Item 5.6

Report

Delayed Discharge – Recent Trends
Edinburgh Integration Joint Board

16 September 2016

Executive Summary

1. This paper provides an overview of performance in managing hospital discharge, showing the total number of Edinburgh people who were delayed at each monthly census point over the past two years, alongside the target level for 2015-16.

2. Changes to national reporting of delayed discharge, outlined in the May 2016 report to the IJB, were introduced for the July 2016 census, and the total of 173 delays for July was the first produced using the revised method. The key change to reporting is that people discharged in the three days following the census date are now included in the total. Using the previous methodology the July figure would have been 160, an increase of 40 from June figures. The August figure was 170.

3. Whilst there was a significant improvement in performance over the period October 2015 to April 2016, there has been a decline in performance from May 2016 to August 2016. This paper explores some of the reasons behind this change.

4. The paper also details work underway to reverse this downward trajectory and the way in which the partnership seeks to maintain the improvement. This includes the work initiated at the flow workshop on 8th March 2016, which is overseen by the Patient Flow Programme Board.

Recommendations

5. That the Edinburgh IJB note that:

- A new Care at Home contract is now in place. Its aim is to improve recruitment and retention of the home care workforce by offering a rate of pay that is comparable with alternative employers, e.g. retail, customer services and the private care market. The transition to these new contracts has until very recently resulted in a reduction in Care at Home capacity.

- Following the improvement in reducing delayed discharge between October 2015 and April 2016, there has been a subsequent increase in the number of delayed discharges from hospital to both Care at Home Packages and Care Homes.

- The changes at national level to delayed discharge reporting with effect from July 2016, slightly accentuated the increase in the total number of people delayed in July by 13 to 173, (160 being the figure using the previous methodology). Note that figures using the former method are not being routinely provided by analysts in NHS Lothian. The July 2016 gives an indication of the level of change brought about by the new method.

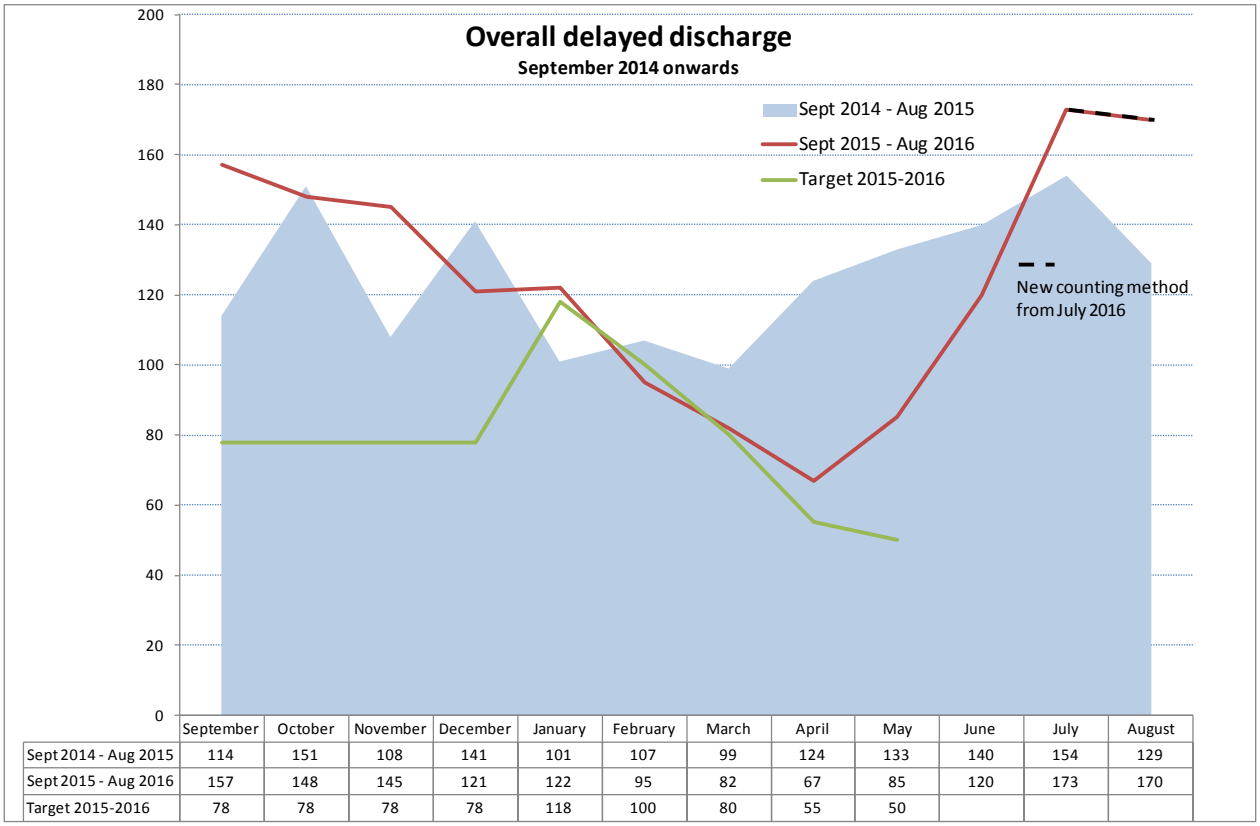
- A review is underway to detail the reasons as to why the previous positive trajectory has reversed, and to ensure that the comprehensive range of actions that are already in place, will secure a return to the reducing trajectory for the number of people delayed in hospital.

Main report

Total number of people delayed

6. The total number of Edinburgh residents who were delayed in hospital over the past two years as at the monthly official census is illustrated in the graph 1. The shaded area shows performance for September 2014 - August 15 and the red line shows levels for the current year. Target levels are shown by the green line. Targets for the period following May 2016 will be determined as part of the work underway to assess capacity, demand and pressures across the whole system.

7. The total number of people delayed at the August 2016 census was 170, fairly similar to the 173 for July.



	September	October	November	December	January	February	March	April	May	June	July	August
Sept 2014 - Aug 2015	114	151	108	141	101	107	99	124	133	140	154	129
Sept 2015 - Aug 2016	157	148	145	121	122	95	82	67	85	120	173	170
Target 2015-2016	78	78	78	78	118	100	80	55	50			

Graph 1

Reasons for delay, 2015-16

8. The broad reasons for delay at the census points over the last 12 months are shown in the table 1. The most common reason across this period has been waiting for domiciliary care, which peaked in October 2015 at 82, and reached similar levels in July and August 2016.

2015-16	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	*July*	*Aug*
Ongoing assessment	21	23	27	26	30	26	27	23	14	20	*34*	*24*
Care Home	41	30	36	26	26	16	14	15	26	35	*58*	*59*
Domiciliary Care	80	82	67	64	59	49	36	22	40	59	*78*	*76*
Legal and Financial	0	0	1	0	0	0	0	2	0	0	*0*	*0*
Other	15	13	14	5	7	4	5	5	5	6	*3*	*11*
Total	157	148	145	121	122	95	82	67	85	120	*173*	*170*
% Domiciliary Care	51%	55%	46%	52%	48%	51%	43%	32%	47%	49%	*45%*	*45%*

Table 1 *July and August figures are shown in italics as these were derived using the new reporting and counting method*

9. It is of concern that the provisional number of patients reported as waiting for care home placements is increasing and accounts for over a third of all delays in August. Guidance on best practice suggests that only in the most exceptional circumstances should a patient move to a care home directly from hospital. Reasons for this are being investigated. Further work and attention is being given to the recommendations made for discharge across all hospitals.

10. A separate issue is that vacancies levels at Gylemuir have been relatively high recently: the average between April and mid July this year was 4 but since than has been 12 since then (see Appendix 2). The increase in vacancy levels has coincided with an increase in the number of delayed in hospital while waiting for a care home.

11. The increase in people waiting for domiciliary care may have been caused by a range of pressures, including the reluctance of agencies to take on service users; lack of capacity (largely due to issues with recruitment and retention of staff); difficulties in securing services for complex packages of care; increased demand for services and increased frailty of service users. The new Care at Home contracts aim to address these issues. However, it is possible that the transition from the existing to new contracts has had an impact on existing providers, and this is being investigated further. In addition, there are two providers under the new contract who are still establishing themselves. They have until October to do so. It is anticipated, therefore, that we will see a significant increase in capacity by winter 2016.

12. The number of contact hours within the new contracts has been increased from 25,000 to 30,000 hours of care per week. The new contracts have been awarded to eight providers of care at home services. These new contracts contain penalty clauses to ensure that the providers commence a package of care within one week of being requested to do so. The new contracts are locality based to support closer working relationships between services, local discharge teams and a renewed service matching unit as part of the new Multi Agency Triage Teams which will include the hospital discharge teams.

13. Although 6 of the 8 contracts have been awarded to existing providers, their current coverage only reaches 47% of what is required. They need to grow their business to meet demand. Contracts remain in place with other existing providers for those packages of care they are currently delivering until such time individual cases are reviewed. There has however been a drop in overall capacity which it is reasonable to presume has impacted negatively on the number of delays. Capacity has now returned to 25,000 hours and it is anticipated that this will have a positive effect on the number of delays. This will be further improved as capacity grows to the full contract of 30,000 hours.

14. One delay can be attributed to a setting in the system, which defaults people with no code to the category ‘waiting allocation for a social worker’. In previous months this group of people would have been treated as people for whom no notification has been made to social care and thus would have been removed entirely.

15. The number and proportion of delays in acute sites is shown in table 2:

2015-16	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	*July*	*Aug*
Delays in acute sites	127	115	115	106	117	80	74	64	82	112	*143*	*146*
Total	157	148	145	121	122	95	82	67	85	120	*173*	*170*
% in acute	81%	78%	79%	88%	96%	84%	90%	96%	96%	93%	*83%*	*83%*

Table 2

16. The numbers of people excluded from the census reporting (X codes and people who are unwell) are given in table 3. Of the X-codes, those which relate to Guardianship (e.g. 20 of the 23 reported in August 2016) are shown separately. The *grand total* row in table 3 shows the number of people delayed, including those who are excluded from the national count.

2015-16	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	*July*	*Aug*
Total	157	148	145	121	122	95	82	67	85	120	*173*	*170*
Excluded cases	20	23	27	27	35	29	33	30	33	27	*25*	*23*
Of which, Guardianship	18	19	23	24	23	21	28	25	30	24	*23*	*20*
Grand total	177	171	172	148	157	124	115	97	118	147	*198*	*193*

Table 3

People supported to leave hospital

17. The main investments, which have been made using the Scottish Government funding to support a reduction in the number of people delayed in hospital, relate to additional capacity for Gylemuir and deployment of clinical support workers. The target for the total number of people supported each week is 60 (see appendix 1). This excludes packages of care which are restarted by ward staff when patients leave hospital (an estimated total of 14 per week). The lease for Gylemuir has been agreed for a further 24 months.

18. Graph 2 shows the average number of discharges per week supported by Health and Social Care, for each month during 2015-16. Figures for provision also exclude the number of packages of care that are estimated to re-start each week, as described above.

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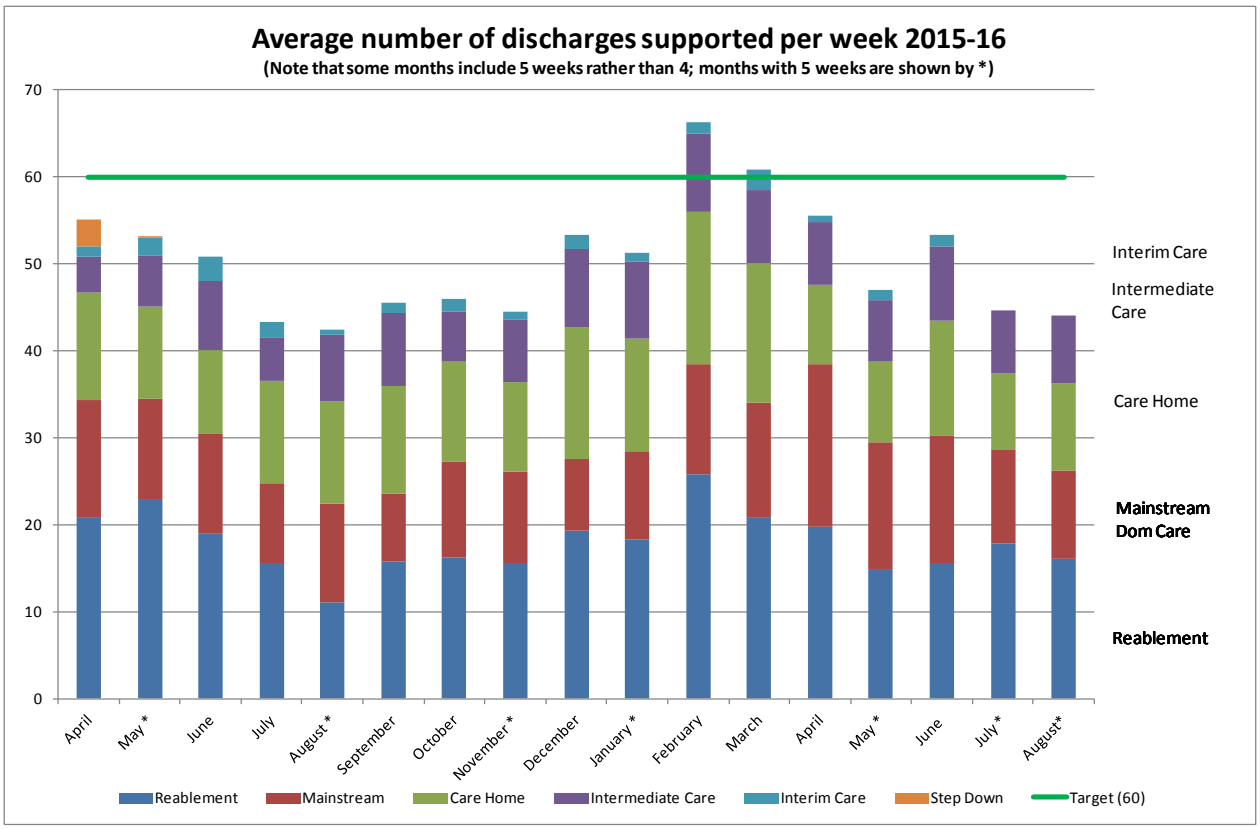

Graph 2

19. Table 4 looks at the specific and different needs of those awaiting transfer of care demonstrates the variety of responses required to meet assessed need. It is noted that around 20% of those awaiting discharge are aged under 65.

		Waiting for:	Age group	28-Jul-16	25-Aug-16 (Provisional)
Assessment	11A	Start	Under 65	1	1
			65+	11	3
		Completion	Under 65	19	2
			65+	3	18
Assessment total				**34**	**24**
Care home	24A	LA care home	Under 65	0	0
			65+	11	11
	24B	Independent residential	Under 65	0	0
			65+	1	2
	24C	Independent nursing	Under 65	0	0
			65+	19	10
	24D	Specialist residential place for younger adults	Under 65	13	16
			65+	2	2
	24E	Specialist residential place for older people	Under 65	0	0
			65+	2	3
	24F	Dementia bed required	Under 65	0	0
			65+	10	15
Care home total				**58**	**59**
Care arrangements	25D	Social care support at home	Under 65	8	4
			65+	70	76
	25E	Equipment/adaptations	Under 65	0	2
			65+	0	1
	25F	Rehousing	Under 65	0	2
			65+	3	1
	27A	Intermediate Care facility	Under 65	0	0
			65+	0	1
Care arrangements total				**81**	**87**
Patient/Carer/Family	51	Legal	Under 65	0	0
			65+	0	0
Patient/Carer/Family total				**0**	**0**
Complex			*Under 65*	*3*	*4*
			65+	*22*	*19*
Complex total (not included in the published totals)				***25***	***23***
			Under 65	41	27
			65+	132	143
Total (excluding complex)			**Total**	**173**	**170**

Table 4

Note: 11A total includes 5 cases where reason was missing in July and 1 in August

Other work streams to address delayed discharge

20. The three key work streams which are underway and being overseen by the Patient Flow Programme Board are as follows:

- Delays within the hospital pathway – the objective is to improve the flow of people through the hospital system through the implementation of effective,

person centred, timely and well coordinated approaches which support a shift the balance of care from institutional to community based support; this work is progressing actions to identify people in the discharge pathway at an earlier point including the application of improved multiagency working with a greater focus on expediting action required to support discharge, as well as clearer lines of accountability across the multidisciplinary team.

- Admission avoidance – this work is seeking to maximise the benefits associated with the effective use of Anticipatory Care Planning, to improve the use of the Key Information Summary, to support continuity and effective communication, and to promote more effective use of the 'Falls pathway'.

- Rehabilitation and recovery – this work has focussed on targeting Reablement services to those who can achieve most benefit from goal setting and reabling approaches. This differs from the previous approach where the policy had been for all discharges from hospital to go through reablement.

- In addition, the roll out of the Locality Hubs and Multi Agency Triage Teams (MATTs) is continuing, with the objectives of identifying people who can be supported to leave hospital early and preventing hospital admissions. It is intended that the MATTs will perform a 24/7 model, supporting weekend hospital discharge, effectively increasing capacity by 29%.

Key risks

21. The main risk is that the additional non-recurring Scottish Government funding has been used to increase capacity in care and support services and that the reductions in delayed discharge levels will not be sustainable unless alternative approaches or funding sources are identified.

22. Phase 2 of the Health and Social Care restructure may see a reduction in the level of staffing resource. The full implications of this phase of the restructure are currently being quantified and will be reported to the Board in due

Financial implications

23. As noted above, the Scottish Government funding is temporary and is being used to underpin care and support services. Alternative funding sources or approaches to providing care will need to be considered.

Involving people

24. As we move towards the locality model and develop the locality hubs, there will be engagement with local communities and other partners to inform the further development of the model.

Impact on plans of other parties

25. This report outlines progress of the Edinburgh Health and Social Care Partnership in addressing the pressures within acute services and has been developed with input from partners.

Background reading/references

Memorandum of Understanding Reducing Delayed Discharges in Edinburgh

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Links to priorities in strategic plan

Priority 4	Providing the right care in the right place at the right time
Priority 6	Managing our resources effectively

Appendix 1 – Target number of packages of support per week for people leaving hospital

Appendix 2 – Gylemuir vacancies

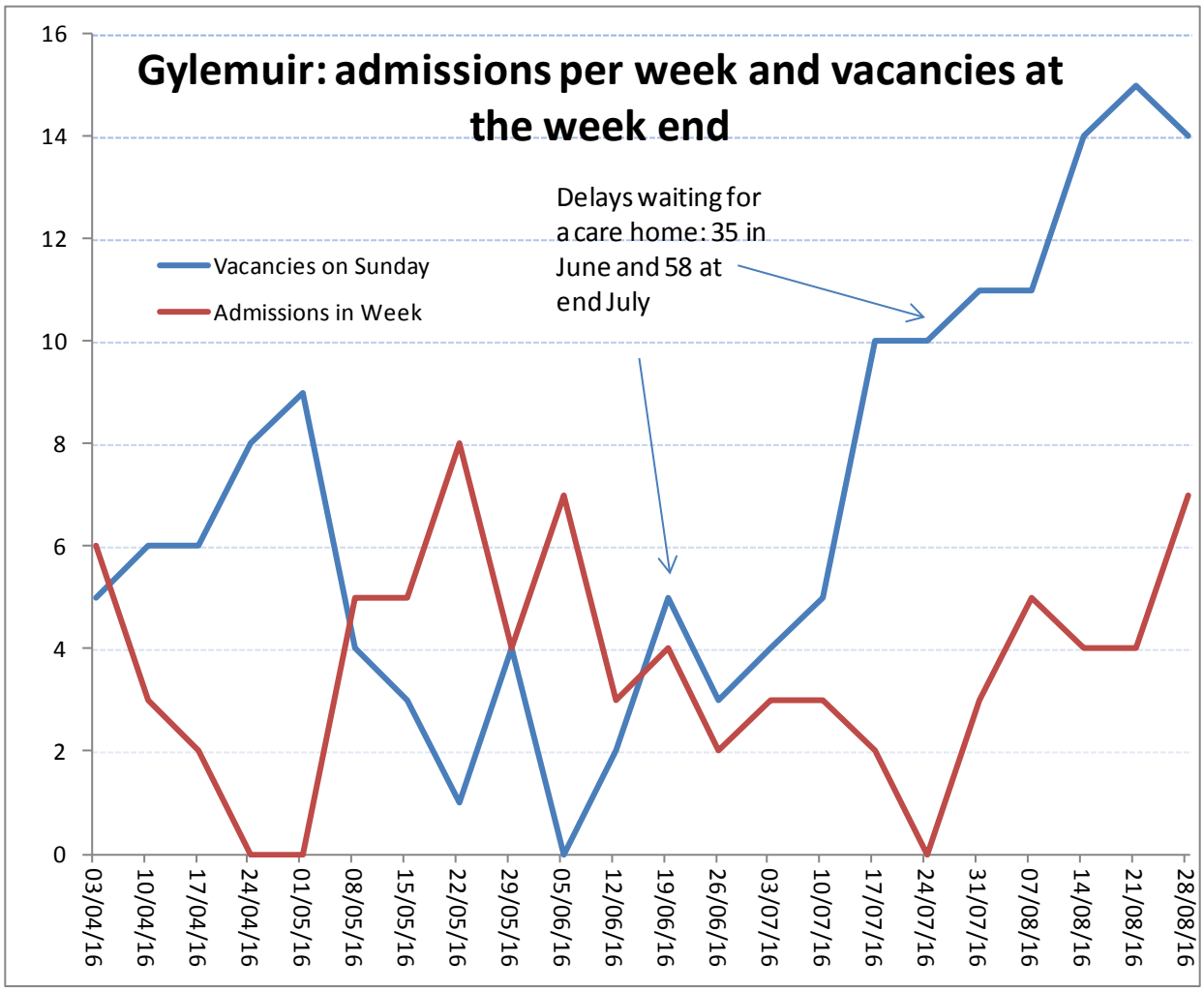
Appendix 3 – Delayed discharge codes (from July 2016)

Appendix 1

Target number of packages of support per week for people leaving hospital

Domiciliary care (excluding informal re-starts)	40
Care Homes	10
Intermediate Care and Interim Care	10
Total	**60**

Appendix 2: Gylemuir activity – admission and vacancies



Appendix 3 Delayed discharge codes (from July 2016)

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
Transport	44	Awaiting availability of transport

Patient/Carer/Family-related reasons		
Legal/Financial	51	Legal issues (including intervention by patient's lawyer) - e.g. informed consent and/or adult protection issues
	51X*	Adults with Incapacity Act
	52	Financial and personal assets problem - e.g. confirming financial assessment
Disagreements	61	Internal family dispute issues (including dispute between patient and carer)
	67	Disagreement between patient/carer/family and health and social care
Other	71	Patient exercising statutory right of choice
	71X*	Patient exercising statutory right of choice – interim placement is not possible or reasonable
	72	Patient does not qualify for care
	73	Family/relatives arranging care
	74	Other patient/carer/family-related reason
Other reasons		
Complex Needs	9	Code 9 should be used with the following secondary codes: 24DX, 24EX, 25X, 26X, 46X, 51X, 71X. All code 9 delays should have a secondary reason code.
Code 100	100	Reprovisioning/Recommissioning