Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	19 November 2024
Report Title	Specialist Mental Health and Learning Disability Services (MHLDS), Discharge Without Delay (DwD)
Report Number	HSCP .24.087
Lead Officer	Judith McLenan
Report Author Details	*Name: Judith McLenan/Claire Smith* *Email Address:* Judith.mclenan@nhs.scot
Consultation Checklist Completed	Yes
Directions Required	No
Exempt	No
Appendices	a.
Terms of Reference	The IJB shall consider the following; 1c) Any other matter that the Chief Officer determines appropriate to report to the IJB

1. Purpose of the Report

1.1. The purpose of this report is to update the IJB on improvement activity in relation to the national oversight of Discharge without Delay (DwD), relating to Specialist Mental Health and Learning Disability Services (MHLDS).

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

ABERDEEN CITY COUNCIL NHS Grampian

a) Notes the content of the report; and
b) Notes that ongoing implementation of the improvement plan will be reported within Specialist MHLDS report to each meeting of the Clinical and Care Governance Committee (CCGC).

3. Strategic Plan Context

3.1. This is linked to Aberdeen City's Health & Social Care Partnership's (HSCPs) 3 year Delivery Plan and Strategic Delivery Plan. The project description is 'develop and deliver local and sustainable system flow and return to home pathways with partners, supporting reduced hospital admissions, delays in hospital discharge and out of area placements.' This project is key to delivering on DwD, a strategic priority for the Partnership.

4. Summary of Key Information

4.1 Following the last report presented to the Board 24th September 2024 with an update of the implementation of the ACHSCP DwD Action Plan, it was agreed that an update would be provided on the implementation of the Specialist MHLDS improvement plan – Appendix 1 of this report.

4.2 Specialist MHLDS cover a range of specialist inpatient pathways, 17 inpatient wards including; Functional Acute Admission (Adult and Older Adult), Dementia Assessment, Forensic Mental Health, Intensive Psychiatric Care, Learning Disabilities, Rehabilitation, Acquired Brain Injury (Neuropsychiatry) and Eating Disorders within Royal Cornhill Hospital (RCH) (and additionally, Adult Mental Health Rehabilitation at Polmuir Road and Forensic Rehabilitation at Great Western Lodge). Our inpatient wards provide specialist beds for all three HSCP's. RCH remains under sustained pressure with current performance summary reflecting a high number of delays to discharge, low percentage of available beds, high overnight occupancy, and high occupied bed days, with a dependence on use of surge beds. RCH has had 110% occupancy on average for the last 12 months with the service most often in G-OPES level 4 (systems pressures escalation system, where Level 4 denotes highest pressure and Level 1 the lowest). There are 22 unfunded surge beds in use across the hospital, this means that surge beds are staffed with supplementary staffing required for safe staffing of the high demand and high acuity of patients over and above our funded workforce establishment. Delayed Discharges (DD) and Delayed Transfers of Care (DToC) can be seen in the table below. The clinical teams in

RCH have identified areas where dedicated activity would lead to improvements in pathways and patient experience of discharge.

Mental Health

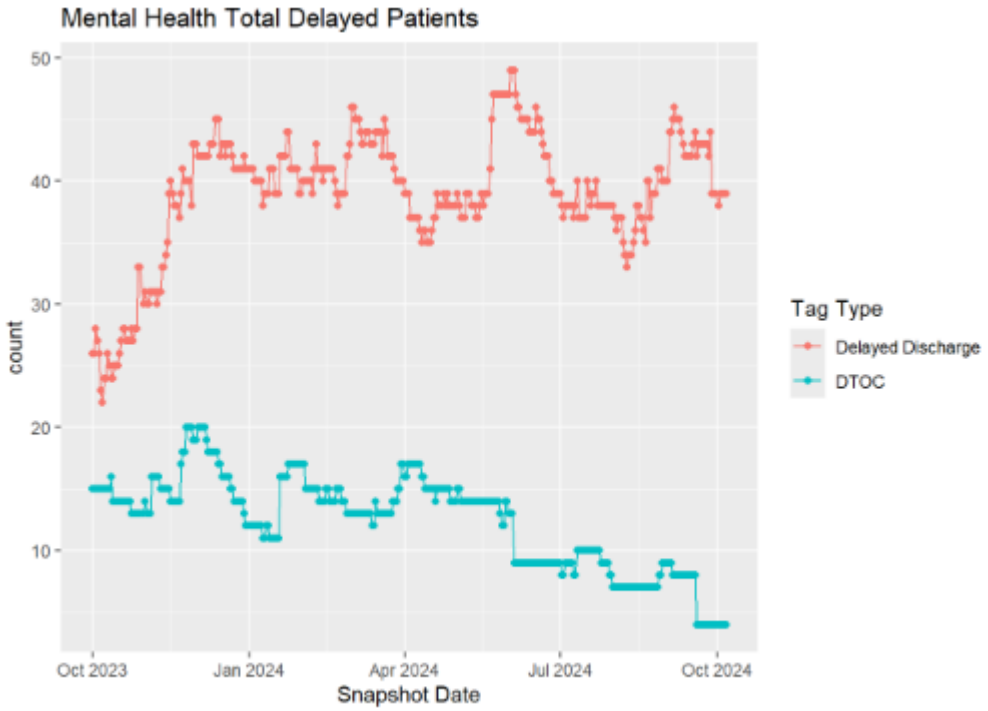
Mental Health Is Including all wards in the following hospitals

Hosp Desc
Pluscarden Clinic
Bennachie View Care Home
Royal Cornhill Hospital
Polmuir Rehab Hospital

And in addition the following specific wards:

Ward Desc
Muirton Ward, Seafield Hospital
Fraserburgh, Brucklay Ward

Total Trend



4.3 Specialist MHLDS are engaged in both the Grampian DwD Group and the ACHSCP DwD short life working group (SLWG). Following agreement to develop a separate action plan for Grampian wide MHLDS, a group has been convened with representation from all three HSCP's and professional disciplines. The aim of this group is to review and build on the previously agreed actions from the MHLDS cross system discharge planning and improvement group, with the aim of reducing delayed discharges, length of occupied bed day delay and improving the quality of care and multidisciplinary working around discharges. The group now meets weekly to review the live project action plan. In the development of this plan national guidance and best practice has been reviewed and included.

The Daily Dynamic Discharge Approach: Improving the timeliness and quality of patient care by planning and synchronising the day's activities (www.gov.scot)

Emergency Department Guidance Signposting/ Redirection: Best Practice Guidance (Update) (www.gov.scot)

4.4 Activity identified and undertaken to date includes;

Achieved;

- A 'Day of Care Audit' has been completed in the 6 acute admission wards (Adult and Older Adult Mental Health, RCH), a report completed and shared for learning and application to improvement work.
- Review of current discharge processes and pathways at RCH.
- Improved the timing of Core Discharge Document (CDD's) to ensure discharge medication is available 24 hours prior to discharge.
- Improvement work has been implemented to the format and function of the weekly DD/DTOC meeting. Each week every delayed patient is discussed collaboratively between ward nursing staff and social work from ACHSCP and Aberdeenshire HSCP to improve communication, identify any barriers and seek solutions to delays.
- Pop up demonstrations regarding Technology Enabled Care have been attended by ward staff.

In progress:

- Review of NHS Grampian MHLDS RCH 'Admission and Discharge Policy', exploring criteria led discharge and scoping current policies and procedures from other NHS boards.
- Improvement in use of the Planned Date of Discharge (PDD) function on the electronic patient record system 'TRAKCARE' and monitor compliance.
- Development of a discharge tab on TRAKCARE to support early planning or discharge.
- Social work access to electronic patient record on TRAKCARE.
- Developing the patient flow co-ordinators role in discharge support.
- Reinstate the delayed discharge co-ordinator
- Inclusion of family and carers in discharge planning. Supporting consistent and courageous conversations between clinicians and family and carers, promotion of appropriate policies to support this.

To be commenced:

- Implementation of the Specialist Pathway based planning model to support early recognition of patients likely to face delays to discharge.
- 'Daily Dynamic Discharge' meeting is a national approach that has been used traditionally in acute hospitals to support early discharge planning. This is being included within the MHLDS Action Plan for evaluation.
- Implementation of the 'Golden hour' Multi-Disciplinary Team meeting (MDT) format to prioritise appropriate tasks within (MDTs) to facilitate effective discharge.
- Develop an escalation process for persistent delays.
- Education for ward staff in relation to DD/DTOC and guardianship.
- Embed 'Home first' approach and improved co-ordination with community teams and social care services.

4.5 The Specialist MHLDS DwD group has been working collaboratively with Healthcare Improvement Scotland (HIS) identifying areas HIS can support the service to understand the challenges and make sustained changes to improve discharges. Two workshops have taken place with HIS who are in the process of identifying improvement projects they will support the service with. A test of change has been identified to improve communication and engagement for delayed discharges where there is regularly no update with the aim to identify barriers to discharge, seek solutions and escalate where necessary.

5. Implications for IJB

5.1. Equalities, Fairer Scotland and Health Inequality

The Grampian MHLDS RCH Admission and Discharge Policy review will adhere to the NHS Grampian "Procedure for the Development, Approval, Review, Revision and Communication of Clinical Policies.

5.2. Financial

Specialist Mental Health and Learning Disability Services budget is retained by NHS Grampian. It is noted that due to current financial pressures, NHS Grampian are not in a position to invest additional monies beyond the budget set for 2024/25 to create additional capacity to contribute towards meeting the discharge demand. Improvement will focus on streamlining and improving processes and collaborative working cross system to achieve the intended results.

There has been no additional funding allocated to Adult Health & Social Care Specialist Mental Health and Learning Disability Services to progress the improvement plan. Therefore, teams are redesigning within existing resources to make improvements.

5.3. Workforce

There are no direct workforce implications arising from the recommendations of this report.

5.4. Legal

There are no direct legal implications arising from the recommendations of this report.

5.5. Unpaid Carers

There are no direct implications relating to unpaid carers arising from the recommendations of this report.

5.6. Information Governance

There are no direct information governance implications arising from the recommendations of this report.

5.7. Environmental Impacts

There are no direct environmental implications arising from the recommendations of this report.

5.8. Sustainability

There are no impacts on sustainable development arising from this report.

5.9. Other

There are no other direct implications arising from the recommendations of this report.

6. Management of Risk

6.1. Identified risks

- Failure to implement the Strategy and Action Plan.

This risk is minimal due to the ongoing engagement with partners. Failure to implement the Strategy and Action Plan could lead to reputational damage, to mitigate this, there is an established oversight and working group structure which will report to the Clinical and Care Governance Committee.

- Increase in delays due to closure of interim care home placements

There is a risk that due to the reduction in our interim bed base, our delays increase. To mitigate this risk we continue to work closely with our providers to ensure people are discharged home in a timely manner and progress our home to assess work to reduce the need for reliance on interim beds.

- Increase in delays over the requested target

The reason for delayed discharge is often challenging especially for those with complex needs or who fall under Adults with Incapacity where moving someone

out of hospital without legal status in place cannot be done. We have, like other partnerships raised the issues around this and a national campaign on Power of Attorney and national communication around hospital delays have been agreed. The need for placements for those with most complex needs (including MHLDS patient pathways) is also a national issue which CoSLA have also agreed to address in the longer term.

MHLDS social work team continue to have a focus on delays and are collaborating with Specialist Mental Health and Learning Disability Services clinical colleagues in terms of discharge planning from the point of admission. There is risk of our local figures increasing as demand continues. A weekly focus health and social care meeting on discharges is ongoing with the weekly group driving forward the required improvements.

6.1. Link to risks on strategic or operational risk register:

DwD has been added to the operational risk register.

Appendix 1 – Specialist MHLDS LIVE Action Plan as at 17th October 2024, as requested for submission process. A verbal update will be provided to IJB at 19th November meeting.

Approvals

Fiona Mitchelhill

Chief Officer