Agenda Item 3.2

NHS Highland	

Meeting:	**Highland Health and Social Care Committee**
Meeting date:	**2 September 2026**
Title:	**Discharge Without Delay Programme**
Responsible Executive/Non-Executive:	**Arlene Johnstone, Chief Officer**
Report Author:	**Joyce Forsyth, Interface Manager**

Report Recommendation:
The Health and Social Care Committee and committee are asked to **note** the report and take **moderate** assurance.

Report Recommendation:

The Committee is asked to note the contents of the report and the current position in relation to delivery of the Discharge Without Delay Programme across the Highland Health and Social Care Partnership and to take assurance from the actions being taken to improve discharge performance and support delivery of Home First principles.

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- 5 Year Strategy, Together We Care, with you, for you.
- National Framework /Government policy/directive
- Local policy
- NHS Board/Integration Joint Board Strategy or Direction

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		Live Well		Respond Well		Treat Well	
Journey Well		Age Well		End Well		Value Well	
Perform well		Progress well		**All** Well Themes	x		

2 Report summary

2.1 Situation

The Discharge Without Delay (DWD) Programme is a key national improvement programme supporting delivery of Home First principles and improved outcomes for people through timely discharge from hospital and reduced reliance on hospital-based care. NHS Highland has participated in the programme since 2022 and, during 2026/27, has refreshed its governance arrangements, delivery structures and performance framework in line with national priorities.

The DWD Programme is based on a nationally agreed framework which is being implemented consistently across NHS Scotland. Within Highland, improvement activity is being delivered in line with this national approach whilst reflecting local geography, service configuration and community need.

Figure 1: National DWD Framework

The principle of “Home First “underpins the DWD programme four pillars with the specific objective for people: ***People should recover, be assessed, and receive support in their own home (or a homely setting) whenever it is safe and appropriate to do so, rather than remaining in hospital unnecessarily.***

Across the Highland Health & Social Care Partnership, a range of discharge improvement initiatives have been established, including multidisciplinary discharge planning, Planned Dates of Discharge, Decision Making Teams, Discharge to Assess pathways and digital discharge coordination processes. These provide an important foundation for improvement and support delivery of a whole-system approach to discharge planning and care coordination.

Whilst progress has been made, discharge performance remains variable across the Highland Health and Social Care Partnership and further improvement is required to support timely discharge and delivery of Home First principles. The immediate focus is on strengthening discharge coordination, embedding Home First consistently, improving use of Discharge to Assess pathways and supporting more integrated working across acute, community and social care services.

2.2 Background

The Highland Health and Social Care Partnership has participated in the national Discharge Without Delay Programme since 2022. During this period a range of discharge improvement measures have been introduced, including multidisciplinary discharge planning, Planned Dates of Discharge, Decision Making Teams, digital discharge coordination processes and Discharge to Assess pathways. These developments have established important foundations for the delivery of Home First principles and more effective discharge planning across acute, community and social care services.

The 2026/27 programme is focused on moving from individual improvement initiatives towards a more consistent and integrated approach across the Partnership. Key priorities include development of an Integrated Discharge Team model, wider adoption of Discharge to Assess pathways, strengthening discharge coordination across the acute and community interface, and improving oversight of discharge performance and patient flow. Learning from the East Ross Discharge to Assess pilot will inform future implementation across the Partnership.

2.3 Assessment

The NHS Highland programme for 26/27 has re-established governance, work stream leadership and a performance framework based on the National DWD programme priorities :

Figure 2: DWD National Priorities for 26/27

As part of this approach, a dedicated Interface Manager post has been established to provide leadership and coordination across the programme and to strengthen oversight of discharge performance and patient flow across the Health and Social Care Partnership.

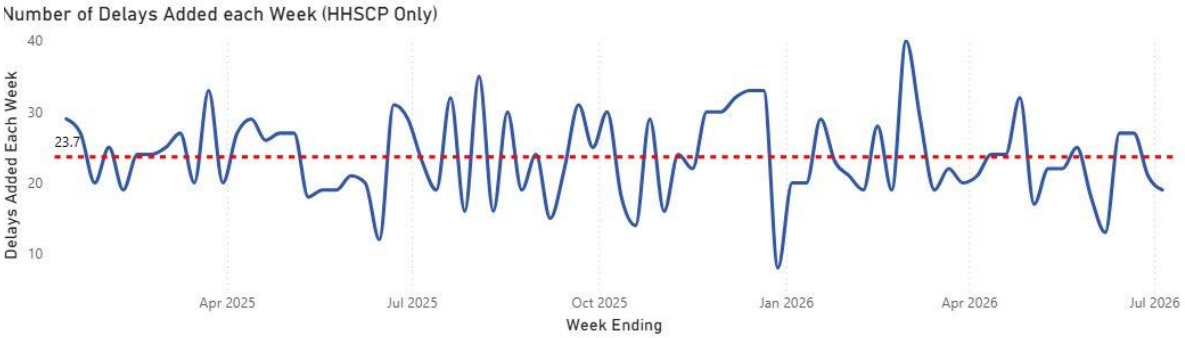
The Partnership's most recent self-assessment against the four national pillars of the Discharge Without Delay Programme identified variation in the maturity and implementation of key elements of the programme. Whilst progress has been made, variation remains in discharge coordination arrangements, use of Planned Dates of Discharge, adoption of Discharge to Assess pathways and visibility of community capacity. These factors continue to limit consistent delivery of Home First principles and contribute to variation in discharge performance across the Partnership.

The current assessment of delivery against the four national Discharge Without Delay pillars is summarised below. The assessment reflects the current position within the Highland Health and Social Care Partnership and identifies the priority actions required to support further improvement.

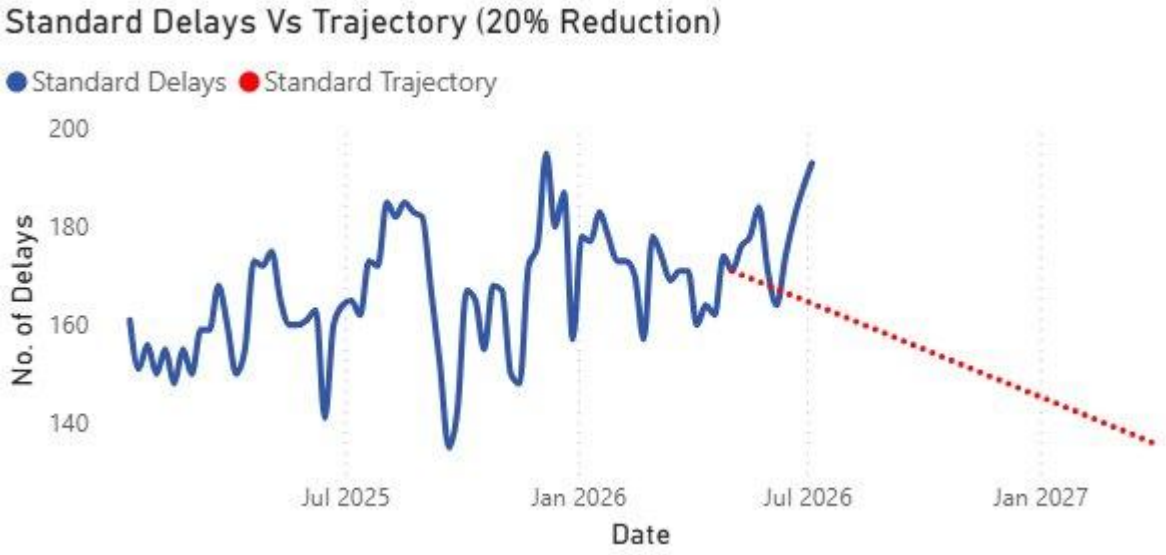
DWD pillar	Status	Current position	Priority next step
PDD / IDT	Amber	Discharge functions exist but remain distributed. No fully integrated discharge team is yet embedded across the acute-community interface.	Progress the substantive phased IDT model for Raigmore and Inner Moray Firth, with governance, workforce engagement, clear roles, SOPs and measurable outcomes.
Home First / D2A	Amber	East Ross has provided useful learning, but provision and use remain variable across districts.	Agree a standard Highland model, referral criteria, operating processes, workforce requirements and

			outcome measures, then plan phased spread.
Acute Frailty	Amber	A four-bed frailty assessment area operates within AMU at Raigmore, but seven-day multidisciplinary provision is not yet in place.	Improve early identification, multidisciplinary assessment and links to Hospital at Home, community MDTs and discharge pathways.
Community Hospitals / Step-Down	Red	Step-down waits of 2-3 weeks and variation between hospitals continue. Pathways are not yet standardised.	Complete demand and capacity work, standardise criteria and pathways, clarify ownership and strengthen operational oversight of capacity and flow.

Figure 1: Current RAG rated performance against DWD Pillars July 2026



Current performance data demonstrates that, despite the progress made in establishing programme infrastructure and improvement initiatives, discharge performance remains off trajectory and further improvement is required. The measures below illustrate current performance trends and will be used to monitor the impact of the improvement actions described in this report.



The data highlights the need for continued focus on discharge coordination, consistent application of Home First principles, wider adoption of Discharge to Assess pathways and improved management of patient flow across the Partnership.

2.3.2 Integrated Discharge Team

The implementation of the Integrated Discharge Team (IDT) will be undertaken through a phased approach. Phase 1 will focus on establishing and embedding the model across Raigmore Hospital and Inner Moray Firth, bringing together discharge coordination functions within a single integrated operational structure. The model is intended to strengthen coordination across the acute and community interface, improve oversight of discharge pathways and support more consistent delivery of Home First principles.

Implementation activity is underway and will focus on agreeing governance arrangements, workforce engagement, roles and responsibilities, standard operating procedures and performance measures. Phase 1 implementation is expected to be completed during 2026/27, with an initial review of performance and outcomes undertaken during the final quarter of the year.

The implementation of the Integrated Discharge Team (IDT) will be undertaken through a phased approach.

Milestone	Timescale
Governance and operating model agreed	Autumn 2026
Workforce engagement and implementation arrangements completed	Autumn 2026
Phase 1 IDT operational across Raigmore Hospital and Inner Moray Firth	Winter 2026/27

Initial review of performance and outcomes	Quarter 4 2026/27
Evaluation and recommendations for future development	End of 2026/27

Subject to evaluation findings and governance approval, consideration will then be given to extending the model across the wider Highland Health and Social Care Partnership.

2.3.3 Discharge to Assess (D2A)

Discharge to Assess is a key component of the national Discharge Without Delay Programme and supports delivery of Home First principles by enabling people to leave hospital as soon as they are clinically ready, with further assessment and support provided in their own home or a homely setting.

The Highland Health and Social Care Partnership has undertaken a Discharge to Assess pilot within East Ross. Learning from this work has informed development of a more consistent approach across the Partnership. Whilst local models may require to reflect differences in geography, workforce and community capacity, the aim is to establish a common framework, referral process and operating principles across all districts.

An accelerated programme of implementation is underway between August and November 2026. This will focus on adoption of Discharge to Assess pathways across all districts, supported by workforce development, standardised processes and closer alignment with the Integrated Discharge Team model.

The key milestones for the programme are:

Milestone	**Timescale**
Review of East Ross learning and agreed HHSCP approach	Autumn 2026
Standardised pathway and referral arrangements agreed	Autumn 2026
Workforce development and implementation support completed	Autumn/Winter 2026
Discharge to Assess pathways operating across all districts	Winter 2026/27
Initial review of activity, outcomes and impact on patient flow	Quarter 4 2026/27

The anticipated benefits include earlier discharge from hospital, improved patient experience, reduced length of stay and more consistent delivery of Home First principles across the Highland Health and Social Care Partnership. Progress and outcomes will be monitored through the programme performance framework and reported through established governance arrangements.

Together, the Integrated Discharge Team and Discharge to Assess workstreams form the principal improvement actions intended to address the variation identified through the programme self-assessment and support sustained improvement in discharge performance across the Partnership.

2.4 Proposed level of Assurance

Substantial		Moderate	x
Limited		None	

There is clear programme direction, governance and active improvement work. However, current performance remains off trajectory.

3 Impact Analysis

3.1 Quality/ Patient Care

The Discharge Without Delay Programme is intended to support earlier, safer and more coordinated discharge planning, reducing unnecessary time spent in hospital and enabling more people to receive assessment, treatment and care in their own home or a homely setting where it is safe and appropriate to do so.
The anticipated benefits include reduced delays, improved patient flow and more consistent delivery of Home First principles. Progress will be monitored through programme performance measures including delayed discharge, length of stay, discharge destination and patient outcomes.
There remains a risk that earlier discharge could adversely affect patient care if community capacity, assessment arrangements or support services are not available. These risks will be mitigated through multidisciplinary decision-making, agreed clinical criteria, performance monitoring and ongoing review of outcomes.

3.2 Workforce

Delivery of the programme requires close collaboration across acute, community and social care services. During 2026/27, programme leadership has been strengthened through the establishment of a dedicated Interface Manager role to coordinate delivery of the programme and support implementation of the agreed improvement workstreams.

The development of the Integrated Discharge Team and wider implementation of Discharge to Assess pathways will require workforce engagement, clear roles and responsibilities, training and support for staff. Appropriate organisational change processes will be followed where required.

3.3 Financial

The DWD Programme seeks to improve patient flow and reduce avoidable delays through more effective use of existing resources
Workforce and service capacity will require ongoing modelling to ensure resources are aligned across acute, community and social care services. While some elements may be delivered through the redesign and realignment of existing resources, any

additional investment requirements will be subject to business case approval, financial governance processes, and benefits realisation monitoring. Financial impacts will be managed through regular programme oversight, performance reporting, and collaboration with Finance colleagues.

3.4 Risk Assessment/Management

The main risks to delivery of the DWD Programme relate to community capacity, workforce availability, consistent implementation of Home First principles, digital system reliability and financial sustainability. These risks may impact the ability to reduce delayed discharges and improve patient flow.

Mitigating actions include strengthened governance, workforce planning, performance monitoring, standardised discharge processes through implementation of the IDT and consistent D2A pathway use , capacity modelling and close partnership working across Acute Services, HSCPs and community teams. The most significant risks relate to community capacity and workforce pressures.

Risk ID	Risk Description	Impact to project	Sta	Dat identi	Risk owr	Likelih	Impa	Risk S	Chosen Ac Type	Mitigating actions
R-001	Access tto social care capacity (packages of care, reablement, care home placements) limits ability to discharge patients in a timely way.	Constrains reduction in delayed discharge and shifts bottleneck from acute to community system.	Open	3/31/2026	Director of ASC	4	5	20	Prevent	Daily system escalation; surge reablement capacity; joint acute/HSCP discharge coordination; escalation to Executive Directors Group.
R-002	Inconsistent adoption of Home First, Discharge to Assess (D2A) and pathways-based planning across system partners.	Variation in discharge practice leading to uneven performance and reduced programme impact.	Open	15/05/2026	Associate Director AHPs, Area Manager	3	5	15	Prevent	Standardised DwD operating model; leadership engagement; audit and assurance; inclusion in performance frameworks.
R-003	Planned Date of Discharge (PDD) not consistently set within 24–48 hours of admission.	Delayed discharge decision-making and increased stranded patients.	Open	6/2/2026	Associate Director of Nursing, Area manager	3	4	12	Prevent	Mandatory PDD within admission window; dashboard monitoring; clinical governance oversight; escalation of non-compliance.
R-004	Community hospital step-down and rehabilitation capacity becomes unsustainable due to being misaligned to demand.	Delayed transfers from acute hospitals leading to sustained bed pressures.	Open	6/2/2026	Head of Community Services	3	5	15	Prevent	Dynamic bed management; clear admission/discharge criteria; weekly flow reviews; flexible use of capacity across localities.
R-005	Digital tools (Discharge App) do not function reliably or are not consistently used across teams.	Reduced communication efficiency between acute and community teams, increasing discharge delays.	Open	6/2/2026	Programme Lead	2	4	8	Prevent	Contract renewal; system resilience planning; fallback communication processes; standardised usage protocols and training.
R-006	Financial model does not adequately support shift from acute to community-based care.	Limits scalability of D2A and Home First models and reduces benefits realisation.	Open	6/2/2026	Head of Community Services & Head of Ops (Acute) with HoF HHSCP	3	5	15	Prevent	System financial modelling; investment-benefit alignment; agreement of recurrent funding pathways via governance structures.
R-007	Workforce capacity and skill mix across acute, community and social care is insufficient to support seven-day flow and discharge activity.	Reduced ability to sustain DwD model, particularly out of hours and weekends.	Open	6/2/2026	Service and Area Managers	4	4	16	Prevent	Workforce planning and redesign; recruitment and retention plans; skill mix optimisation; escalation of critical gaps.

3.5 Data Protection

The DWD Delivery does not introduce new purposes for processing personal information. Personal data will continue to be processed solely for the purposes of direct care, discharge planning, care coordination and associated operational functions, which are lawful activities under the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. .

3.6 Equality and Diversity, including health inequalities

The programme supports equitable access to timely discharge and delivery of Home First principles. Particular consideration is required for people living in rural and

island communities, people who live alone, those with limited informal support and individuals requiring reasonable adjustments. The Equality Impact Assessment undertaken for the Integrated Discharge Team development identified an overall positive impact, with mitigating actions in place to address any identified risks
The DWD Programme supports the Public Sector Equality Duty and Fairer Scotland Duty by promoting a Home First approach, reducing the impact of prolonged hospital stays, and supporting people to receive care in the most appropriate setting. The programme aims to improve outcomes and reduce inequalities through timely access to assessment, discharge planning and community-based support.

3.7 Other impacts

Not Applicable

3.8 Communication, involvement, engagement and consultation

Communication and engagement have been undertaken through the DWD Delivery Group, IDT workstream, MDT forums and established governance structures. Consultation in respect to the programme delivery has included Acute Services, HSCP, Social Care and professional leads, with discussions taking place through the HHSCP Senior Leadership Group, Acute Services Senior Leadership Team, Executive Directors Group, Clinical Governance Committee, Unscheduled Care Portfolio Board and Local Partnership Forums.

Reporting internally to the Unscheduled Care Programme Board and Nationally to the Centre for Sustainable Delivery (CFSD) .

3.9 Route to the Meeting

Not applicable

4.1 List of appendices

The following appendices are included with this report: