for criteria-led discharge to support early discharge.	To support structured ward/board rounds, a huddle script, was developed and shared with the wards. Ongoing training is being provided to clinical staff regarding "structured board rounds". Criteria Led discharge was introduced to all medical wards on 13 March, and UHA's site safety huddle template was modified to depict "CLD discharges" as opposed to Queries. Training on the effective utilisation of CLDs is ongoing.
Allocation of care	Commission/organise care in response to the pipeline of upcoming work (patients approaching their PDD), not just when patients are delayed.	A prioritisation tool has been developed to support the allocation of care across hospital sites, interim beds and the community based on a range of factors including geographical availability of care, length of wait, complexity of package etc.
Complex discharges	Early identification of complex discharges and appropriate referral as soon as possible. Every older person with frailty should have a clinical	Patients attending ED/CAU who meet the acute frailty scoring (Rockwood) are assessed at this point by Acute Care of the Elderly practitioner team. Appropriate referrals are then put in place to ICT/SW or home care if required.

	frailty score identified on admission to the ED or the admissions ward and appropriate referrals for specialist care made in accordance with local guidelines as well as early identification of needs (Medical, Mobility and self-care, Medicines, Mental Health, Me and Mine – family and carer support, and What Matters to Me) on admission with onward referral to appropriate professions and coordinated multi-agency team management.	Patients at this point after review by ACE are referred on to our care of the Elderly consultants for consideration for transfer to downstream bed capacity for ongoing assessment and rehab. A new Mental Health Officer Team has been established improving capacity and giving a greater focus to those undergoing guardianships. This has resulted in the number of people delayed due to guardianships having reduced from 15 to 5 and the length of time they wait having reduced considerably.
Family and carer engagement	Earliest possible engagement with families/carers to manage expectations, recognising it is not a valid option to remain in an acute setting once clinically fit to be discharged.	Discussions at ward level happen consistently and families are provided with Care Home guidance in writing. There is a multidisciplinary approach to supporting people and families and a letter is issued to set clear expectations where these discussions become difficult.
Discharge to assess	Implement discharge to assess models and intermediate care (bed or team) to support discharge home, wherever possible patients should not be assessed for ongoing care whilst at their most vulnerable or in an unfamiliar environment. Use community rehabilitation as the preferred place of recovery and intermediate care (and	10 intermediate care beds open in Racecourse Rd. 37 admissions and 25 discharges so far with 23 requiring no care and 2 reductions in the size of care packages. Reablement investment in 2020 to achieve discharge to assess but lack of capacity in mainstream care at home has limited the impact. Currently there is a 15% vacancy rate and 25% of capacity is blocked due to a lack of Care at Home capacity. There has been good use of interim care beds within South Ayrshire. There remain 18 people who have an interim placement under the

	interim care home beds in the short-term) with a clear recovery plan in place.	contracts in place since Winter 2021-22 with 7 progressing to permanent placements and 11 awaiting Care at Home with exit plans expected by mid-May 2023. There are 6 people who are in placements under the winter 2022-23 contract.

4.2 **Governance and Oversight**

The improvements detailed in table 1 and a range of other improvements (appendix 1) have been implemented over a period of more than three years through a range of pan-Ayrshire and South Ayrshire specific improvement activity including:

- Adult and Older People Service Plan overseen by Driving Change
- Team level plans – Reablement redesign, Intermediate Care Team plan, Care at Home redesign, Hospital Social Work, Mental Health Officer Team.
- Frailty Extreme Team.
- Discharge Without Delay Oversight Group.
- Multi-Agency Discharge Events and Whole System Interventions.

4.2.1 Ongoing oversight will be provided on a South Ayrshire basis through Driving Change and Directorate Management Team and on a Pan-Ayrshire basis through the Discharge Without Delay Oversight Group and Strategic Partnership Operational Group.

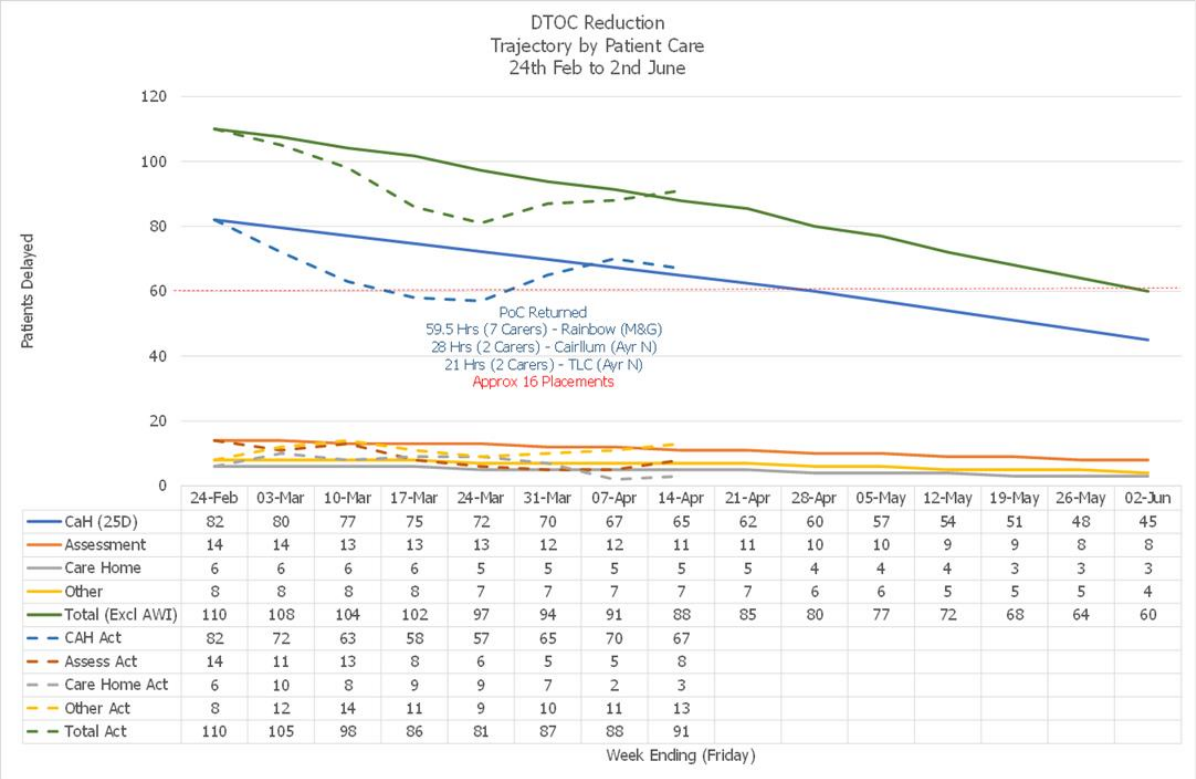
4.2.2 South Ayrshire HSCP will work with Scottish Government colleagues to provide additional evaluation of these and other improvement measures, and to identify any further improvements that will support the reduction in delayed transfers of care and minimise hospital occupancy.

4.3 **High Impact Changes For South Ayrshire**

The main reasons for DTOCs in South Ayrshire are related to Care at Home Capacity. Therefore the team have focussed their attention on improving efficiency, minimising demand and maximising capacity through recruitment and retention activity as previously reported to the IJB (appendix 1).

South Ayrshire have set a trajectory to reduce Delayed Transfers of Care to 60 by the 2nd June (Fig. 1). Good progress was made during February to March with delays falling to 81 (16 ahead of trajectory) due to improved recruitment into In House Care at Home, a number of staff taking on additional hours and a stabilisation in the private sector. Unfortunately progress in March to April has stalled with delays rising to 91 due to slower recruitment, a moratorium in place for our largest provider (providing 20% of all commissioned care) and 109hrs being handed back by the private sector (equivalent to 16 placements). A DTOC meeting is chaired weekly by the Head of Community Health and Care Services to oversee performance with a focus on escalating and resolving the 10 longest delays.

Figure 1: DTOC trajectory and performance

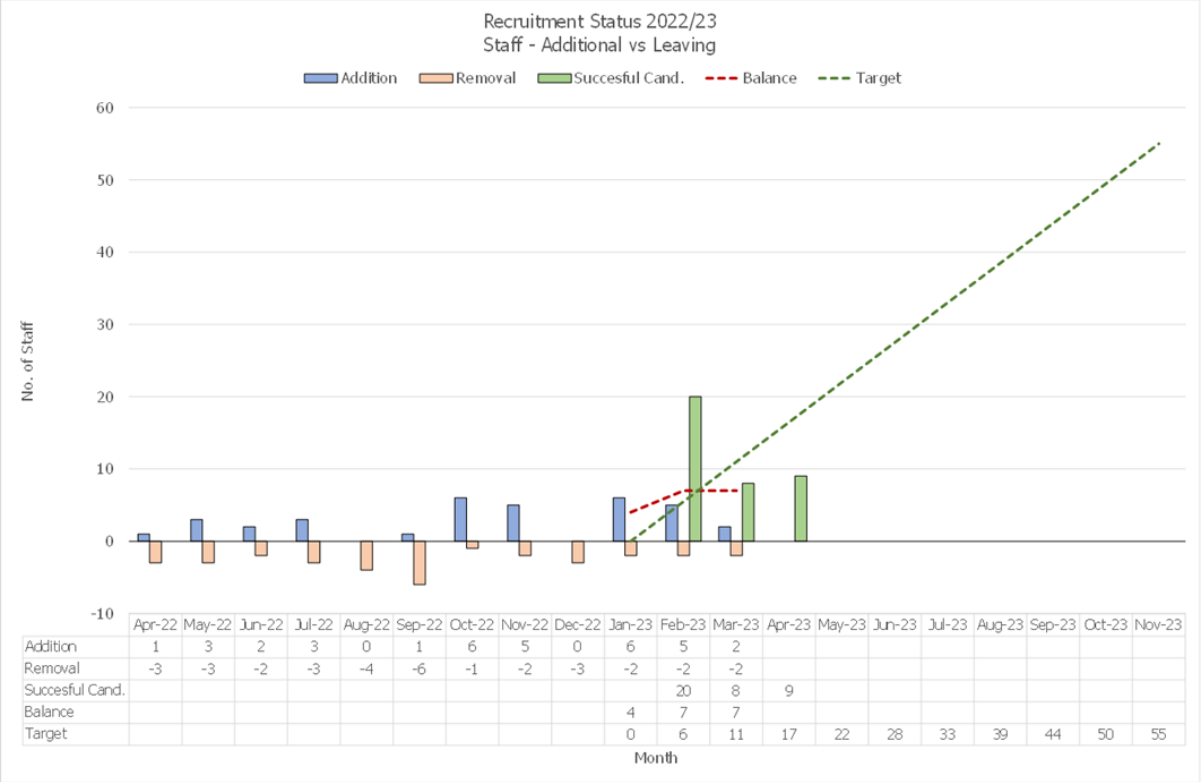


	24-Feb	03-Mar	10-Mar	17-Mar	24-Mar	31-Mar	07-Apr	14-Apr	21-Apr	28-Apr	05-May	12-May	19-May	26-May	02-Jun
CaH (25D)	82	80	77	75	72	70	67	65	62	60	57	54	51	48	45
Assessment	14	14	13	13	13	12	12	11	11	10	10	9	9	8	8
Care Home	6	6	6	6	5	5	5	5	5	4	4	4	3	3	3
Other	8	8	8	8	7	7	7	7	7	6	6	5	5	5	4
Total (Excl AWI)	110	108	104	102	97	94	91	88	85	80	77	72	68	64	60
CAH Act	82	72	63	58	57	65	70	67							
Assess Act	14	11	13	8	6	5	5	8							
Care Home Act	6	10	8	9	9	7	2	3							
Other Act	8	12	14	11	9	10	11	13							
Total Act	110	105	98	86	81	87	88	91							

The partnership has a Care at Home and Reablement recruitment and retention group that meets weekly and oversees activity (table 1) and performance against our recruitment goals and trajectory (increase net 5 staff per month to fill all 55 additional posts by the end of the year). This group reports into the Workforce Recruitment and Retention Subgroup which in turn reports into the partnership Workforce Governance Group Chaired by the Director of SA HSCP.

Figure 2 demonstrates that recruitment has been significantly better (more people have been recruited during the first three months of 2023 than were recruited in the whole of 2022) and although the current balance leaves us slightly short of trajectory there are a number of people going through their recruitment and on-boarding process that mean that we should remain largely on trajectory as we progress through the year.

Figure 2: Care at Home Recruitment Summary Against Trajectory



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Addition	1	3	2	3	0	1	6	5	0	6	5	2								
Removal	-3	-3	-2	-3	-4	-6	-1	-2	-3	-2	-2	-2								
Succesful Cand.											20	8	9							
Balance										4	7	7								
Target										0	6	11	17	22	28	33	39	44	50	55

4.4 **Summary and Recommendations**

The report demonstrates that the improvements set out in the Scottish Government Action Plan are in an advanced stage of implementation and in many cases are well embedded. Leadership and support to ensure that improvements are sustained will be provided through regular Whole System Interventions and local and Pan-Ayrshire oversight. Improvement in performance will rely on continued positive recruitment and retention balance within Care at Home and maintaining the stability of the private sector.

5. STRATEGIC CONTEXT

5.1 The report evidences' that strategic direction setting and leadership for improvement have enabled teams to deliver improvements that achieve the outcomes set out by the Scottish Government Action Plan.

6. IMPLICATIONS

6.1 **Financial Implications**

6.1.1 There are no financial implications arising from the consideration of this report.

6.2 Human Resource Implications

6.2.1 There are no human resource implications arising from the consideration of this report.

6.3 Legal Implications

6.3.1 There are no legal implications arising from the consideration of this report.

6.4 **Equalities implications**

6.4.1 There are no equalities implications arising from the consideration of this report.

6.5 Sustainability implications

6.5.1 There are no environmental or sustainability issues associated with this report.

7. CONSULTATION AND PARTNERSHIP WORKING

7.1 Partnership working is a key feature in the work undertaken for the completion of the action plan.

8. RISK ASSESSMENT

8.1. There are reputational risks associated with not delivering on the recommendations made within this report.

REPORT AUTHOR AND PERSON TO CONTACT

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BACKGROUND PAPERS